CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 9DHU

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY A	GENCY	I	Facility ID: 00078
1. MEDICARE/MEDICAID PROVIDER N (L1) 245523 2.STATE VENDOR OR MEDICAID NO. (L2) 017740700	0.	3. NAME AND ADI (L3) GOOD SAM. (L4) 305 3RD AVE (L5) CLEARBRO	ARITAN SOCIE	CTY - CLEA) 56634	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7(L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	02 (L'	7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 04/13 . 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(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)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	43 (L18) 43 (L17)	B. Not in Com	ce With quirements	n	2. Tec 3. 24 4. 7-I	chnical Personnel	e Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room St 9. Beds/Room (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 43 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY M	MEETS r 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :				RVEY AGENCY AP		Date:
Lyla Burkman, Unit	•		04/15/2015	(L19)			, Enforcement Speci	04/15/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR	SINGLE STAT	TE AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			IPLIANCE WITH O	CIVIL	2.		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Clos 02-Dissatisfaction	on W/ Reimbursemen	INVOLUNT 05-Fail to M	L30) CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Invol	luntary Termination n for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	}		
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION (03/26/2015	OF APPROVAL DA		Posted 04/	/22/2015 Co.		
	(L32)			(L33)	DETERMIN	IATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245523

April 15, 2015

Mr. Gordon Hormann, Administrator Good Samaritan Society - Clearbrook 305 3rd Avenue Southwest Clearbrook, Minnesota 56634

Dear Mr. Hormann:

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

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

Effective March 25, 2015 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 15, 2015

Mr. Gordon Hormann, Administrator Good Samaritan Society - Clearbrook 305 3rd Avenue Southwest Clearbrook, Minnesota 56634

RE: Project Number S5523023

Dear Mr. Hormann:

On March 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 20, 2015. 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 April 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 30, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 20, 2015, effective March 25, 2015 and therefore remedies outlined in our letter to you dated March 5, 2015, will not be imposed.

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

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

Sincerely,

-Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697 5523s15

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA /	(Y2) Multiple Construction		(Y3) Date of Revisit
	Identification Number	A. Building		4/13/2015
	245523	B. Wing		4/13/2013
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - CLEARBRO	OOK	305 3RD AVENUE SOUTHWEST	
			CLEARBROOK, MN 56634	

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

(Y4) Item		(Y5)	Date	(Y4)	Item	((Y5)	Date	(Y4)	Item	((Y5)	Date
			Correction					Correction					Correction
15 5 °C			Completed		ID D 6			Completed		ID D . C			Completed
ID Prefix	F0248		_03/25/2015		ID Prefix	F0279		03/25/2015		ID Prefix	F0282		03/25/2015
_	483.15(f)(1)		-		-	483.20(d), 483.20(k)(1)				-	483.20(k)(3)(ii)		_
LSC			•	 	LSC				<u> </u>	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0311		03/25/2015		ID Prefix	F0318		03/25/2015		ID Prefix	F0329		03/25/2015
Reg. #	483.25(a)(2)				Reg. #	483.25(e)(2)				Reg. #	483.25(I)		
LSC			-		LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0353		Completed 03/25/2015		ID Prefix	F0441		Completed 03/25/2015		ID Prefix	F0520		Completed 03/25/2015
	483.30(a)		_			483.65					483.75(o)(1)		
LSC	403.30(a)		-		LSC	403.03				LSC	403.73(0)(1)		_
			-	-					+-				
			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			•		ID Prefix			•		ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC			-		LSC					LSC			_
												1	
Reviewed By	<i>'</i>	Reviewed I	Ву	Da	te:	Signature of S	urve	yor:				Date:	
State Agency	у	LB/mn	1	04	1/15/20	15		2803	55			04/1	3/2015
Reviewed By	<i>ı</i> —	Reviewed I	Ву	Da	te:	Signature of S	urve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:				Check for	any	Uncorrected	Defici	encies. Was	a Summary of		
	2/20/	2015				Uncorr	ecte	d Deficiencies	(CMS	S-2567) Sent	to the Facility?	YES	NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245523	(Y2) Multiple Constr e A. Building B. Wing	BUILDING WITH ADDITIONS	(Y3) Date of Revisit 3/30/2015
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - CLEARBRO	ООК	305 3RD AVENUE SOUTHWEST	
			CLEARBROOK MN 56634	

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	(Y	4) Item		(Y5)	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			03/25/2015		ID Prefix				ID Prefix			_
Reg. #	NFPA 101				Reg. #				Reg. #	-		_
LSC	K0029				LSC				LSC			_
			Correction				Correction					Correction
ID Danfin			Completed		ID Deefis		Completed		ID Deefin			Completed
ID Prefix					ID Prefix		=					_
Reg. #					Reg. #				Reg. #			_
LSC					LSC				LSC			
			0				0					0
			Completed				Correction					Correction Completed
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Reg. #							-		Reg. #			
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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Reg. #					Reg. #				Reg. #			_
LSC					LSC							_
Reviewed By	Review	ved B	у	Da	te:	Signature of Surve	yor:				Date:	
State Agency	, PS/	mn	ı	04	4/15/2015		272	200)		03/3	30/2015
Reviewed By	Review	ved B	Sy	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on:	:				Check for any	Uncorrected	Def	iciencies. Was	a Summary of	1	
	2/19/2015								MS-2567) Sent	_	YES	NO
				1								

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL ATE SURVEY AGENCY		ID: 9 Facilit	ty ID: 00078
1. MEDICARE/MEDICAID PROVID (L1) 245523 2.STATE VENDOR OR MEDICAID N (L2) 017740700		3. NAME AND AE (L3) GOOD SAM (L4) 305 3RD AV (L5) CLEARBRO	IARITAN SOO ENUE SOUTI	CIETY - (CLEARBROOK (L6) 56634	 Initial Termi Valida 	2. nation 4. ation 6.	2 (L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 02/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	OWNERSHIP 0/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATECO OS HHA O6 PRTF O7 X-Ray O8 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/II 12 RHC	14 CORF	FISCAL YE	urvey After Comp AR ENDING D. 2/31	•
2 AOA 3 Other		04 5111	00 01 1/01	12 Kile	TO HOST ICE			
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	43 (L18) 43 (L17)	Complianc1. Ao X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers O. 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code	1 6. So 7. M NF) 8. P 9. E	Requirements: cope of Services ledical Director atient Room Size Beds/Room	
		Requireme	ents and/or Appl	ied Waivers		(L12)		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)		1801 (6) (1) 01 1801 (1) (1).	(
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	1	Date:
Vienna Andresen, H	FE NEII	0	3/16/2015	(L19)	Mark Meath	, Enforceme	nt Specialist	03/25/2015 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	` ′	L OFFICE OR SINGLE S	STATE AGE	NCY	(EZO
DETERMINATION OF ELIGIBIT 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. 1. Statement of Fin2. Ownership/Contr3. Both of the Abov	ol Interest Discle	,	A-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	ī:	(L30)	
OF PARTICIPATION 02/01/1988	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure		INVOLUNTAR' 05-Fail to Meet I	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		06-Fail to Meet A	,
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal		OTHER 07-Provider Stat 00-Active	tus Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE	Posted 03/26/2015 Co).		

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 5, 2015

Mr. Gordon Hormann, Administrator Good Samaritan Society - Clearbrook 305 3rd Avenue Southwest Clearbrook, MN 56634

RE: Project Number S5523023

Dear Mr. Hormann:

On February 20, 2015, 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 1, 2015, 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 April 1, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Fax: (651) 215-0525

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

Sincerely,

Mark Weath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

cc: Licensing and Certification File 5523s15

PRINTED: 03/16/2015 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245523	B. WING _	····	02/20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE AP	JLD BE COMPLÉTION
F 000	INITIAL COMMENT		F 00	00	
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 248 SS=D	on-site revisit of you validate that substa		F 24	48	3/25/15
	of activities designed the comprehensive	ovide for an ongoing programed to meet, in accordance with assessment, the interests and all, and psychosocial well-being			
	by: Based on observative review, the facility for been offered according to the control of the c	NT is not met as evidenced tion, interview and document ailed to ensure activity's had ding to the assessed need for 10) reviewed for activities.		Preparation and execution of the response and plan of correction constitute an admission or agree the provider of the truth of the fa alleged or conclusions set forth is statements of deficiencies. The	does not ement by cts n the
	Findings include:			correction is prepared and/or ex- solely because it is required by the provisions of federal and state la	ecuted he w. For
	R10 was diagnosed	port dated 2/20/15, indicated divith Alzheimer's disease, phagia and depressive		the purposes of any allegation the center is not in substantial comp with federal requirements of part	liance
ABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

03/13/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIET			30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST ELEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	disorder. R10's annual Mini 7/4/14, indicated R cognition, required staff with transfers The MDS further is activities of interest - listen to music - participating in far - participate in reliance - participate - participa	mum Data Set (MDS) dated R10 had severely impaired dextensive assistance of two s and locomotion on the unit. Indicated R10 felt the following st were very important to her: avorite activities gious services or practice sive activities assessment indicated R10 enjoyed the interests: Children/youth, etry, tending garden, 1:1 ctivities that involved old time sic, movies, television shows by type interaction such as Little irie, beach ball toss, humor and visits, devotions, worship	F2	248	this response and plan of correction constitutes the center is allegation compliance in accordance with section 7305 of the State Operations Manual. 1. R10 was reassessed for her accordance in activities. Also considered is her to tolerate extended periods of sitting Care plan was updated and new placare was initiated. Ability to tolerate too long was addressed by inviting shorter activities and bringing her town if she says she needs to lay of 2. All current residents Care Plan reviewed and updated as appropriate activity preferences and abilities. 3. A system of staff notification she being developed to inform staff of residents that prefer certain activitic Changes will be monitored for and updated Quarterly with MDS and Activity Staff. a. There will be a notification she each activity topic b. On each sheet will be the nam residents that prefer this activity Staff will be able to track resident preferences with these notification sheets and be able to in activities of their choice Staff educated on 3-10-15 and 3-1 introduce new system of staff notification documentation of resident refunctivities. 4. Activity staff will audit this systepicking a different activity each day check if residents with that preferences with that	of stion ial. ctivity cipate ability ng. an of e sitting to o her down. sate with neets is es. prn by et for es of 1-15 to cation is als for em by and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634			20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	attend special even. On 2/17/15, from 4 was observed being meal and assisted in not involved with an On 2/18/15, at 9:30 seated in her room. 11:36 a.m. R10 was common corridor wroom for the noon of the dining room, early 2015, at 9: seated in front of the residents while the R10 had her eyes obe engaged in water on 2/19/2015, at 1 held and R10 was ractivity. On 2/19/2015, at 1 held and R10 was ractivity.	its, activities and meals. i45 p.m. until 7:30 p.m. R10 g assisted to eat the evening to bed at 7:23 p.m. R10 was ny activities. i a.m. R10 was observed. No television or radio on. At sobserved seated in the raiting to go into the dinning meal. i 44 a.m. R10 was observed in thing breakfast. i 34 a.m. R10 was observed in the raiting breakfast.	F 2	248	attending. Will do these 5 days a week for 2 then 1x a week x1 month, then q2 x 1 month. All findings will be repo QA committee for further recommendations. Activity Director will be responsible 5. Corrective action will be comp 3/25/2015	weeks rted to	
		n. a monthly resident birthday wever, R10 was not asked or					

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ISTRUCTION		E SURVEY IPLETED
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK	•	305 3R	T ADDRESS, CITY, STATE, ZIP CODE D AVENUE SOUTHWEST RBROOK, MN 56634	,	
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	assisted to join the Review of R10's ac	birthday party / activity. tivity documentation indicated	F 2	48			
	in 2 activities, howe documentation wha provided and if R10 activity or even like the activity participa February 2015, reve 22 1:1 activities and the actual type of a activity was not iden	O had attended / participated ever it was unclear by the at activities R10 had been actually participated in the did the activity. Further review of ation documentation in ealed R10 had participated in the did 11 group activities. However, activity and the length of the ark by a time and a checkmark etivity had occurred.					
	(AD) was asked who participated in on 2, 2/19/15, activity door first activity which to educational / cognit surveyor asked who R10 had participate AD stated she could exactly what the activity lasted. To call the activity pactivity in order to k was and how long in phone call to the 2/the call, the AD stat participated in a mucould not tell what pactivity occurred or how long the activity activity occurred or how long the activity.	8 a.m. the activity director at activities R10 had /19/15. The AD confirmed the cumentation and stated the pok place at 1:03 p.m. was an ive activity. When the at the actual activity was and if ad or enjoyed the activity, the don't tell by the documentation tivity actually was nor how long. The AD stated she would have erson who documented the now what the activity actually tractually actually tractually actually activity person. After activity on television but brogram it was, what time the if R10 enjoyed the activity nor y lasted but stated there was television. The AD also					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245523	B. WING _		02	/20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 248	confirmed R10 was service nor the group 2/19/15. The AD veidentified as activities tated R10 should leassisted to the activativity charting systyear and it was now activities residents the activities lasted activity. The AD state anywhere from 2-15 from a conversation member or simply the resident all of which 1:1 activity. The AD system did not give	ge 4 Inot assisted to the church up birthday party held on rified both activities were es of interest for R10 and have been asked to join and vities. The AD also stated the tem had changed in the past vitard to tell what specific actually attended, how long and if the resident enjoyed the ted 1:1 activities could last 5 minutes and could range in the hallway about a family urning on the television for an accurate reflection of how vity R10 had actually	F 24	48		
F 279 SS=D	and not provided. 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment.	CARE PLANS he results of the assessment and revise the resident's	F 2	79		3/25/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE D5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	to be furnished to highest practicable psychosocial well-§483.25; and any significant be required under due to the resident §483.10, including under §483.10(b)(a). This REQUIREME by: Based on intervier facility failed to demonitor side effect use for 1 of 1 reside couradin (an antieliminate or reduce addition, the facility management inter (R22) who was diabetic. Findings include: R22's Diagnosis RR22's diagnoses a heart rate), hypertecongestive heart fato pump blood), diareplacement.	attain or maintain the resident's e physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment 4). ENT is not met as evidenced w and document review, the velop care plan interventions to its of anticoagulation medication dent (R22) reviewed on icoagulation medication used to the the risk of blood clots). In y failed to develop diabetic ventions for 1 of 1 resident Report dated 12/29/14, identified its atrial fibrillation (irregular ension (high blood pressure), ailure (decrease in heart failure abetes and a heart valve	F 2	279	1. R22 Care Plan has been review and updated to reflect current diagrom and Atrial Fibrillation and Councuse. Interventions and monitoring heen added to Care Plan Nurses educated on 3/11/15 regarding Car Interventions, Updates and Develo CNA seducated on 3/11/15 regarviewing Care Plan interventions. 2. All resident Care Plans have be reviewed and updated as appropriacurrent unstable diagnosis per Car Policy and Procedure. 3. Upon admission of new residencomprehensive review will be comp With CP focuses and Interventions reflect current unstable diagnosis a interventions per CP Policy and Procedure. With change in any cur resident condition CP will be updat reflect unstable diagnosis. All Care will be reviewed and updated as appropriate with quarterly review and completion of MDS and prin with change in Care Plans on 3 residents per weeks then q2 weeks x4, then ran	nosis of nadin nave e Plan pment. ding een ate with e Plan nts pleted to and rent ed to e Plans audits veek x4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245523	B. WING		 	02/2	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	 Conduct blood Administer Coulevery Sunday, Tues Administer Coulet Thursday, and Sature 	ary Report directed staff to: glucose checks twice a day imadin 2.5 milligrams (mg) sday, Wednesday, Friday imadin 5 mg every Monday,	F 2	79	audits. All findings will be reviewed committee with action taken as needs. Completion date 3/25/15		
	R22's diagnosis of corresponding inter to observe for side therapy usage, suc bruising and internamonitoring (INR- lal levels). In addition, R22's diagnosis of corresponding inter to observe signs ar (high blood glucose blood glucose level	R22's care plan dated 12/29/14, failed to identify R22's diagnosis of atrial fibrillation and corresponding interventions which directed staff to observe for side effects of anticoagulation herapy usage, such as excessive bleeding, bruising and international normalized ration monitoring (INR- lab work to identify blood clotting levels). In addition, the care plan failed to identify R22's diagnosis of diabetes and the corresponding interventions which directed staff to observe signs and symptoms of hyperglycemic high blood glucose levels), hypoglycemic (low blood glucose levels), blood glucose monitoring and administration of insulin etc.					
	(DON) confirmed R fibrillation and was R22's care plan lac interventions with reanticoagulation maconfirmed it would lincluded on R22's of fibrillation and the santicoagulation the	4 p.m. the director of nursing 22 was on Coumadin for atrial a diabetic. The DON verified ked focus areas and egards to diabetes and nagement. The DON be appropriate to have care plan the diagnosis of atrial ide effect monitoring for rapy, in addition the care plan ore specific with regards to nagement.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245523	B. WING		 	02/2	20/2015
	PROVIDER OR SUPPLIER	- CLEARBROOK		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 7	F 2	279			
F 282 SS=E	each resident woul comprehensive can departmental asse any problems, need identified and addressure that the rescare and services. 483.20(k)(3)(ii) SEPERSONS/PER Compared to the services provided to the services and services are and services.	cy dated 9/2012, indicated d have an individualized re plan. Through the use of ssments and physician orders, ds and concerns would be essed. The care plan would ident received appropriate RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F 2	282			3/25/15
	by: Based on observareview, the facility faccordance with the care for 4 of 4 reside the sample who remotion services an required assistance the facility failed to offered according the need for 1 of 3 residentiation. Findings include:	tion, interview and document failed to provide services in e resident's written plan of dents (R21, R7, R49, R33) in quired assistance with range of d 1 of 1 resident (R21) who e with ambulation. In addition, ensure activity's had been o the residents care planned idents (R10) reviewed for			1. R 7, 21, 33 and 49 have had evaluations by skilled therapy and treatment as ordered. Plan of Care reviewed and after completion of skitherapy will have updated Restorati Nursing and/or Functional Maintena Program Implemented. R21 ambulation is being completed therapy at this time along with Rest LPN and CNA s as she allows. CF been updated to reflect resident wis regarding ambulation. R10 Activity preferences and ability participate in activities has been revand updated in Care Plan. Activity 8 educated on following POC on 3-10 and Nursing Staff educated on 3-11	killed ive ance I with corative has shes viewed Staff 0-15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 805 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	and range of motion care plan. R21's care plan date to provide R21 with 2-3 times a week. - ambulation and an exercised for the some x 20 repetition and a lifts with a hamstring cunder a ball squeezes minimal resistance and a standard encourage keeps and a support of the squeezes of the squeezes with squeezes and a squeezes of the	ated 5/12/15, directed the staff in nursing rehabilitation services. The plan included to following: Is tolerated the staff the staff the plan included to following: Is tolerated the plan	F 2	282	 LPN is filling Restorative Positic completing restorative services for residents with a Restorative and/of Functional Maintenance Program of Care. All current residents with Restorative/ Functional Maintenance program are currently being review updates or therapy referrals as appropriate. All staff responsible for resident were educated on Care Plan Policy Procedure including routine daily practice, development, implements and access to Care Plans on 3-11-nursing staff educated on 3-11-15 regarding following plan of care to the residents receive appropriate of services. With any turnover in staff with restorative position the position be posted internally, externally through the position will be covered by existing until filled. Therapy will be involved any noted changes, decline or inable tolerate restorative FMP. Any issue 	all or oer Plan ce yed and ation 15. All ensure are and ffing n will ough ary staff with bility to	
	On 2/18/15, at 3:00 stand and transfer of one staff memb limitations in her lo	not include R21's ambulation 0 p.m. R21 was observed to to a commode with assistance er. R21 did not display ROM ower extremities.			4. DNS or designee will complete weekly x4 weeks, then q2 weeks x random audits to follow to ensure Restorative/Functional Maintenanc Programs are being followed per F Care. Activities will be completing to ensure activities are being offerencouraged per resident preference days /week x2 weeks then 1x/weel	4 , then ee Plan of audits ed and ees 5	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245523	B. WING		 	02/20/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	feed herself the nodutensils without proutensils without proof On 2/19/15, at 1:20 and NA-B were obsambulate 36 feet in On 2/20/14, at 9:00 stated the facility diprovide the program was aware the restrained completed. She we been followed. R7 had not received as directed by her of R7's care plan date restorative interven physical mobility rel ROM. R7's care plan ROM.	p.m. nursing assistant (NA)-A served to assist R21 to the corridor. a.m. registered nurse (RN)-A d not have a restorative NA to a services and confirmed she orative programs had not been rified R21's care plan had not d restorative nursing services care plan. d 3/20/14, identified tions due to R7's limited ated to arthritis and her limited an directed staff to conduct	F2	282	month, then q2 weeks x1 month. A findings will be reported to QA for f recommendations. 5. Completion date 3/25/15		
	the following exerci Upper extremity program: upper ex overhead pulley x 3 extension: elbow ar cones off of the floo While seated in marching; heel/toe hamstring stretch a	y functional maintenance tremity bike with resistance; minutes; number 2 dowel nd shoulder 1 x 30; pick up					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		245523	B. WING		02	02/20/2015		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP O 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 282	On 2/18/15, at 1:00 propelling herself in	p.m. R7 was observed her wheelchair down the hom where she remained	F 2	82				
	currently did not ha restorative nursing	5 p.m. RN-A stated the facility ave anyone providing services. RN-A confirmed R7 er restorative nursing services care plan.						
		32 p.m. the director of nursing 16/14, was the last day R7 had e therapy.						
	R49 had not receiv as directed by his o	red restorative nursing services care plan.						
	restorative intervent performance deficit R49's care plan dir rehab 2-3 times a variable following exercises of leaving flexion, hamstri (exercise resistant bilateral abduction hamstring stretch all laying down: AR flexion and stretch. left; passive range	t and limited physical mobility. ected staff to conduct nursing week which included the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245523	B. WING		····	02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	REET ADDRESS, CITY, STATE, ZIP CODE 5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	2 x 20. PROM right up wrist, fingers, all pla movement of thum tolerated. Yellow textremity 2 x 10 ea and horizontal abduleft upper extremity x 10 beach ball. Ne	per extremity, shoulder, elbowenes 2 x 10 each. Encourage band pointer finger as band extension left upper ch elbow flexion, extension, uction/adduction. Ball toss to have him hit it back to you 2 eck stretches, have him look up al second seconds 1 x 10, do	F2	82			
	transferred with a number wheelchair to his be	p.m. R49 was observed being nechanical lift from his ed by NA-C and licensed N)-D. R49 required total nsfer.					
	had not received hi as directed by his overified 10/16/14, w	p.m. RN-A confirmed R49 s restorative nursing services are plan. In addition, RN-A was the last day the facility had restorative nursing services.					
		22 p.m. the DON confirmed the a formalized restorative					
		led restorative nursing d by her current care plan.					
		s indicated on the Diagnosis					

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, Z 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 282	generalized osteoa failure, bursitis disorderessive disorderessive disorderessive disorderessive disorderessive disorderessive disorderessive disorderessive disorderessive disorderes deficity, transfipersonal hygiene. In motion (ROM) impand lower extremition (ROM) impand lower extremition (ROM) impand lower extremition disorderes disordered disorderes disordered disordered staff to conduct a week which inclusion. Overhead pullered planes 20 each. As a Bilateral stretch minutes each. Sit the work on standing to the Kegals for streed disordered manual adduction stand in shifting for 5 to 10. On 2/20/15, at 10:0 had not provided a exercises to any reserved months. On 2/20/15, at 10:3 had not received here several months.	arthrosis, congestive heart orders, generalized pain and r. Inimum data (MDS) set dated I R33 had severe cognitive quired extensive assist with terring toileting, dressing and n addition, R33 had range of airment on both sides for upper es. Ited 2/19/15, identified ations due to performance cal mobility. R33's care plan anduct nursing rehab 2-3 times ded the following exercises: by X 3 minutes Yellow t-band all sist to stand all directions including tham curls and sit to stand 1-2 to stand in parallel bars and oblerance sis incontinence lly resisted abduction and stand aid and work on weight minutes. Item 18	F 2	82				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED		
		245523	B. WING		0:	2/20/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CO 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	of restorative service had not provided residents for the particle. On 2/20/15, at 11:1 had not received residents for the particle. The DON been provided the scare plan.	ast day R33 received any type ces. RN-A stated the facility estorative services to the	F 2	82			
	6/2012, indicated the care was to assure independence for eand declines were would receive restreated extent possible, an strengths, needs an nursing assessment care would be outlined.	ne goal of restorative nursing the maximum possible each resident was maintained prevented. Each resident orative nursing care to the d based on their individual and problems as defined by the ots. In addition, the restorative ned in the resident's care plan.					
	directed by the care	ed to participate in acitivies as e plan. port dated 2/20/15, indicated d with Alzheimer's disease.					
	indicated R10 was activities, cognitive interaction. The cal R10 1:1 bedside/in attend out of room activities such as c stay in room, naps,	ted as last revised on 1/13/15, dependent on staff for stimulation and social re plan directed staff to provide room activities if unable to events as well as preferred onversation, music, prefers to children, outdoor and spiritual lan had not identified how					

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		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	often 1:1 activities who preferred to strequency of the dir family involvement,	were to be provided to R10 ay in her room nor the rective to encourage ongoing invite residents and family to its, activities and meals.	F 2	282			
	was assisted with e	:45 p.m. until 7:30 p.m. R10 eating the evening meal and 7:23 p.m. R10 was not involved					
	On 2/18/15, at 9:30 a.m. R10 was observed seated in her room. No television or radio on. At 11:36 a.m. R10 was observed seated in the common corridor waiting to go into the dinning room for the noon meal.						
	On 2/19/2015, at 8: the dining room, ea	44 a.m. R10 was observed in ting breakfast.					
	seated in front of the residents while the	34 a.m. R10 was observed te television with other morning news show was on. closed and did not appear to ching the television.					
		1:03 a.m. Church service was not assisted to the service /					
		:00 p.m. R10 was observed non lounge area just watching					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/:	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	REET ADDRESS, CITY, STATE, ZIP CODE 5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
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F 282	Continued From pa	ge 15	F 2	82			
	birthday party was I	p.m. a monthly resident neld. However, R10 was not to the birthday party / activity.					
	(AD) was asked wh participated in on 2/2/19/15, activity doc first activity which to educational / cognit surveyor asked wha R10 had participate AD stated she coule exactly what the activity last was not assisted to	8 a.m. the activity director at activities R10 had (19/15. The AD confirmed the cumentation and stated the pok place at 1:03 p.m. was an ive activity. When the at the actual activity was and if ad or enjoyed the activity, the donot tell by the documentation tivity actually was and how seed. The AD confirmed R10 the church service nor to the y held on 2/19/15, and should					
F 311 SS=D	care plan would em development of the the resident receive services.	cy dated 9/2012, indicated the phasize the care and whole person ensuring that ed appropriate care and TMENT/SERVICES TO IN ADLS	F3	311			3/25/15
	services to maintain	the appropriate treatment and n or improve his or her abilities uph (a)(1) of this section.					
	This REQUIREMEN	NT is not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	, 52	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	by: Based on observareview, the facility for services in order to resident's ability to (R21) in the sample nursing rehabilitation. Findings include: R21's quarterly Mir 1/27/15, indicated Idementia and anxioning airment and recombination in in the corridor. The R21 displayed physher lower extremition. R21's care plan dates assist R21 to ambured a week at R21's Restorative of 10/3/12, by the physher lower extremition. R21's Restorative of 10/3/12, by the physher lower extremition. R21's Restorative of 10/3/12, by the physher lower extremition.	tion, interview and document failed to provide ambulation improve or maintain the ambulate for 1 of 4 residents e who were reviewed for on ambulation services. Inimum Data Set (MDS) dated R21 was diagnosed with ety, had severe cognitive quired extensive assistance her room and did not ambulate assessment also indicated sical limitations on one side of es. Ited 5/12/15, directed staff to alate with a two wheeled walker is tolerated. Care Program established resical therapist directed staff to a two wheeled walker as R21 conducted on 2/17/15, from p.m., on 2/18/15, from 7:00 a.m. ras observed to utilize a	F 31	1. R21 CP reviewed, updated resident current abilities and progregarding ambulation. R21 curr working with skilled therapy ser CNA s / Restorative ambulatin resident as she allows. All nursi educated on 3-11-15 regarding plan of care to ensure the resid receive appropriate care and set 2. LPN is filling Restorative Procompleting restorative services residents with a Restorative and Functional Maintenance Prograt of Care. All current residents with Restorative / Functional Mainter program are currently being revupdates or therapy referrals as appropriate. 3. All nursing staff educated or regarding following plan of care the residents receive appropriates services. All staff responsible for care educated on Care Plan Por Procedure including routine daid development, implementation at Care Plans. With any turnove staffing with restorative position position will be posted internally externally through online postion position will be involved with an changes, decline or inability to the restorative FMP. Any issues with brought up with QA committee. 4. DNS or designee will comp weekly x4 weeks, then q2 weeks.	eferences ently is vices. g with ng staff following ents rvices esition and for all d/ or m per Plan th ance iewed and in 3-11-15 to ensure e care and r resident licy and y practice, nd access er in the g, will be ed. y noted olerate ll be	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 311	stand and pivot-trar assistance of one s during this observation of the services. R21's clir further documentation of the services. R21's clir further documentation of the services. The last of the was documented of the services. The last of the was documented of the services. The last of the was documented of the services. The last of the was documented of the services. The last of the was documented of the was documented of the services. The last of the was documented of the was documented of the services. The last of the was documented of th	p.m. R21 was observed to asfer to a commode with taff member. R21 did not walk tion. 4, Follow Up Question Report documentation) indicated ed assistance with ambulation nical record did not contain any ton related to ambulation entry related to ambulation in 10/16/14. p.m. family member (FM)-A at recall the last time she had e. She stated R21 had her had not seen the walker in s. FM-A stated she was not ability to ambulate. p.m. nursing assistant (NA)-A at R21 to ambulate. p.m. nursing assistant observed to the therapy room and lA-A and NA-B were observed affect in the corridor. At this ated the facility usually had a vide personal cares to the the facility did not have a ovide restorative services.	F3	311	random audits to follow to ensure Restorative Programs are being fo per POC. All findings will be report QA for further recommendations 5. Completion date 3/25/15		
	On 2/19/15, at 1:30	p.m. NA-B stated the facility					

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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
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F 311	had been short state residents had not re	f members therefore, the eccived assistance with because they did not have	F3	311			
	(LPN)-A stated the nursing assistants to	p.m. licensed practical nurse facility had been short of for the past several months. ity did not have the staff to nursing.					
	On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services.						
	had staffing issues. doing the best they	p.m. LPN-B stated the facility She stated the staff were could, but they did not have restorative programs for the					
	stated R21's ability related to the amount having. She confirm not direct the staff a ambulate. She state offered assistance facility did not curred She stated the facil NA who was in charestorative nursing of 2014, the restorative RN-A stated the facil RN-A stated the facil state of the st	a.m. registered nurse (RN)-A to ambulate fluctuated daily ant of back pain she was ned R21's clinical record did as to how far R21 was to ted R21 had not been routinely to ambulate because the ently have a restorative NA. ity use to have a restorative rge of completing the program, however, in October ative NA had left the facility. cility had hired another NA to rative programs, however, she					

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F 311	because she was n the residents instea none of the restora completed as direc concern to the direc verified R21's care	ge 19 ed to provide the services eeded to provide direct care to id. She stated she was aware tive programs had been ted and had reported the ctor of nursing (DON). RN-A plan had not been followed to services were provided to	F 3	11		
F 318 SS=E	care plan would em development of the the resident receive services. 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility	rehensive assessment of a must ensure that a resident	F 3	18	3	3/25/15
	appropriate treatmerange of motion and decrease in range of motion and decrease in range of the second seco	NT is not met as evidenced cion, interview and document ailed to provide range of order to maintain or prevent of motion (ROM) ability for 4 of 17, R49, R33) in the sample		1. R 7, 21, 33 and 49 have had evaluations by skilled therapy antreatment as ordered. Plan of Careviewed and after completion of therapy will have updated Restor Nursing Program Implemented. 2. LPN is filling Restorative Posicompleting restorative services for	d re skilled ative tion and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	TREET ADDRESS, CITY, STATE, ZIP CODE 15 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	Findings include: R21 did not ROM s plan. R21's quarterly Min 1/27/15, indicated F dementia and anxis impairment and rec with bed mobility, tr and had unilateral limitations. R21's care plan dat provide R21 with nu a week. The plan in Seated over head the search of	imum Data Set (MDS) dated R21 was diagnosed with ety, had severe cognitive quired extensive assistance ansfers, dressing, grooming ower extremity physical red 5/12/15, directed staff to ursing rehabilitation 2-3 times included: lead bounce passes x 20 over head pulleys I (elastic exercise strap) houlder and elbow stretches walk to elevated with walker a three pound weight Is with a red theraband and hip abduction with or red theraband tercises as tolerated.	F3	318	residents with a restorative/function maintenance program per Plan of All current residents with Restoratir Functional Maintenance program acurrently being reviewed and upda therapy referrals as appropriate. 3. Nursing Staff educated on 3-1 regarding Care Plan Policy and Program and following plan of care to ensur residents receive appropriate care services including routine daily pradevelopment, implementation and to Care Plans. With any turnover in staffing with restorative position the position will be posted internally, externally through online posting, newspaper, radio, Facebook as appropriate. Temporary position with covered by existing staff until filled. Therapy will be involved with any nuchanges, decline or inability to tole restorative FMP. Any issues will be brought up with QA committee. 4. DNS or designee will complete weekly x4 weeks, then q2 weeks x random audits to follow to ensure Restorative Programs are being foper POC. All findings will be report QA for further recommendations. 5. Completion date 3/25/15	Care. ve/ tre tes or 1-15 cedure e the and ctice, access te Il be oted rate e e audits 4, then Illowed	

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F 318	squeezes and hip a resistance or red the repetitions and sit to tolerated.	ourls with red theraband, ball abduction with either manual eraband bilaterally x 15 o stand exercises as R21	F 3 ⁻	18			
	(restorative nursing R21 had received F	4, Follow Up Question Report documentation) indicated ROM 6 of 15 opportunities. ed assistance with ROM on					
	R21's clinical record did not contain any further documentation related to the restorative nursing program services.						
	stand and transfer	p.m. R21 was observed to to a commode with assistance er. R21 did not display ROM wer extremities.					
		0 p.m. R21 was observed to on meal. R21 was able to use blems.					
	stated the facility us provide personal ca did not have a resto assistance with res	p.m. nursing assistant (NA)-A sually had enough staff to ares to the residents, however, prative NA to provide torative services. NA-A stated had a restorative NA for the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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F 318	On 2/19/15, at 1:30 had been short staresidents did not re	p.m. NA-B stated the facility ff members. She stated the acceive assistance with because they did not have	F 31	8		
	(LPN)-A stated the nursing assistance	p.m. licensed practical nurse facility had been short of for the past several months the staff to provide restorative				
	assistants did not h nursing services. A stated the facility h were doing the bes	p.m. NA-C stated the nursing have time to provide restorative of the same time, LPN-B and staffing issues and the NAs at they could, but did not have a restorative programs for the				
	stated the facility uncharge of completing program, however, restorative NA had the facility had hire restorative program allowed to provide needed to provide instead. RN-A state the restorative program directed and had redirector of nursing care plan had not be	o a.m. registered nurse (RN)-A se to have a NA who was in any the restorative nursing in October of 2014, the left the facility. RN-A stated d another NA to complete the as, however, she had not been the services because she was direct care to the residents ed she was aware that none of grams had been completed as exported the concern to the (DON). RN-A verified R21's been followed to ensure services were provided.				

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F 318	cue R21 to raise he her arms above her outward and compl shoulders. R21 wa	ge 23 a.m. RN-A was observed to er arms. R21 was able to raise head, extended her arms eted a full circle with her s not observed to display any ions in her upper extremities.	F3	18			
	as directed by her of R7's diagnoses, as Report, included shanemia, Alzheimer' congestive heart fa function to pump bl R7's quarterly MDS had moderate cognextensive assist wit locomotion on and personal hygiene. In	indicated on the Diagnosis ortness of breath, cataracts, s, generalized pain, ilure (decrease in heart ood), depression and arthritis. dated 11/26/14, indicated R7 itive impairment and required h bed mobility, transferring, off the unit, toileting and n addition, R7 had ROM ower extremities (hip, knee,					
	restorative interven physical mobility rel ROM. R7's care planursing rehab three the following exerci Upper extremity program: upper ex	d 3/20/14, identified tions due to R7's limited ated to arthritis and her limited an directed staff to conduct times a week which included ses: y functional maintenance tremity bike with resistance; minutes; number 2 dowel					

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F 318	extension: elbow a cones off of the flo. While seated is marching; heel/toe hamstring stretch a sets, hamstring set. On 2/18/15, at 2:45 currently did not have restorative nursing been about two modern without someone in R7 had not received.	age 24 nd shoulder 1 x 30; pick up or x 1 while seated. In the wheelchair: hip flexion, raises x 10 each side; supine: and calf stretch 2 x 30, quad its and heel slides x 10 each. 5 p.m. RN-A stated the facility ave anyone providing services. RN-A thought it had onths that the facility had gone in this position. RN-A confirmed and her restorative nursing id on her care plan.	F3	318			
	(PTA)-A stated she have a current rest place. PTA-A state frustrated because see a resident, a re	O p.m. the physical therapy aide was aware the facility did not torative nursing program in ed the therapy department was when they no longer could estorative program was set up d we know they are not eeded.					
	propelling herself in	D p.m. R7 was observed in her wheelchair down the om where she remained elchair.					
		32 p.m. the DON verified last day R7 had received					
	On 2/20/15, at 9:32	2 a.m. occupational therapist					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 318	and evaluation on F extension of her up assisted R7 into the propel herself in he and with a gait belt and completed the the toilet with minim on review of R7's b today, she did not stransfers and upper OT-A thought it wou to work with R7, evitime. R7's occupational the 2/20/15, indicated F occupational therap The occupational the	ed conducting an assessment R7. OT-A stated R7 had full per extremities. OT-A be bathroom. R7 was able to r wheelchair into the bathroom around R7's waist; R7 stood transfer from the wheelchair to hal assistance. OT-A stated aseline and where R7 was see a decline in her ability with r body strength. However, all be appropriate for therapy en just for a short period of the herapy plan of care dated R7 had not received skilled by services since 5/4/2012. The herapist stated R7 would	F3	18		
	compensatory tech levels. In addition, for further gains wit transfers. R49 had not receive as directed by his compensatory as diagnosis, as Report, included ce (stroke), congestive or total loss of ability.	ed work with breathing and niques to improve her energy the resident showed potential h upper extremity strength and ed restorative nursing services urrent care plan. sindicated on the Diagnosis rebrovascular disease heart failure, aphasia (partial y to communicate), atrial heart rate), anxiety and				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	R49 had severe correquired extensive transferring, dressir hygiene. In addition on one side for upp R49's care plan data restorative interven performance deficit R49's care plan dire rehab 2-3 times a war following exercises: If seated: active hip flexion, hamstring (exercise resistant bilateral abduction a hamstring stretch a If laying down: AR6 flexion and stretch. left; passive range of knee flexion and stretch. left; passive range of knee flexion and stretch. PROM right up wrist, fingers, all pla movement of thumber tolerated. Yellow the extremity 2 x 10 earned horizontal abduleft upper extremity x 10 beach ball. Neup and hold for sev do this to each side	S dated 12/9/2014, indicated gnitive impairment and assist with bed mobility, ng, toileting and personal, R49 had ROM impairment er and lower extremities. ed 10/26/14, identified tions due to R49's and limited physical mobility. ected staff to conduct nursing week which included the extremities with yellow t-band band) 2 x 10 on right; AROM and adduction 2 x 10, and heel cord stretch bilaterally, DM on right hip and knee Abduction and adduction on of motion (PROM): hip and retch, abduction and adduction and adduction and adduction and addu	F3	118			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245523	B. WING		·····	02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	and Discharge Sun R49 had participate PT had worked with increase his lower of addition, they we amount of assistant which resulted in lit discharged from Pfunctional maintenance provided the directi R49's care plan with maintenance progretherapy. On 2/18/15, at 2:09 transferred with a rewheelchair to his be practical nurse (LP assistance with transferred by his coverified 10/16/14, we someone providing On 2/19/15, at 11:1	nmary dated 9/30/14, indicated ed in PT from 9/5/14 - 9/30/14. In R49 and attempted to extremity strength bilaterally. In R49 and extremity strength bilaterally. In R49 and extremity strength bilaterally. In R49 and extremity strength bilaterally. In R49 was of services and placed on a sance program. Care Program dated 10/10/14, on which was reflected on having the regards to his functional am as recommended by the p.m. R49 was observed being nechanical lift from his led by NA-C and licensed N)-D. R49 required total	F3	318	,		
		0 a.m. NA-B confirmed she estorative nursing exercises					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 318	Continued From pa with the residents.	ge 28	F 3	318			
	sometimes she wor residents; however NA-A stated the fac	3 a.m. NA-A confirmed uld do exercises with the she did not document these. sility used to have a restorative tercises with the residents.					
		0 a.m. NA-F confirmed she estorative nursing exercises					
		2 p.m. the DON confirmed the a formalized restorative					
	assessment and exconcluded that throwhich she conducted	a.m. PT-A conducted an valuation on R49. PT-A ugh her partial evaluation ed today and her review of on she had not seen a decline					
	R33 had not receiv as directed by her	ed restorative nursing services current care plan.					
	Report, included ch generalized osteoa	indicated on the Diagnosis pronic airway obstruction, rthrosis, congestive heart orders generalized pain and r.					
		S dated 10/25/14, indicated gnitive impairment and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245523	B. WING		 	02/2	20/2015
	ROVIDER OR SUPPLIER	- CLEARBROOK		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	transferring, toileting hygiene. In addition on both sides of up R33's care plan darestorative interver deficit/limited physidirected staff to coa week which inclusion. Overhead pulle planes 20 each. As Bilateral stretch hamstring stretch, minutes each. Sit twork on standing to Kegals for stresseated manual adduction stand in shifting for 5 to 10 R33's Physical The and Discharge Sur R33 had participate 9/7/12. PT had work her lower extremity status. PT provided R33's abilities in all discharged from Prestorative services maintain strength from m	assist with bed mobility, and, dressing and personal and, R33 had ROM impairment oper and lower extremities. Ited 2/19/15, identified antions due to performance ical mobility. R33's care plan and and the following exercises: by X 3 minutes Yellow t-band all exist to stand and all directions including tham curls and sit to stand 1-2 to stand in parallel bars and oblerance incontinence and sit in parallel bars and stand aid and work on weight minutes. Perapy (PT)- Therapist Progress the mary dated 9/15/12, indicated and in therapy from 8/9/2012 - the with R33 and had gains in a ROM and improved transfer digait services which improved I functional mobility. R33 was T services and placed on a	F3	318			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		245523	B. WING _		02	/20/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 318	had not provided a exercises to any re On 2/20/15, at 10:1 not received restor several months. On 2/20/15, at 10:2 R33'S physical their verified R33's restor recommendations was 9/10/12. PTA-/expectation the factor services. PTA-A coassessment following and verified there with the physical mobility. On 2/20/15, at 10:3 had not received redirected by her carry was the last day R3 services. RN-A starrestorative services. On 2/20/15, at 11:1 10/14/14, was the last day R3 services.	15 a.m., NA-C verified that he my restorative nursing sident. 0 a.m. LPN-B stated R33 had ative services for the past 11 a.m. during observation of capy assessment, PTA-A	F 31	,			
	6/2012, indicated the care was to assure independence for eand declines were	e plan. ursing Care policy dated ne goal of restorative nursing the maximum possible each resident was maintained prevented. Each resident brative nursing care to the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 F 329 SS=D	strengths, needs ar nursing assessmer care would be outline	d based on their individual and problems as defined by the ats. In addition, the restorative ned in the resident's care plan. EGIMEN IS FREE FROM	F3				3/25/15
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and residendrugs receive gradubehavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical atts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on observative review, the facility f	NT is not met as evidenced tion, interview and document ailed to ensure there was a for the use of Seroquel			 R48 seen by MD on NH Round Reduction of Seroquel started 3 with potential for DC as appropriate 	3-5-15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		LE CONSTRUCTION		SURVEY PLETED
		245523	B. WING			02/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- CLEARBROOK			305 3RD AVENUE SOUTHWEST		
GOOD O	AMAINTAN OOOILTT	CLEARBROOK		(CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 32	F 3	329			
	(anti-psychotic) me	dication for 1 of 5 residents e reviewed for unnecessary			Mood/behavior monitoring being completed currently. Diagnosis was updated per MD to indicate current diagnosis of Psychosis and Delusionafter MD reviewed chart and evaluations.	ons	
	Findings include:				resident. Behavioral Interventions in Care Plan to reflect current behavioral interventions to reduce behavioral interventions to reduce behavioral interventions to reduce behavioral interventions.	updated viors	
	R48 was diagnosed generalized pain, d	eport dated 2/20/15, indicated d with memory loss, ementia with behavioral ralized anxiety disorder and			without pharmacological interventic Pharmacist will review and make recommendation in regards to alte behavioral interventions/medication 2. All residents with antipsychotic medications have been reviewed a again be reviewed by Pharmacist.	nnate ns. nd will	
	9/1/14, identified RaLPN and R48 had hearing, was able to understood, had se displayed patterns (disorganized or illorambling or irreleva illogical flow of idea switching from one admission MDS als delusions, was indead	inimum Data Set (MDS) dated 48's lifetime occupation was a moderate difficulty with colearly make self verely impaired cognition, and of disorganized thinking egical flow of conversation nt conversation, unclear or s, or unpredictable speech idea to the next rapidly). The oidentified R48 had ependent with ambulation and did not have any balance			Plans have been reviewed and upor regarding behavioral interventions updated as appropriate. 3. Prior to start of Antipsychotic medications resident will be monitoral and Care Plans updated to reflect behavioral interventions to decrease behaviors nonpharmacologically. A report appropriate diagnosis with uneeded medications. Pharm D will monthly with recommendations as appropriate. Reductions will be corrust appropriate to meet lowest dose maintain function. Facility is in the of procuring Mental Health MD to complete NH Rounds in facility.	dated and ored for current se MD will se of review on pleted e to	
	following: R48 is or attempting to elope other resident up, s Reduction attempte interventions includ WARNINGS: #1 Other	t revised 12/6/14, revealed the Seroquel related to attempting to toilet or get toring garbage in drawers. End in November 2014. The ed the following: "BLACK BOX observe for increased mortality with dementia-related			Reviewed quarterly with MDS and changes. Nursing Staff educated 3 regarding behavioral interventions, Psychotropic medications and follo Psychotropic Medication Policy and Procedure. All findings will be reported. 4. DNS or designee will complete	-11-15 use of wing d orted to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE D5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634	, , ,	, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	suicide risk. Potemagitation, anxiety, i constipation, dizzir has a behavior synwanders, attempts other residents for cares Intervene as necessafety of others, as manner, divert atteand take to an alte opportunity for pos Minimize potential behaviors, elopem which divert attenti puzzles and visiting indication of reside behavior. Resident as listed above puzzles as listed above puzzles when the care plan identification of resident as listed above puzzles of the care plan identification for PRN -BEHAVIOR #1 eloscrabble, puzzles when the care plan identification for garbage or food-BEHAVIOR #2 Std drawers. Check drawers. Check drawers attempting to toilett every 30 minutes. Outside. Redirect. R48's Social Servicincluded the follow behavior symptom	worsening of depression and tial adverse effects include ncreased cholesterol, ness, drowsiness. The resident optom related to poor memory, elopements, attempts toileting as in at night and awakes other. The interventions included: sarry to protect the rights and oproach and speak in a calm ention, remove from situation rnate location, provide itive interaction and attention. for residents disruptive ent attempts by offering tasks on such as scrabble games g with other ladies. Praise any ents progress/ improvement in at prefers diversional activities excles, scrabble. tified the following behaviors: spement attempts: likes with other ladies. Target Xanax. oring garbage in dresser esser drawers once every shift	F3	29	on all resident with Antipsychotic medications q2 weeks x4, then moreview per Pharm D. 5. Completion date 3/25/15	nthly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIF 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 329	residents for cares. same as above whand interventions the section of the care aforementioned progresident has potent dementia, less than included: check resident has potent dementia, less than included: check resident help the nurses in tresidents. The physician progress 12/18/14, which ide prescribed the antip behaviors that inclusione behaviors who care of the patient, feed them, entering etc." The physician helping." but does a behaviors occurred interventions attem	The care plan is virtually the ere it lists the same problems here is nothing new in this plan just a repeat of the oblem and intervention. The cial for elopement related to a 5 minute recall. Interventions eldent every 30 minutes. Ogress notes dated 11/10/14, was started because R48 had alded wanting to assist in the ents in the facility as well as the facility care for the elician progress note indicated nations or delusions. The next note provided was dated entified that R48 was obsychotic medication for added: "continues to have here she tends to interrupt the like transferring them, trying to go into other residents' rooms, wrote "Seroquel seems to be not identify how often the l, non-pharmacological	F3	329			
	11/17/14, indicated and the NPN dated Seroquel had been no physician progre	ress notes (NPN) dated Seroquel was discontinued 12/4/14, identified the restarted, however there was ess note that explained the ng the medication on 11/17/14,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		MPLETED
		245523	B. WING _		02	2/20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	Review of R48's ph	e medication on 12/4/14. ysician orders revealed that	F 3:	29		
		uel 25 milligrams (mg) (an cation) was restarted for aviors.				
	that monthly summ	48's medical record revealed aries of behavior were lay and night shift from 9/1/14-ed the following:				
	identified R48 had I included delusions are firmly held, con section of the repor restless at times ar quickly will settle do gets distracted talk activity. Seems to be documentation had behavior was occur pharmacological ar interventions were	ocumentation dated 9/16/14, behavior symptoms that (misconceptions or beliefs that trary to reality.). The comment it identified "res becomes and walks hallways rather own after gets ready for bed or ang with other ladies or an oe worse in evening. The not identified how often this tring nor what type of and non-pharmacological attempted to remove or relieve oms and if they were				
	9/17/14, identified F symptoms exhibited documentation had behaviors were or h The boxes that iden interventions include	r nursing documentation dated R48 had mood and behavior d during the night shift. The dinot identified what the now frequently they occurred. Intified non-pharmacological ed "phone calls to daughter, aterials and TV programs."				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		305	REET ADDRESS, CITY, STATE, ZIP CODE 3RD AVENUE SOUTHWEST EARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	available." Under t was identified that I roommate." Under as "Specify:" the fol and confusion."	ge 36 terventions were "PRN Xanax he section for sleep patterns it R48 had "Issues with the section that was identified llowing was written: "Anxiety	F 3	29			
	identified R48 had a included delusions. report identified "be evening wanting to into other residents walking up and down kitchen wanting to a times when told she toilet transfer states do what she wants often not successfuterm memory. The identified how often and what type of phenon-pharmacological attempted and if the "Some decrease in Seroquel. Will cont documentation date mood and behavior the night shift. The identified what the lifter frequently they had monthly nursing do identified non-pharmicluded "Redirect pharmacological in the seven in the service of the seven in the service of the seven in the service of the seven in the	cehavior symptoms that The comment section of the ecomes very restless in the push other residents, going rooms wanting to help on hallwaysgoing to the help,,, becomes agitated at e is not to help either residents this is her house an she can here,,,needs redirection that is all related to poor and short documentation had not this behavior was occurring					

-	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245523	B. WING			02/	20/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	, 02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	dated 12/24/14, ide symptom. Night shi dated 12/18/14, ide and behavior symp but had not identifie how frequently they that identified non-pand pharmacologic blank. Further docuappeared to rest co	ge 37 Ithly nursing documentation ntified again no behavior ft monthly documentation ntified that R48 had mood toms exhibited during the night ed what the behaviors were or had occurred and the boxes pharmacological interventions al interventions were left imentation identified R48 emfortably through the night.	F3	329				
	dated as completed had no behavioral of documentation ider and paced up and or redirect most of the included Seroquel's monthly nursing do 1/18/15, identified F symptoms exhibited identified what the liftequently they had identified non-pharm pharmacological into the symptoms of the sy	athly nursing documentation of on 1/24/15, revealed R48 or mood symptoms. The office R48 got very anxious down the hallways, unable to time. New medications started on 12/18/14. Night shift cumentation completed R48 had mood and behavior of during the night but had not behaviors were or how occurred and the boxes that macological interventions and terventions were left blank. tion identified R48 appeared to rough the night.						
	reports were review the following was ic -On 11/17/14, the p included: "Please u	pacist drug regimen review yed from 9/1/14-2/1/15, and lentified: harmacist recommendations pdate care plan to reflect non se to try, consider discontinuing						

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY IPLETED
		245523	B. WING		-	02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STAT 305 3RD AVENUE SOUTHWI CLEARBROOK, MN 5663	EST	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 329	place. If medication trazodone 12.5 mg Please document in failed and perform analysis at least quidetermine triggers re-assess/update cwas no indication the recommendation has entirety. The Seroq 11/17/14, however started in it's place,	he non- pharm interventions in is needed, consider BID instead of Seroquel. on pharm interventions which qualitative and quantitative arterly of this information to of the behaviors and are plan as needed." There	F 3	29			
	recommendations in "Discussed need to interventions and to psychotropics with aware. Utilize antipreasons for behavior documenting intervanalysis of behavior patterns, # of times around the behavior needed continues On 2/18/2015 11:20 seated in the commendations and the commendations are seated in the commendations.	DON and staff. They are sychotic when all other ors are ruled out. Be sure entions failed and perform rs at least quarterly for , other pertinent information rs. Update care plan as from Nov." Dia.m. R48 was observed non lounge area nicely dressed					
	holding her purse. I was getting ready to was a few blocks a was just working he still had a car in the	R48 told the surveyor that she of go home and that her house way from here and that she ere filling in. R48 stated she of garage at home and was it for a drive into the country					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		245523	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		305	REET ADDRESS, CITY, STATE, ZIP CODE 5 3RD AVENUE SOUTHWEST EARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	the nursing home r retired. R48 stated practical nurse (LP residents and helpi could.	age 39 ated she was working here in allow only part time as she was that she was a licensed N) and liked visiting with the ng them as much as she	F3	29			
	she had verbally ex starting antipsycholifirst doing a complet then identifying and non-pharmacologic pharmacist stated to the antipsychotic melopement attempts other residents in the stated that R48 had the facility working for over 40 years). R48 did not have a use of the antipsychotic medication for its use and the facility wou behavior and develont indication for its use and the facility wou behavior and develonterventions and defailed including the pharmacological mantipsychotic medication for its use and the facility wou behavior and develonterventions and defailed including the pharmacological mantipsychotic medication for its use and the facility wou behavior and develonterventions are develonterventions.	pressed her concerns with tic medication for R48 without ete assessment of the behavior					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		TE SURVEY MPLETED
		245523	B. WING		02	2/20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP COD 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	and R48 was easily helping residents to hard for R48 to ren working here in the stated R48 was usher a cup of coffee common lounge ar out so that she could on 2/20/15 at 9:33 been an employee 40 years. The DOI Seroquel for indicate elopement from the assist other resider not provide a comp R48's behaviors ar non-pharmacologic those that had faile DON confirmed R4 eloped from the fact medication to deter other residents was	vior was not a huge problem of redirected if she started too much. NA-F stated it was nember that she was not a nursing home anymore. NA-F wally redirected easily by giving or setting her out in the ea where other residents hangeled converse with them. a.m. the DON stated R48 had of the nursing home for over N stated R48 was receiving tions which included the facility and attempting to ents. The DON stated she could brehensive assessment of	F3	29		
	nurse (LPN)-C statevening that included residents. LPN-C stanyone, and didn't a behaviorand RelPN-C also stated people and there we	0:17 a.m. licensed practical ed R48 had behaviors in the ed trying to help other tated R48 would never harm really think of R48's actions as 48 would never hurt anyone. R48 liked to be around other vere no residents in danger as ng to be helpful. LPN-C stated				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		TIPLE CONSTRUCTION ING	COMPLETED		
		245523	B. WING		02/20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP COI 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634	DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLÉTION
F 329	cup of coffee or get other residents.	direct by asking her to have a ting her involved in reading to	F 3	29	
F 353 SS=F	not provided.	e policy was requested and ENT 24-HR NURSING STAFF	F 3	53	3/25/15
	provide nursing and maintain the highes and psychosocial w	eve sufficient nursing staff to d related services to attain or st practicable physical, mental, rell-being of each resident, as dent assessments and care.			
	numbers of each of personnel on a 24-l	ovide services by sufficient if the following types of hour basis to provide nursing in accordance with resident			
		d under paragraph (c) of this urses and other nursing			
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of			
	by: Based on observat review, the facility	NT is not met as evidenced tion, interview and document failed to ensure sufficient aff was available to meet the		R 7, 21, 33 and 49 have had by skilled therapy and treatme ordered. Plan of Care reviewe	ent as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- CLEARBROOK			D5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	restorative services physical, mental and thus enhancing each practice had the poresiding in the facility failed to accordance with the for 4 of 4 residents sample who require motion (ROM) services. See F282 The facility failed to in order to improve ability to ambulate it the sample who we restorative rehability. The facility failed to services in order to further decrease in (R21, R7, R49, R33 limitations in range.) Review of the nurse weeks, (1/1/15 - 2/2)	r nursing care related to in a manner which promoted of psychosocial well-being, ch residents' quality of life. This tential to affect all 38 residents ty. I provide services in e resident's written care plan (R21, R7, R49, R33) in the ed assistance with range of ices and 1 of 1 resident (R21) tance with ambulation	F3	353	completion of skilled therapy will have updated Restorative Nursing Progrimplemented. LPN is working restrosition to meet Care Plan needs 2. LPN is filling Restorative Positic completing all restorative/functional maintenance programs following Picare. All current residents with Restorative/ Functional Maintenance program are currently being review updates or therapy referrals as appropriate. 3. With any turnover in the restorn position the center will post the pointernally, externally through online posting, newspaper, radio, Facebo appropriate. Temporary position wire covered by existing staff until filled. Education completed on 3-11-15 wire Nursing staff regarding following Picare, Care Plan Policy and Proceed development, implementation and to Care Plans. 4. DNS or designee will complete weekly x4 weeks, then q2 weeks x random audits to follow to ensure Restorative Programs are being for per POC. All findings will be report QA for further recommendations. 5. Completion date 3/25/15	am orative on and I lans of ee ed and ok as I be ith all ans of ure, access audits 4, then lowed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245523	B. WING		· · · · · · · · · · · · · · · · · · ·	02/:	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	stated the facility us provide personal cadid not have a resta assistance with rest the facility had not past 4 months. On 2/19/15, at 1:30 had been short staresidents had not restorative nursing staff members to poor 2/19/15, at 1:45 (LPN)-A stated the nursing assistants and they had not have time to proservices. On 2/19/15, at 2:00 not have time to proservices. On 2/19/15, at 2:00 had staffing issues doing the best they perform the restorative residents. On 2/20/15, at 8:45 stated she was in contractive sidents.	D p.m. nursing assistant (NA)-A sually had enough staff to ares to the residents, however, orative NA to provide storative services. NA-A stated had a restorative NA for the D p.m. NA-B stated the facility ff members. She stated the eceived assistance with because they did not have rovide it. 5 p.m. licensed practical nurse facility had been short of for the past several months ad the staff to provide	F3	353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245523	B. WING			02/:	20/2015	
	PROVIDER OR SUPPLIER			305 3	ET ADDRESS, CITY, STATE, ZIP CODE RD AVENUE SOUTHWEST ARBROOK, MN 56634			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 353	2014. Since that ti to complete the rest the NA was needed residents therefore the training require services. RN-A stated two interim dirmade aware of the unable to hire enougher restorative NA programs. She consufficient nursing a restorative program. On 2/20/15, at 9:00 stated the facility who provide restorative week for a five hou per week. She stated the DON per week. She stated the DON per was told the farestorative position nursing programs added the restorative facility priority. On 2/20/14, at 10:00 restorative NA was services however sprovided for a long	ility in the middle of October ime, a NA was hired internally storative programs, however, d to provide direct care to the had not been able to complete ed to provide the restorative ated the facility had recently ectors or nursing that had been econcern, however, they were ugh staff members to ensure was able to complete the nfirmed the facility did not have assistants to complete the ms as directed. Dia.m. the director of nurses was to have a specified NA to nursing either four days a sur shift, or 2 full 8 hour shifts ated she had been informed the exact a restorative NA when she osition on 2/17/15. She stated acility had been unable to fill the mand was aware the restorative were not being completed but inverse program would become a stated the they had not been it time.	F3	53				
		05 a.m. the administrator						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/:	20/2015
	PROVIDER OR SUPPLIER	- CLEARBROOK		305 3RD A	DDRESS, CITY, STATE, ZIP CODE AVENUE SOUTHWEST BROOK, MN 56634		
(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 SHOULI COSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	Continued From pa programs had not b of nursing assistant	een completed due to a lack	F 3	53			
F 441 SS=D	directed the facility to provide nursing a or maintain the high spiritual, mental and each resident, as d assessment and ind	es Staff policy dated 9/2012, to have sufficient nursing staff and related services to attain nest practicable physical, d psychosocial well-being of etermined by the resident dividual plans of care.	F 4	41			3/25/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission otion.					
	Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections cocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise	ion Control Program esident needs isolation to of infection, the facility must					

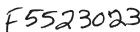
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE D5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(3) The facility must hands after each of hand washing is in professional practic. (c) Linens Personnel must hat transport linens so infection.	ransmit the disease. st require staff to wash their direct resident contact for which dicated by accepted	F 4	41			
	by: Based on observareview, the facility glucometers (device sugars) were approposed for exident use. This 3 resident use. This 3 residents (R14, I community glucometers (R14, I community glucometers) findings include: On 2/17/15, at 4:3 was observed to con R14. Immediate glucose check, RN the glucometer with contained 70% iso R14, R22, and R5 and that she routine by wiping it down weach resident use. On 2/18/15, at 8:3 nurse (LPN)-B community glucometers with the second	ation, interview and document failed to ensure the ces utilized for monitoring blood opriately disinfected after each had the potential to affect 3 of R22, R54) who used a neter. 1 p.m. registered nurse (RN)-B onduct a blood glucose check rely following R14's blood I-B was observed to wipe off h an alcohol prep wipe which propyl alcohol. RN-B confirmed 4, all utilized this glucometer rely disinfected the glucometer with an alcohol prep wipe after			1. On 2-19-15 R 14, 22, 54 receivindividual glucometers. Glucometer cleaned and disinfected per manufacturer significations and Po Procedure. Nursing Staff were immediately educated on proper cleaned disinfecting. 2. All residents who require blood glucose monitoring have individual glucometers that are stored in their rooms. Upon admission if needed resident will receive personal glucometers that are stored with all restaff regarding correct procedure for cleaning and disinfecting glucometers. 3. Policy and Procedure, manufacting recommendation reviewed for Cleaned disinfecting glucometers at 3-1 nursing staff meeting. 4. DNS or designee will complete Random audits x3 months to ensurindividual glucometers are being us disinfecting log is being completed.	rs were licy and eaning meter. aursing or ers on cturers uning 1-15 re sed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245523	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		30	TREET ADDRESS, CITY, STATE, ZIP CODE D5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	stated she disinfect resident use by wip wipe.	ge 47 4, R22, and R54. LPN-B ed the glucometers after each ing them down with an alcohol 4 p.m. the director of nursing	F 4	41	Findings reported to QA. 5. Completion date 3-25-15		
	(DON) verified the r not have their own of DON stated the glu- after each use and wipe was an approp	residents on the first floor did designated glucometer. The cometers should be cleaned she believed the alcohol prep oriate disinfecting wipe, hould follow the facility policy					
	Meters policy dated properly disinfect th resident use with 1:	Disinfecting Blood Glucose 11/2014, directed staff to e glucometer after each 10 bleach to water solution or nicidal disposable wipe.					
F 520 SS=F	instructions directed the glucometer betw EPA (Environmenta		F 5	20			3/25/15
	assurance committe nursing services; a facility; and at least facility's staff.	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the					
	The quality assessr	ment and assurance					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245523		B. WING		·····	02/20/2015		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - CLEARBROOK				3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	HOULD BE COMPLÉTI	
F 520	committee meets a issues with respect and assurance act develops and impliance of the respect in the second in the respect in the sample who remotion services are second in the seco	at least quarterly to identify t to which quality assessment ivities are necessary; and ements appropriate plans of entified quality deficiencies. cretary may not require ecords of such committee such disclosure is related to the n committee with the is section. s by the committee to identify deficiencies will not be used as	F 5	520	1.Plan developed for restorative nuprogram at 3-5-15 QA Meeting to ideconcerns and develop corrective ac QAPI Committee determined that restorative position cannot be pulled must be maintained throughout any staffing issues. Committee develop immediate action plan that casual L be providing the program for the immediate and foreseeable future (RN oversight with referrals to theral needed). Also, CNA already on staff be trained for the position. 2. QA will continue to meet month prn for updates to existing action pland Performance Improvement Progrewiew, and initiate action plans for new or potential concerns. 1:1 train provided for QAPI coordinator on available QAPI tools, processes, ar	lentify ction. d and red lentify with pies as f will ly and ans objects, any ing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245523	B. WING		02/2	20/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 520	treatment and serve the resident's abilitive residents (R21) in the for nursing rehabilities. The facility failed to services to prevent motion (ROM) for AR33) in the sample of motion. See F31 The facility failed to nursing staff was a needs for nursing opposed each respective promoted each respective for all 38 resident F353. On 2/20/15, at 1:40 (RN)-A/QA&A coor committee had idea concern of the lack quarterly QA&A mecommittee had attemore staff member generated a solution committee had not concern of lack of slack of restorative reconfirmed the QA&A confirmed the QA&A conf	o provide the necessary ices to improve and maintain ies to ambulate for 1 of 4 the sample who were reviewed tation. See F311. o provide range of motion further decrease in range of 4 of 4 residents (R21, R7, R49, who had limitations in range	F 520	plans. Also discussion to ensure to correct issues are brought to the Committee carried out on 3-5-15 at -15. 3. In the event the restorative powas vacated it will be posted interexternally via online, newspapers, Facebook as appropriate. During transition, if there are no restorative available, Activities will provide a 2 week stretching and ROM programensure no declines are noted, this program is already operating. The department was involved in discus with this decision and they did fee intervention was appropriate to he reduce declines if able. Nursing Seducated on 3-11-15, all other departments to be educated 3-23-regarding QA committee and purphow to report concerns, be made updates with other departments to as they have their meetings. Also, placed on QAPI coordinators docurrent projects, purpose, and plad. Admin or representative will automonthly x3 to ensure QA coordinator/committee have identificated appropriate process to correct. Audit findings reviewed at QAPI meetings. Restavill be added to the QAPI agenda with audits addressed monthly. 5. Completion date 3-25-15	sition nally, radio, the ve aides 2-3xper n to erapy ssion I this lp taff 15 ose, aware of follow posters or with ns. dit fied e plan or will be prative		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245523		B. WING			02/20/2015		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - CLEARBROOK				30	REET ADDRESS, CITY, STATE, ZIP CODE 5 3RD AVENUE SOUTHWEST LEARBROOK, MN 56634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 520	residents received directed. On 2/20/15, at 11:0 confirmed he was a programs had not be of nursing assistant. The Quality Improv 3/2012, under Proc "Action plans will be	their restorative programs as 5 a.m. the facility administrator aware the restorative nursing been completed due to a lack ts. ement procedure dated edure bullet number 7 read: e implemented to address d will be evaluated for	F 5	20	DEFICIENCY)		



PRINTED: 03/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A: BUILDING 01 - 1953 BUILDING WITH ADDITIONS 245523 B. WING 02/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST **GOOD SAMARITAN SOCIETY - CLEARBROOK** CLEARBROOK, MN 56634 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE 1D (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on March 13, 2014. At the time of this survey Good Samaritan Society Clearbrook was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:

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

TITLE

(X6) DATE

Electronically Signed

03/13/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - 1953 BUILDING WITH ADDITIONS			(X3) DATE SURVEY COMPLETED	
		245523	B WING _		02/	19/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
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K 000	Continued From pa Marian.Whitney@s or Angela.Kappenmar	tate.mn.us	K 000			
	DEFICIENCY MUS FOLLOWING INFO 1. A description of vocorrect the deficience.	what has been, or will be, done				
	3. The name and/or responsible for correprevent a reoccurre. The Good Samarita story building with a building was built in system making this					
	to the south and on building, which are basements and are These additions are barriers. In 1999 a I was added to the w determined to be Ty	e to the east of the original one story buildings with Type II (111) construction. E separated with 2- hour fire pasement laundry addition est of the north wing and was type II(111) construction. The all 1st floor and the 1st story is				
	automatic sprinkler system with smoke	etely protected by an system and has a fire alarm detection in the corridors and corridors that is monitored for the the thickness of the thic				
	The facility has a ca	pacity of 43 beds and had a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY	
		245523	B. WING		02/	19/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK	3	STREET ADDRESS, CITY, STATE, ZIP CODE 805 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From pa	ge 2 time of the survey.	K 000			
K 029 SS=D	NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are s field-applied protect	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 029			3/25/15
	Based on observation revealed that the faproper protection from accordance with NF (2000 edition) section conditions could in smoke and flames effected corridors a untenable, which conditions capabilities in Findings include:	s not met as evidenced by: tions and staff interview, it was cility has failed to provide om 1 of several hazardous ghout the facility in FPA Life Safety Code 101 on 19.3.2.1. This deficient the event of a fire, allow to spread throughout the nd areas making them ould negatively affect the for residents, staff and visitors.		 The inner wood ply on door to Elevator Equipment room detached the main supporting structure- no in door material was lost or damaged outer ply was securely reglued and back into place. Maintenance staff will be check this weekly for separation issues at any noted concerns a new door will purchased and installed. Maintenance staff will have one monitoring of doors to prevent future occurrences with repairs/replacement appropriate. Maintenance staff edu on 3-10-15 regarding monitoring domaintenance concerns. Weekly audits will be recorded 	nternal . The bolted king nd if I be going re ent as cated pors,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - 1953 BUILDING WITH ADDITIONS			
		245523	B, WING	<u> </u>	02/19/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- CLEARBROOK	;	STREET ADDRESS, CITY, STATE, ZIP CODE 805 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTIO	
K 029	rated door to the el	servation revealed, that the filevator equipment room was led and splitting exposing the		weeks and findings reported to C 5. Completion date 3-25-15	2A .	
	This deficient pract Maintenance Supe	tice was verified by the rvisor.				
				9		
	at .					



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered March 5, 2015

Mr. Gordon Hormann, Administrator Good Samaritan Society - Clearbrook 305 3rd Avenue Southwest Clearbrook, Minnesota 56634

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5523023

Dear Mr. Hormann:

The above facility was surveyed on February 17, 2015 through February 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Good Samaritan Society - Clearbrook March 5, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Sincerely,

mark Weath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

cc: Original - Facility

Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00078		B. WING		02/20	/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK		/ENUE SOUTH OOK, MN 5663			
0/4) ID	SHIMMADV STA	ATEMENT OF DEFICIENCIES	CLEARDR	1	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTEN	TION*****					
	NH LICENSING CO	ORRECTION ORDER					
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon						
	result in the assessme	item of multi-part rule ent of a fine even if the ng the initial inspection	e item				
	that may result from rorders provided that a	earing on any assessmon-compliance with the written request is man 15 days of receipt of for non-compliance.	ese de to				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electro sure orders consistent tment of Health 14-01, available at te.mn.us/divs/fpc/profir icensing orders are	with				

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

03/13/15 **Electronically Signed**

TITLE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3			(3) DATE SURVEY COMPLETED	
		00078		B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	LEARBROOK	305 3RD A	DRESS, CITY, STAT VENUE SOUTH OOK, MN 5663	WEST		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From page Department of Healty you electronically. As is necessary for State enter the word "corrected. You must then it State licensure processory for text. You must then it State licensure processory for the department of the State licensure processory for the department of the State Licensure of the State Licensure of the State Licensure federal software. The assigned to Minneson Nursing Homes. The assigned tag nurcolumn entitled "ID statute/rule out of constitute/rule out of constitute of the State Licensure of the State Licensure of the State Licensure federal software. The assigned tag nurcolumn entitled "ID statute/rule out of constitute of the State Licensure and replaces the "Tocorrection order. This findings which are in after the statement, evidence by." Follow are the Suggested Minne period for Correction Correct	h orders being subralthough no plan of one Statutes/Rules, placeted" in the box available in the electronicate in the electronically submitting the following correction that you have read in the following correction orders up any precion of the state statutes/rule in the following in the following in the following in the following in the state statutes in the following in the state in the following in the surveyors fill the following the surveyors fill fethod of Correction for ection.	correction lease ailable for ronic ling ill be ng to the 2015, ited the tion our we date when umenting sing en es for e far left ate olumn the des the te statute et as indings in and	2 000			
	PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.						

Minnesota Department of Health

STATE FORM 9DHU11 If continuation sheet 2 of 56

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/20/2015
	ROVIDER OR SUPPLIER	EARBROOK 305 3RD	DDRESS, CITY, STA AVENUE SOUTI ROOK, MN 566	HWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000		ON EACH PAGE. IREMENT TO SUBMIT A ION FOR VIOLATIONS OF	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.		2 255		3/25/15
	facility did not ensure Assurance (QA&A) co implemented appropr correct identified qual lack of restorative nur	the Quality Assessment and committee developed and liate plans of action to lity deficiencies related the sing services. This had the 34 residents who resided in		corrected	

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00078	B. WING		02	2/20/2015
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA			
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	RD AVENUE SOUTH ARBROOK, MN 5663			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 255	Continued From page	e 3	2 255			
	care for 4 of 4 resider the sample who requi motion services and	rovide services in resident's written plan of hts (R21, R7, R49, R33) in ired assistance with range of 1 of 1 resident (R21) who with ambulation services.				
	The facility failed to provide the necessary treatment and services to improve and maintain the resident's abilities to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing rehabilitation. See F311.					
	services to prevent fur motion (ROM) for 4 o	rovide range of motion orther decrease in range of f 4 residents (R21, R7, R49, ho had limitations in range				
	nursing staff was ava needs for nursing car promoted each reside psychosocial well-bei quality of life. This pra	nsure that sufficient qualified ilable to meet the residents' e in a manner which ent's physical, mental and ng, thus enhancing their actice had the potential to residing in the facility. See				
	committee had identif	nator stated the QA&A fied and discussed the f nursing assistants at the				

Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00078	B. WING		02	/20/2015	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - CLE	ARBROOK 305 3RD	DRESS, CITY, STATE AVENUE SOUTHV ROOK, MN 56634	/EST			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL (C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
more staff members, b generated a solution. committee had not speconcern of lack of staff lack of restorative nurs confirmed the QA&A confirmed the QA&A confirmed a formal action plans will be imidentified issues and weffectiveness on a regular SUGGESTED METHO administrator or design policies related to the a QA committee and relation plan. The administrator or develop and auditing scompliance.	ted to be proactive in hiring ut their efforts had not She stated the QA&A orifically discussed the ing in relationship to the ing programs. RN-A committee had not it ion plan to ensure the restorative programs as a method of the ingent of	2 255				

Minnesota Department of Health STATE FORM

STATE FORM 9DHU11 If continuation sheet 5 of 56

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED	
		00078	B. WING		0	2/20/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - CI	EARBROOK	ET ADDRESS, CITY, STA RD AVENUE SOUT ARBROOK, MN 566	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 302	Continued From pag	e 5	2 302			
2 302	MN State Statute 14- or related disorder tra	4.6503 Alzheimer's disease ain	2 302			3/25/15
	ALZHEIMER'S DISE DISORDER TRAININ MN St. Statute 144.6	NG:				
	Alzheimer's disease or related dis segregated or genera care staff	y serves persons with sorders, whether in a all unit, the facility's direct must be trained in dementia				
	related disorders; (2) assistance with a (3) problem solving v and (4) communication sl (c) The facility shall p written or electronic f training program, the trained, the frequence topics covered.	Alzheimer's disease and ctivities of daily living; vith challenging behaviors;				
	by: Based on interview a facility failed to ensur in a written or electro facility staff training for dementia/Alzheimer's	and document review, the re consumers were provided onic form, a description of or the care of residents with s, categories of staff trained, and topics covered in the		corrected		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00078		B. WING		02/	20/2015
	ROVIDER OR SUPPLIER	EARBROOK	305 3RD A\	RESS, CITY, STA /ENUE SOUTH DOK, MN 5663	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 302	training. This had the residents residing in trepresentatives/familian Findings Include: On 2/19/15, at 8:43 a (DON) stated the faciliconsumer education in dementia/Alzheimer's DON verified there was consumer education for training. On 2/19/15, at 8:50 a designee (SSD) proving Admissions Checklist verified there was not of the required educan never seen it identifies SUGGESTED METHOR administrator or designiformation describing categories of employed frequency of the training or electronic form. The could develop an audicompliance.	potential to affect a he facility and resides. .m. the director of a lity did not have an regarding their a staff training program for the dementia/Al commendation on the dementia/Al commendation on it and state did before. OD OF CORRECT gnee could add/program trained and the set training program of the staff training program of the	nursing y ram. The ding zheimer ce rk 4, and provision d she had rion: The vide program, e in written designee sure	2 302	DEFICIE	NOT)	
	TIME PERIOD FOR (21) days.	CORRECTION: Tw	enty-One				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/20/2015
	ROVIDER OR SUPPLIER	EARBROOK	ET ADDRESS, CITY, STA RD AVENUE SOUT ARBROOK, MN 566	HWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	<u> </u>
2 560	Continued From page	e 7	2 560		
2 560	Plan of Care; Contents of comprehensive plan objectives and timetal long- and short-term and mental and psycidentified in the compassessment. The comust include the indiverguired by Minnesot subdivision 14, parage. This MN Requirement by: Based on interview a facility failed to devel monitor side effects of use for 1 of 1 resident Coumadin (an antico eliminate or reduce the addition, the facility failed to devel addition, the facility failed to devel monitor side effects of the council failed to the	f plan of care. The of care must list measurable ables to meet the resident's goals for medical, nursing, hosocial needs that are prehensive resident mprehensive plan of care vidual abuse prevention plan ta Statutes, section 626.557, graph (b). In this not met as evidenced and document review, the op care plan interventions to of anticoagulation medication	2 560	corrected	3/25/15
	Findings include:				
	R22's diagnoses as a heart rate), hypertens congestive heart failu	oort dated 12/29/14, identified atrial fibrillation (irregular sion (high blood pressure), are (decrease in heart failure etes and a heart valve			
	R22's admission Min	imum Data Set (MDS) dated			

Minnesota Department of Health STATE FORM

9DHU11 If continuation sheet 8 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - CL	.EARBROOK	ADDRESS, CITY, STATE AVENUE SOUTHW BROOK, MN 56634			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	anticoagulant therapy	22 received insulin and	2 560			
	 Conduct blood g Administer Coun every Sunday, Tueso Administer Coun Thursday, and Saturo 	lucose checks twice a day nadin 2.5 milligrams (mg) lay, Wednesday, Friday nadin 5 mg every Monday,				
	R22's diagnosis of at corresponding interverse to observe for side of therapy usage, such bruising and internati monitoring (INR- labelevels). In addition, the R22's diagnosis of discorresponding interverse to observe signs and (high blood glucose levels).	entions which directed staff fects of anticoagulation as excessive bleeding, onal normalized ration work to identify blood clotting he care plan failed to identify abetes and the entions which directed staff symptoms of hyperglycemic evels), hypoglycemic (low h, blood glucose monitoring				
	(DON) confirmed R2: fibrillation and was a R22's care plan lacked interventions with regulanticoagulation manal confirmed it would be included on R22's callibrillation and the side	gards to diabetes and agement. The DON				

Minnesota Department of Health

STATE FORM 9DHU11 If continuation sheet 9 of 56

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT COM		
		00078	B. WING		02/20/2015	
	ROVIDER OR SUPPLIER Maritan Society - Cl	305 3RD	DDRESS, CITY, STA AVENUE SOUTI BROOK, MN 566	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 560	Continued From page could have been more R22's diabetes mana	e specific with regards to	2 560			
	each resident would he comprehensive care properties and problems, needs identified and address	dated 9/2012, indicated have an individualized plan. Through the use of ments and physician orders, and concerns would be sed. The care plan would ent received appropriate				
	administrator or design policies and provide sidevelopment of compadministrator or design.	OD OF CORRECTION: The inee could review and revise staff education related to the rehensive care plans. The inee could develop and der to ensure compliance.				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-One				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565		3/25/15	
		nprehensive plan of care ersonnel involved in the				
	by:	t is not met as evidenced				
	Based on observation	n, interview and document		corrected		

Minnesota Department of Health

STATE FORM 9DHU11 If continuation sheet 10 of 56

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		00078	B. WING		02/20)/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	-
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	AVENUE SOUTH ROOK, MN 5663			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	accordance with the recare for 4 of 4 resider the sample who required assistance with facility failed to enoffered according to the need for 1 of 3 reside activities. Findings include: R21 did not receive a and range of motion seare plan. R21's care plan dated to provide R21 with note 2-3 times a week. The ambulation as the Seated over he 4 minutes of over red theraband (exercised for the shown as 20 repetitions. - ankle lifts with a hamstring curls ball squeezes a minimal resistance or	ed to provide services in resident's written plan of hts (R21, R7, R49, R33) in ired assistance with range of 1 of 1 resident (R21) who with ambulation. In addition, insure activity's had been the residents care planned ints (R10) reviewed for services according to the distribution services according to the distribution services according to following: If 5/12/15, directed the staff the ursing rehabilitation services are plan included to following: If old a distribution services are plan included to following: If old a distribution services are plan included to following: If old a distribution services are plan included to following: If old a distribution services are plan included to following: If old a distribution included to following and bounce passes x 20 are head pulleys are lastic exercise strap) If old a distribution included to following and bounce passes a three pound weight with a red theraband and hip abduction with a red theraband recises as tolerated.	2 565			
	Review of R21's Octo	bber 2014, Follow Up				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		D	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00078	E	B. WING		02/20/2015
	ROVIDER OR SUPPLIER	EARBROOK	STREET ADDRES 305 3RD AVEI CLEARBROO	NUE SOUTH	WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 565	Question Report (residocumentation) indicates of 15 opportunities. assistance with ROM documentation did no program. On 2/18/15, at 3:00 p stand and transfer to	torative nursing ated R21 had received F R21 had last received on 10/16/14. The strinclude R21's ambulated include R21's ambulated include R21 was observed to a commode with assistar R21 did not display RO	ROM ion o ance	2 565		
	On 2/19/15, at 12:00 p.m. R21 was observed to feed herself the noon meal. R21 was able to use utensils without problems.					
	On 2/19/15, at 1:20 p and NA-B were obser ambulate 36 feet in th		A)-A			
	stated the facility did provide the program s was aware the restor	.m. registered nurse (RI not have a restorative N services and confirmed s ative programs had not ied R21's care plan had	A to she been			
	R7 had not received it as directed by her call	restorative nursing servi re plan.	ces			
	physical mobility relat	3/20/14, identified ons due to R7's limited ted to arthritis and her lied directed staff to conduct				

Minnesota Department of Health

STATE FORM 9DHU11 If continuation sheet 12 of 56

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	LEARBROOK 305 3R	ADDRESS, CITY, STATE RD AVENUE SOUTHW RBROOK, MN 56634	/EST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	nursing rehab three the following exercis Upper extremity program: upper extroverhead pulley x 3 extension: elbow and cones off of the floor While seated in marching; heel/toe rehamstring stretch and sets, hamstring sets On 2/18/15, at 1:00 propelling herself in hallway into her roor seated in her wheeld On 2/18/15, at 2:45 currently did not have restorative nursing shad not received her as directed by her call	times a week which included es: functional maintenance remity bike with resistance; minutes; number 2 dowel d shoulder 1 x 30; pick up x 1 while seated. the wheelchair: hip flexion, aises x 10 each side; supine: d calf stretch 2 x 30, quad and heel slides x 10 each. p.m. R7 was observed her wheelchair down the m where she remained chair. p.m. RN-A stated the facility re anyone providing ervices. RN-A confirmed R7 r restorative nursing services are plan.	2 565			
	R49 had not receive as directed by his ca	d restorative nursing services are plan.				
	restorative interventi	ed 10/26/14, identified ons due to R49's and limited physical mobility.				

Minnesota Department of Health

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 02/2	0/2010
		305 3RD A	/ENUE SOUTH			
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	OOK, MN 5663			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	: 13	2 565			
	rehab 2-3 times a wee following exercises: If seated: active r hip flexion, hamstring (exercise resistant ba bilateral abduction anhamstring stretch and If laying down: ARON flexion and stretch. A left; passive range of knee flexion and stretch and right upper wrist, fingers, all plane movement of thumb a tolerated. Yellow t-ba extremity 2 x 10 each and horizontal abduct left upper extremity, h x 10 beach ball. Neck	range of motion (AROM) with curls with yellow t-band nd) 2 x 10 on right; AROM d adduction 2 x 10, heel cord stretch bilaterally. If on right hip and knee bduction and adduction on motion (PROM): hip and ch, abduction and adduction er extremity, shoulder, elbowes 2 x 10 each. Encourage				
	transferred with a med wheelchair to his bed practical nurse (LPN)-	by NA-C and licensed -D. R49 required total				
	assistance with transfer. On 2/18/15, at 3:35 p.m. RN-A confirmed R49 had not received his restorative nursing services as directed by his care plan. In addition, RN-A verified 10/16/14, was the last day the facility had someone providing restorative nursing services.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMPI	
		00078	B. WING		02/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•	
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565		e 14 p.m. the DON confirmed the formalized restorative	2 565			
	R33 was not provided services as directed b	d restorative nursing by her current care plan.				
	Report, included chro generalized osteoarth	ndicated on the Diagnosis nic airway obstruction, irosis, congestive heart ers, generalized pain and				
	R33's quarterly minimum data (MDS) set dated 10/25/14, indicated R33 had severe cognitive impairment and required extensive assist with bed mobility, transferring toileting, dressing and personal hygiene. In addition, R33 had range of motion (ROM) impairment on both sides for upper and lower extremities.					
	deficit/limited physica directed staff to condi- a week which include · Overhead pulley planes 20 each. Assis · Bilateral stretch a hamstring stretch, ha minutes each. Sit to s work on standing tole · Kegals for stress · Seated manually	Ins due to performance I mobility. R33's care plan uct nursing rehab 2-3 times d the following exercises: X 3 minutes Yellow t-band all st to stand all directions including m curls and sit to stand 1-2 stand in parallel bars and rance incontinence resisted abduction and and aid and work on weight				
	On 2/20/15, at 10:05	a.m., NA-C verified that he				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	.EARBROOK	ADDRESS, CITY, STATE D AVENUE SOUTHV BROOK, MN 56634	VEST		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	had not provided any exercises to any residence of the past of the	type of restorative nursing dent. a.m. LPN-B verified R33 orative nursing services for a.m. RN-A confirmed R33 restorative nursing services re plan. RN-A verified at day R33 received any type s. RN-A stated the facility corative services to the several months. a.m. The DON verified R33 orative services since stated R33 should have rvices as directed by the sing Care policy dated goal of restorative nursing he maximum possible ch resident was maintained evented. Each resident ative nursing care to the based on their individual problems as defined by the characteristic in addition, the restorative and in the resident's care plan.	2 565			
		rt dated 2/20/15, indicated with Alzheimer's disease.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00078		B. WING		02	2/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK		/ENUE SOUTH DOK, MN 5663			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 16		2 565			
	indicated R10 was de activities, cognitive st interaction. The care R10 1:1 bedside/in-ro attend out of room ev activities such as con stay in room, naps, cl events. The care plar often 1:1 activities we who preferred to stay frequency of the direct family involvement, in	imulation and social plan directed staff to poom activities if unable rents as well as preference wersation, music, preference in the provided to Reference to be provided to Reference and social provided to Reference to be provided to Reference to be provided to Reference directed staff.	rovide to ed ers to piritual v 10				
	On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was assisted with eating the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities.		and				
	seated in her room. N 11:36 a.m. R10 was o	.m. R10 was observed to television or radio or observed seated in the ting to go into the dinnical.	n. At				
	On 2/19/2015, at 8:44 the dining room, eatir	4 a.m. R10 was observ ng breakfast.	ed in				
	seated in front of the residents while the m	orning news show was sed and did not appea	s on.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00078	B. WING		02	20/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - CL	.EARBROOK	TREET ADDRESS, CITY, STA 05 3RD AVENUE SOUT LEARBROOK, MN 566	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	2 565 Continued From page 17		2 565			
		03 a.m. Church service was assisted to the service /	as			
	On 2/19/2015, at 1:00 p.m. R10 was observed seated in the common lounge area just watching the people go by. On 2/19/14, at 2:00 p.m. a monthly resident birthday party was held. However, R10 was not asked nor assisted to the birthday party / activity.					
	(AD) was asked what participated in on 2/1 2/19/15, activity docu first activity which too educational / cognitive surveyor asked what R10 had participated AD stated she could exactly what the activity laste was not assisted to the state of the state o	9/15. The AD confirmed the mentation and stated the k place at 1:03 p.m. was a	an d if e ion			
	care plan would emp development of the w	dated 9/2012, indicated the hasize the care and whole person ensuring that appropriate care and				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	FIED
		00078	B. WING		02/2	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH			
		CLEARBR	OOK, MN 566			
(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	e 18	2 565			
	director of nursing (Direview and revise pol to ensuring the care president is followed. designee (s) could destaff and develop a mataff are providing carplan of care.	OD OF CORRECTION: The ON) or designee (s)could icies and procedures related blan for each individual The director of nursing or evelop a system to educate ionitoring system to ensure re as directed by the written				
2 800	(21) days. MN Rule 4658.0510 S	Subp. 1 Nursing Personnel;	2 800			3/25/15
	Staffing requirements Subpart 1. Staffing re home must have on a number of qualified in registered nurses, lice nursing assistants to residents at all nurses in all buildings if more	equirements. A nursing duty at all times a sufficient nursing personnel, including ensed practical nurses, and meet the needs of the s' stations, on all floors, and e than one building is es relief duty, weekends,				
	by: Based on observation review, the facility fai qualified nursing staff residents' needs for n	t is not met as evidenced n, interview and document filed to ensure sufficient was available to meet the fursing care related to n a manner which promoted		corrected		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l '		CONSTRUCTION	(X3) DATE S	
		00078	В	B. WING		02/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STR	REET ADDRES	SS, CITY, STAT	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	.EARBROOK		NUE SOUTH OK, MN 5663			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	thus enhancing each	psychosocial well-being, residents' quality of life. Thi ntial to affect all 38 resident	is	2 800			
	Findings include:						
	for 4 of 4 residents (R sample who required	resident's written care plan R21, R7, R49, R33) in the assistance with range of es and 1 of 1 resident (R21)				
	The facility failed to provide ambulation services in order to improve or maintain the resident's ability to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing restorative rehabilitation services. See F311.						
	services in order to m further decrease in R	rovide range of motion naintain and/or prevent OM for 4 of 4 residents in the sample who had f motion. See F318.					
	weeks, (1/1/15 - 2/20/	staffing for the past six /15) revealed the facility had aide assigned during the	d				
		.m. nursing assistant (NA)-، ally had enough staff to	Α				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	1 ' '	SURVEY PLETED
		00078	B. WING		02	/20/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	02	72072013
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	AVENUE SOUTHV ROOK, MN 56634			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 O THE APPROPRIATE	(X5) COMPLETE DATE
2 800	did not have a restora	es to the residents, however,	2 800			
	had been short staff r residents had not rec	ecause they did not have				
	On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months and they had not had the staff to provide restorative nursing services.					
	-	.m. NA-C stated the NAs did ide restorative nursing				
	had staffing issues.	.m. LPN-B stated the facility She stated the staff were ould but did not have time to re programs for the				
	stated she was in cha nursing program. Sh NA had left the facility 2014. Since that time to complete the resto	.m. registered nurse (RN)-A arge of the restorative e explained the restorative in the middle of October e, a NA was hired internally rative programs, however, o provide direct care to the				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE : COMPI	
		00078	B. WING		02/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH OOK, MN 5663			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	the training required to services. RN-A state had two interim direct made aware of the counable to hire enough the restorative NA was programs. She confinsufficient nursing assist restorative programs. On 2/20/15, at 9:00 a stated the facility was provide restorative nuweek for a five hour sper week. She stated facility did not have a started the DON posishe was told the facilit restorative position an nursing programs were added the restorative facility priority. On 2/20/14, at 10:00 restorative NA was to services however state provided for a long time.	ad not been able to complete to provide the restorative did the facility had recently tors or nursing that had been oncern, however, they were in staff members to ensure its able to complete the med the facility did not have distants to complete the as directed. I.m. the director of nurses to to have a specified NA to ursing either four days a shift, or 2 full 8 hour shifts dishe had been informed the restorative NA when she tion on 2/17/15. She stated that had been unable to fill the and was aware the restorative re not being completed but program would become a sam. NA-E stated the responsible to provide the ted the they had not been	2 800			
	confirmed he was aw	are the restorative nursing en completed due to a lack				
	The Nursing Services	Staff policy dated 9/2012,				

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	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPI IDENTIFICATION		` ′	CONSTRUCTION	(X3) DATE S COMPL	
		00078		B. WING		02/2	0/2015
	ROVIDER OR SUPPLIER	EARBROOK	305 3RD A\	RESS, CITY, STA PENUE SOUTH COK, MN 5663	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	Continued From page directed the facility to to provide nursing and or maintain the highes spiritual, mental and p each resident, as dete assessment and indiv	have sufficient nud related services st practicable physosychosocial well-ermined by the res	to attain sical, being of sident	2 800			
	SUGGESTED METHOR administrator or design policies, review and a order to ensure the reprovided. The administrator and advelop an auditing succompliance.	nee could review djust scheduling r esidents services a strator or designed	and revise needs in are e could				
2 895	TIME PERIOD FOR (21) days. MN Rule 4658.0525 S		•	2 895			3/25/15
	Motion Subp. 2. Range of m that is directed toward through positioning arimplemented and mai comprehensive reside of nursing services m development of a nursiprovides that: B. a resident with a receives appropriate increase range of modecrease in range of	otion. A supportive of prevention of de and range of motion intained. Based of ent assessment, it ust coordinate the sing care plan which a limited range of treatment and sertion and to prevention and the prevention and th	re program formities n must be n the ne director ch motion				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY
		00078		B. WING		02	/20/2015
	ROVIDER OR SUPPLIER	.EARBROOK	305 3RD A	RESS, CITY, STA	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE OF MUST BE PRECEDED BY LSC IDENTIFYING INFORM	ES ∕ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	Continued From pag This MN Requirement by: Based on observation review, the facility fai motion services in or decrease in range of 4 residents (R21, R7 who had limitations in Findings include:	nt is not met as evident, interview and doculed to provide range der to maintain or premotion (ROM) ability, R49, R33) in the san range of motion.	ument of event of or 4 of mple	2 895	corrected		
	R21's quarterly Minin 1/27/15, indicated R2 dementia and anxiety impairment and requ with bed mobility, tra and had unilateral low limitations.	21 was diagnosed wit y, had severe cognitive ired extensive assistant nsfers, dressing, groot	th ve ance oming				
	- 4 minutes of ov - red theraband exercised for the sho x 20 repetitions. - encourage to w -ankle lifts with a - hamstring curls	sing rehabilitation 2-3 cluded: ead bounce passes x ver head pulleys (elastic exercise strapulder and elbow strewalk to elevated with value to elevated with a three pound weight s with a red therabanciand hip abduction with	20 p) tches walker				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00078	B. WING		02	20/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	02/	20/2015
	MARITAN SOCIETY - CL	305 3RD	AVENUE SOUTH			
	WANTAN SOCIETY - CE	CLEARB	ROOK, MN 566			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	Continued From page	e 24	2 895			
	- sit to stand exe - encourage kega	rcises as tolerated. als				
	10/3/12, by the physic encourage R21 to par strengthening exercise exercises with a three pumps, hamstring cur squeezes and hip aboresistance or red ther	re Program established on cal therapist directed staff to rticipate in lower extremity ses including marching e pound weights, ankle rls with red theraband, ball duction with either manual raband bilaterally x 15 stand exercises as R21				
	R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had received ROM 6 of 15 opportunities. R21 had last received assistance with ROM on 10/16/14.					
		did not contain any further d to the restorative nursing				
	stand and transfer to	.m. R21 was observed to a commode with assistance R21 did not display ROM er extremities.				
		p.m. R21 was observed to meal. R21 was able to use ems.				
	On 2/19/15, at 1:20 p	.m. nursing assistant (NA)-A				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00078	B. WING	·	02	2/20/2015
	ROVIDER OR SUPPLIER	EARBROOK 305 3R	T ADDRESS, CITY, STATE RD AVENUE SOUTHV RBROOK, MN 56634	VEST	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 895	provide personal care did not have a restora assistance with resto	ally had enough staff to es to the residents, however,	2 895			
	had been short staff r residents did not rece	ecause they did not have				
	(LPN)-A stated the fa nursing assistance fo	.m. licensed practical nurse cility had been short of r the past several months staff to provide restorative				
	assistants did not have nursing services. AT stated the facility had were doing the best t	.m. NA-C stated the nursing ve time to provide restorative the same time, LPN-B staffing issues and the NAs hey could, but did not have estorative programs for the				
	stated the facility use charge of completing program, however, in restorative NA had le the facility had hired a restorative programs, allowed to provide the	.m. registered nurse (RN)-A to have a NA who was in the restorative nursing October of 2014, the fit the facility. RN-A stated another NA to complete the however, she had not been a services because she was ect care to the residents				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	EARBROOK 305 3F	T ADDRESS, CITY, STATE RD AVENUE SOUTHV RBROOK, MN 56634	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	instead. RN-A stated the restorative progradirected and had rep director of nursing (D care plan had not be restorative nursing second of the control of the	she was aware that none of ams had been completed as orted the concern to the iON). RN-A verified R21's en followed to ensure ervices were provided. a.m. RN-A was observed to arms. R21 was able to raise nead, extended her arms ed a full circle with her not observed to display any ns in her upper extremities.	2 895			
	as directed by her cu R7's diagnoses, as ir Report, included sho anemia, Alzheimer's, congestive heart failu function to pump bloc R7's quarterly MDS of had moderate cogniti extensive assist with locomotion on and of personal hygiene. In	ndicated on the Diagnosis rtness of breath, cataracts, generalized pain, ure (decrease in heart od), depression and arthritis. dated 11/26/14, indicated R7 ive impairment and required bed mobility, transferring, if the unit, toileting and addition, R7 had ROM wer extremities (hip, knee,				
		3/20/14, identified ons due to R7's limited ted to arthritis and her limited				

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00078	B. WING	B. WING		02/20/2015	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA		02/2	10/2015	
		305 3RD	VENUE SOUTH	•			
GOOD SA	MARITAN SOCIETY - CL	CLEARBE	ROOK, MN 566	34			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY)) BE	(X5) COMPLETE DATE	
2 895	Continued From page	e 27	2 895				
	nursing rehab three ti the following exercise. Upper extremity program: upper extre overhead pulley x 3 n extension: elbow and cones off of the floor: While seated in t marching; heel/toe ra hamstring stretch and sets, hamstring sets a On 2/18/15, at 2:45 p currently did not have restorative nursing set been about two mont without someone in the	functional maintenance emity bike with resistance; ninutes; number 2 dowel shoulder 1 x 30; pick up x 1 while seated. he wheelchair: hip flexion, ises x 10 each side; supine: d calf stretch 2 x 30, quad and heel slides x 10 each. .m. RN-A stated the facility e anyone providing ervices. RN-A thought it had the that the facility had gone his position. RN-A confirmed					
	On 2/18/15, at 3:00 p (PTA)-A stated she w have a current restora place. PTA-A stated frustrated because whose a resident, a rest for the resident and where receiving what is need on 2/18/15, at 1:00 p propelling herself in hallway into her room seated in her wheelch	.m. the physical therapy aide as aware the facility did not ative nursing program in the therapy department was hen they no longer could orative program was set up we know they are not ded. .m. R7 was observed her wheelchair down the where she remained					

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· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00078	B. WING		0;	2/20/2015
	ROVIDER OR SUPPLIER	.EARBROOK	ADDRESS, CITY, STATE AVENUE SOUTHW BROOK, MN 56634	/EST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	common compage	e 28 it day R7 had received	2 895			
	(OT)-A was observed and evaluation on R7 extension of her upper assisted R7 into the big propel herself in her wand with a gait belt and completed the traite toilet with minima on review of R7's bastoday, she did not se transfers and upper big OT-A thought it would	i.m. occupational therapist a conducting an assessment of CoT-A stated R7 had full be extremities. OT-A coathroom. R7 was able to wheelchair into the bathroom round R7's waist; R7 stood cansfer from the wheelchair to a lassistance. OT-A stated coeline and where R7 was a decline in her ability with cody strength. However, a be appropriate for therapy in just for a short period of				
	2/20/15, indicated R7 occupational therapy The occupational the benefit from continue compensatory techni levels. In addition, the	erapy plan of care dated had not received skilled services since 5/4/2012. rapist stated R7 would dwork with breathing and ques to improve her energy e resident showed potential upper extremity strength and				
	R49 had not received as directed by his cur	I restorative nursing services rent care plan.				
	Report, included cere	ndicated on the Diagnosis brovascular disease neart failure, aphasia (partial				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	EARBROOK 305 3RI	ADDRESS, CITY, STATE D AVENUE SOUTHV BROOK, MN 56634	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895		e 29 to communicate), atrial eart rate), anxiety and	2 895			
	R49 had severe cogn required extensive as transferring, dressing hygiene. In addition, I	dated 12/9/2014, indicated litive impairment and esist with bed mobility, toileting and personal R49 had ROM impairment and lower extremities.				
	R49's care plan dated 10/26/14, identified restorative interventions due to R49's performance deficit and limited physical mobility. R49's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises:					
	hip flexion, hamstring (exercise resistant ba bilateral abduction an hamstring stretch and If laying down: ARON flexion and stretch. A left; passive range of	range of motion (AROM) with curls with yellow t-band and) 2 x 10 on right; AROM adduction 2 x 10, at heel cord stretch bilaterally, and on right hip and knee abduction and adduction on motion (PROM): hip and adduction and adduction				
	PROM right upper wrist, fingers, all plans movement of thumb a tolerated. Yellow t-ba extremity 2 x 10 each and horizontal abduct left upper extremity, h x 10 beach ball. Nec	er extremity, shoulder, elbow es 2 x 10 each. Encourage and pointer finger as nd extension left upper elbow flexion, extension, tion/adduction. Ball toss to have him hit it back to you 2 k stretches, have him look al second seconds 1 x 10,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/20/2	015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - CL	305 3RD	DRESS, CITY, STA AVENUE SOUTH ROOK, MN 566	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) COMPLETE DATE
2 895	and Discharge Summ R49 had participated PT had worked with F increase his lower ext In addition, they work amount of assistance which resulted in little discharged from PT s functional maintenance	py (PT) - Therapist Progress ary dated 9/30/14, indicated in PT from 9/5/14 - 9/30/14. R49 and attempted to cremity strength bilaterally. Red on decreasing the he required with transfers or no gain. R49 was ervices and placed on a ce program. The Program dated 10/10/14, which was reflected on regards to his functional	2 895			
	On 2/18/15, at 2:09 p.m. R49 was observed being transferred with a mechanical lift from his wheelchair to his bed by NA-C and licensed practical nurse (LPN)-D. R49 required total assistance with transfer.					
	had not received his r as directed by his car verified 10/16/14, was someone providing re On 2/19/15, at 11:15 a	.m. RN-A confirmed R49 restorative nursing services re plan. In addition, RN-A restorative the facility had restorative nursing services. a.m. NA-C confirmed he had rive nursing exercises on the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH OOK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
2 895	Continued From page	: 31	2 895			
		a.m. NA-B confirmed she torative nursing exercises				
	On 2/19/15, at 11:33 a.m. NA-A confirmed sometimes she would do exercises with the residents; however she did not document these. NA-A stated the facility used to have a restorative aide who did the exercises with the residents.					
	On 2/19/15, at 11:40 a.m. NA-F confirmed she had not done any restorative nursing exercises with the residents.					
		p.m. the DON confirmed the formalized restorative				
	assessment and evalution concluded that through which she conducted	m. PT-A conducted an uation on R49. PT-A her partial evaluation today and her review of she had not seen a decline				
	R33 had not received restorative nursing services as directed by her current care plan. R33's diagnosis as indicated on the Diagnosis Report, included chronic airway obstruction, generalized osteoarthrosis, congestive heart failure, bursitis disorders generalized pain and depressive disorder.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		00078	B. WING		02/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	D AVENUE SOUTH BROOK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page	e 32	2 895			
	R33's quarterly MDS dated 10/25/14, indicated R33 had severe cognitive impairment and required extensive assist with bed mobility, transferring, toileting, dressing and personal hygiene. In addition, R33 had ROM impairment on both sides of upper and lower extremities. R33's care plan dated 2/19/15, identified					
	R33's care plan dated 2/19/15, identified restorative interventions due to performance deficit/limited physical mobility. R33's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: Overhead pulley X 3 minutes Yellow t-band all					
	planes 20 each. Assist to stand Bilateral stretch all directions including hamstring stretch, ham curls and sit to stand 1-2 minutes each. Sit to stand in parallel bars and work on standing tolerance Kegals for stress incontinence Seated manually resisted abduction and					
	shifting for 5 to 10 min R33's Physical Thera and Discharge Summ R33 had participated 9/7/12. PT had worke her lower extremity R status. PT provided g R33's abilities in all fu discharged from PT s	py (PT)- Therapist Progress nary dated 9/15/12, indicated in therapy from 8/9/2012 - ind with R33 and had gains in OM and improved transfer ait services which improved inctional mobility. R33 was iervices and placed on a				
	restorative service program. R33's Restorative Care Program dated 9/10/12, provided goals recommended by therapy for restorative services program to maintain ROM, maintain strength for lower extremities bilaterally, and maintain standing tolerance/endurance. Approaches and recommendations for implementation of the goals are identified on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00078	B. WING		02/20	/2015	
	PROVIDER OR SUPPLIER	LEARBROOK	STREET ADDRESS, CITY, STAT 305 3RD AVENUE SOUTH CLEARBROOK, MN 5663	WEST			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI R LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 895	R33's care plan. On 2/20/15, at 10:09 had not provided an exercises to any result of the care of the care was to assure several months. On 2/20/15, at 10:10 not received restoral several months. On 2/20/15, at 10:22 R33'S physical theraverified R33's restor recommendations for was 9/10/12. PTA-A expectation the facil services. PTA-A colassessment following and verified there with physical mobility. On 2/20/15, at 10:36 had not received resulting directed by her care was the last day R3 services. RN-A state restorative services. On 2/20/15, at 11:14 10/14/14, was the last restorative nursing serviced by the care. The Restorative Nursing services was to assure serviced independence for earlier was to assure services.	5 a.m., NA-C verified the yrestorative nursing ident. D a.m. LPN-B stated R33 tive services for the pass of a.m. during observation apy assessment, PTA-A retive services of a property of the provide the mpleted the physical register of the provide the molecular of the recommended go as no decline in R33's of a.m. RN-A confirmed for the past several more of the past se	3 had t n of PT pals R33 s as 14/14, pvided nths. e as sing ined				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S		
ANDILAN	O CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:	A. BUILDING:		COMPLETED	
		00078	B. WING		02/2	20/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREI	ET ADDRESS, CITY, STA	ATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - CL	.EARBROOK	RD AVENUE SOUT ARBROOK, MN 566				
(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 APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	strengths, needs and nursing assessments care would be outlined. SUGGESTED METH administrator or design policies and provide suprovision of restorative administrator or design auditing system in order.	problems as defined by the . In addition, the restorative d in the resident's care plan. OD OF CORRECTION: The gnee could review and revise staff education related to the	2 895				
2 915	Subp. 6. Activities of comprehensive reside home must ensure the A. a resident is git reatments and service abilities in activities of deterioration is a normal the resident's conditional part, activities of daily resident's ability to: (1) bathe, dress, (2) transfer and (3) use the toilet (4) eat; and	iven the appropriate ces to maintain or improve f daily living unless mal or characteristic part of on. For purposes of this v living includes the , and groom; ambulate; ; language, or other	2 915			3/25/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00078		B. WING		02/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK		POK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From page	e 35		2 915			
	by: Based on observatior review, the facility fail services in order to in resident's ability to an	t is not met as evidence n, interview and docume ed to provide ambulation prove or maintain the nbulate for 1 of 4 reside who were reviewed for ambulation services.	ent on		corrected		
	Findings include:						
	R21's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R21 was diagnosed with dementia and anxiety, had severe cognitive impairment and required extensive assistance with ambulation in her room and did not ambulate in the corridor. The assessment also indicated R21 displayed physical limitations on one side of her lower extremities.						
		d 5/12/15, directed staff te with a two wheeled w colerated.					
	10/3/12, by the physic	re Program established cal therapist directed sta two wheeled walker as	aff to				
	12:00 p.m. to 8:00 p.r	nducted on 2/17/15, fror m., on 2/18/15, from 8:0 on 2/19/15, from 7:00 a	0				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH OOK, MN 5663			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 915	Continued From page	: 36	2 915			
	to 3:30 p.m. R21 was wheelchair for mobility					
	stand and pivot-transf	.m. R21 was observed to fer to a commode with ff member. R21 did not walk n.				
	R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had not received assistance with ambulation services. R21's clinical record did not contain any further documentation related to ambulation services. The last entry related to ambulation was documented on 10/16/14.					
	On 2/19/15, at 1:00 p.m. family member (FM)-A stated she could not recall the last time she had seen R21 ambulate. She stated R21 had her own walker but she had not seen the walker in her room for months. FM-A stated she was not sure if R21 had the ability to ambulate.					
	was asked to assist R looked in R21's room her walker. NA-A wellocated a walker. NA to ambulate R21 36 fe same time, NA-A statenough staff to provide residents, however, the restorative NA to provide the same time.	a.m. nursing assistant (NA)-A 121 to ambulate. NA-A and was unable to locate in to the therapy room and 1-A and NA-B were observed eet in the corridor. At this ed the facility usually had be personal cares to the ne facility did not have a ride restorative services. In had not had a restorative eths.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00078		B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	_EARBROOK	305 3RD A	DRESS, CITY, STAT VENUE SOUTH OOK, MN 5663	WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENC CY MUST BE PRECEDED I LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page 37			2 915			
	On 2/19/15, at 1:30 p had been short staff residents had not rec restorative nursing be staff members to pro	members therefore beived assistance we ecause they did not	, the ith				
	On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months. She stated the facility did not have the staff to provide restorative nursing. On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services. On 2/19/15, at 2:00 p.m. LPN-B stated the facility had staffing issues. She stated the staff were doing the best they could, but they did not have time to perform the restorative programs for the residents.						
			were ot have				
	On 2/20/15, at 9:00 a stated R21's ability to related to the amoun having. She confirme not direct the staff as ambulate. She state offered assistance to facility did not curren She stated the facility NA who was in charge restorative nursing pof 2014, the restorati RN-A stated the facility RN-A stated the facility RN-A stated the facility RN-A stated the facility and stated RN-A stated the facility of 2014, the restoration of 2014, the resto	o ambulate fluctuate to f back pain she was R21's clinical received R21's clinical received R21 had not been ambulate because the type to have a restorative year to have a restorative of completing the rogram, however, in we NA had left the formation of the state o	ed daily vas ord did s to n routinely the ve NA. orative n October acility.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE: COMPI					
		00078		B. WING		02/2	20/2015
	ROVIDER OR SUPPLIER	EARBROOK	305 3RD A\	RESS, CITY, STA /ENUE SOUTH DOK, MN 5663	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E .SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETE DATE
2 915	Continued From page complete the restorat had not been allowed because she was neet the residents instead, none of the restorative completed as directed concern to the directed verified R21's care plansure ambulation see R21. The Care Plan policy care plan would empled development of the withe resident received services.	ive programs, howed to provide the serveded to provide directly she stated she was a programs had been and had reported for of nursing (DON), and had not been following the provided dated 9/2012, indicated 9/2012, indicated person ensuring appropriate care and	ices ct care to as aware en the RN-A lowed to ed to atted the	2 915			
21375	administrator or design policies and provide suprovision of ambulation administrator or design auditing system in order to the suprovision of ambulation administrator or design auditing system in order to the suprovision of the suprovision of ambulation administrator or design auditing system in order to the suprovision of ambulation of the suprovision	gnee could review a staff education relation services. The gnee could develop der to ensure complete to ensure complete. The CORRECTION: Two control program. A and maintain an infigned to provide a sa	nd revise ed the and iance. enty-One ontrol; a nursing ection	21375			3/25/15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00078	B. WING		02/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - CL	EARBROOK 305 3RD A	VENUE SOUTI	HWEST	
		CLEARB	ROOK, MN 566	34	
(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21375	Continued From page	e 39	21375		
	This MN Requiremen by: Based on observation review, the facility fail glucometers (devices sugars) were appropri	n, interview and document ed to ensure the sutilized for monitoring blood riately disinfected after each ad the potential to affect 3 of 2, R54) who used a		corrected	
	Findings include:				
	On 2/17/15, at 4:31 p.m. registered nurse (RN)-B was observed to conduct a blood glucose check on R14. Immediately following R14's blood glucose check, RN-B was observed to wipe off the glucometer with an alcohol prep wipe which contained 70% isopropyl alcohol. RN-B confirmed R14, R22, and R54, all utilized this glucometer and that she routinely disinfected the glucometer by wiping it down with an alcohol prep wipe after each resident use.				
	nurse (LPN)-B confirr currently stored in the were utilized by R14, stated she disinfected	.m. the licensed practical med the two glucometers e first floor treatment cart R22, and R54. LPN-B d the glucometers after each g them down with an alcohol			
	(DON) verified the res not have their own de DON stated the gluco after each use and sh wipe was an appropri	ould follow the facility policy			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00078	B. WING		02/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH OOK, MN 5663			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21375	Meters policy dated 1 properly disinfect the resident use with 1:10 an acceptable germic. The Assure Platinum instructions directed sthe glucometer betwee EPA (Environmental Fregistered disinfectan wipe.	sinfecting Blood Glucose 1/2014, directed staff to glucometer after each bleach to water solution or idal disposable wipe. glucometer manufacture staff to clean and disinfect en each resident, using an	21375			
	policies and procedur cleaning/disinfecting of glucometers and prov administrator or desig auditing system in ord	es related the appropriate				
21435	home must provide an recreation program. based on each individual strengths, and needs meet the physical, mewell-being of each rescomprehensive reside comprehensive plants	General requirements. A nursing in organized activity and The program must be dual resident's interests, and must be designed to cental, and psychological sident, as determined by the	21435			3/25/15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00078	B. WING		02	/20/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - CL	EARBROOK 305 3R	ADDRESS, CITY, STA D AVENUE SOUT BROOK, MN 566	HWEST		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21435	Continued From page provided opportunitie planning and develop recreation program.		21435			
	by: Based on observatior review, the facility fail been offered accordir	n, interview and document ed to ensure activity's had ng to the assessed need for reviewed for activities.		corrected		
	Findings include:					
		rt dated 2/20/15, indicated with Alzheimer's disease, agia and depressive				
	7/4/14, indicated R10 cognition, required ex staff with transfers an The MDS further indicated R10	m Data Set (MDS) dated had severely impaired ktensive assistance of two id locomotion on the unit. cated R10 felt the following were very important to her:				
	- listen to music - participating in favor - participate in religion	rite activities us services or practice				
	completed 7/2/14, inc following activity inter Entertainment, poetry activities, music activ and Christian music,					

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02	/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	02	72072010	
	MARITAN SOCIETY - CL	FARBROOK 305 3RD	AVENUE SOUTH	IWEST			
		CLEARB	ROOK, MN 5663				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21435	Continued From page	e 42	21435				
		beach ball toss, humor and bits, devotions, worship utdoors.					
	indicated R10 was de activities, cognitive st interaction. The care R10 1:1 bedside/in-roattend out of room evactivities such as constay in room, naps, clevents. The care plan often 1:1 activities we who preferred to stay frequency of the direction.	imulation and social plan directed staff to provide com activities if unable to ents as well as preferred versation, music, prefers to nildren, outdoor and spiritual had not identified how ere to be provided to R10 in her room nor the ctive to encourage ongoing evite residents and family to					
	On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was observed being assisted to eat the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities.						
	seated in her room. N 11:36 a.m. R10 was o	.m. R10 was observed lo television or radio on. At observed seated in the ting to go into the dinning eal.					
	On 2/19/2015, at 8:44 the dining room, eating	4 a.m. R10 was observed in ng breakfast.					
	On 2/19/2015, at 9:34 seated in front of the	a.m. R10 was observed television with other					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	EARBROOK 305 3R	ADDRESS, CITY, STATE O AVENUE SOUTHV RBROOK, MN 56634	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21435	residents while the m	orning news show was on. osed and did not appear to	21435			
		03 a.m. Church service was t assisted to the service /				
		0 p.m. R10 was observed n lounge area just watching				
	party was held. Howe	a monthly resident birthday ever, R10 was not asked or rthday party / activity.				
	that on 2/19/14, R10 in 2 activities, however documentation what a provided and if R10 a activity or even liked the activity participati February 2015, revea 22 1:1 activities and the actual type of activity was not identification.	aled R10 had participated in 11 group activities. However, ivity and the length of the ified. The documentation k by a time and a checkmark				
	(AD) was asked what participated in on 2/1 2/19/15, activity docu	a.m. the activity director t activities R10 had 9/15. The AD confirmed the mentation and stated the				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED	
			7 50.25 10.			
		00078	B. WING		02/20/2015	
			-			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		305 3RD	AVENUE SOUTI	IWEST		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK				
		CLEARB	ROOK, MN 566	34		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
			1	DEFICIENCY)		
04405	0 " 15	4.4	24425			
21435	Continued From page	9 44	21435			
	educational / cognitive	a activity. When the				
	_	the actual activity was and if				
		or enjoyed the activity, the				
	AD stated she could r	not tell by the documentation				
	exactly what the activ	rity actually was nor how long				
		e AD stated she would have				
		son who documented the				
	• •	ow what the activity actually				
		asted. The AD left to make a				
	· ·	9/15, activity person. After				
	the call, the AD stated	d she was informed R10 had				
	participated in a musi	ic activity on television but				
	T	ogram it was, what time the				
	•	R10 enjoyed the activity nor				
	-	lasted but stated there was				
		elevision. The AD also				
		ot assisted to the church				
	service nor the group	birthday party held on				
		ied both activities were				
	identified as activities	of interest for R10 and				
		ive been asked to join and				
		<u>-</u>				
		ies. The AD also stated the				
		em had changed in the past				
	year and it was now h	nard to tell what specific				
	activities residents ac	ctually attended, how long				
	the activities lasted ar	nd if the resident enjoyed the				
		d 1:1 activities could last				
	_	minutes and could range				
	-	•				
		n the hallway about a family				
		ning on the television for a				
		would be documented as a				
	1:1 activity. The AD c	confirmed the charting				
	system did not give a	n accurate reflection of how				
	often and what activit					
	participated in.	, That actually				
	participated iii.					
	an activy policy and p	procedure was requested				
	and not provided.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		00078	B. WING		02/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK 305 3RD A	VENUE SOUTH	WEST		
		CLEARBR	OOK, MN 5663	34		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21435	Continued From page	e 45	21435			
21535	SUGGESTED METH administrator or design policies and provide suprovision of activity sedesignee could develorder to ensure composition. TIME PERIOD FOR (21) days.	OD OF CORRECTION: The gnee could review and revise staff education related to the ervices. The administrator or op an auditing system in correct corre	21535			3/25/15
	Subpart 1. General. must be free from uni unnecessary drug is a A. in excessive d therapy; B. for excessive d C. without adequ D. in the presence which indicate the dos discontinued. In addition to the dru part 4658.1310, the r with provisions in the Code of Federal Regu 483.25 (1) found in A Operations Manual, O Long-Term Care Faci Department of Health Health Care Financin This standard is incor available through the	A resident's drug regimen necessary drugs. An any drug when used: ose, including duplicate drug duration; ate indications for its use; or se 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 and Human Services, g Administration, April 1992. Prorated by reference. It is Minitex interlibrary loan Law Library. It is not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3			(3) DATE SURVEY COMPLETED	
		00078		B. WING		02	/20/2015
	ROVIDER OR SUPPLIER	_EARBROOK	305 3RD A	PRESS, CITY, STA	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY LSC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21535	Continued From pag	e 46		21535			
	This MN Requirement by: Based on observation review, the facility fair adequate indication for (anti-psychotic) medications in the sample of medications.	n, interview and doculed to ensure there we for the use of Seroquication for 1 of 5 residents.	ument vas el dents		corrected		
	Findings include:						
	R48's Diagnosis Rep R48 was diagnosed generalized pain, der disturbances, general hearing loss.	with memory loss, mentia with behaviora	al				
	R48's admission Min 9/1/14, identified R48 LPN and R48 had mearing, was able to understood, had seved displayed patterns of (disorganized or illog rambling or irrelevan illogical flow of ideas switching from one idadmission MDS also delusions, was indeptransfer ability and dideficits.	B's lifetime occupation oderate difficulty with clearly make self erely impaired cognited disorganized thinkin ical flow of conversation, uncled, or unpredictable species to the next rapidly identified R48 had bendent with ambulation of conversation.	n was a h ion, and ig tion ear or eech y). The				
	R48's care plan last following: R48 is on \$		ealed the				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			D WING			
		00078	B. WING		02/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			/ENUE SOUTH			
GOOD SA	MARITAN SOCIETY - CL	EARBROOK				
		CLEARBRO	OOK, MN 5663	34		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	KLOOLATOKT OKL	ESCIDENTII TING INI CHWATION)	TAG	DEFICIENCY)	MAIL	5,112
21535	Continued From page	e 47	21535			
	-44					
		attempting to toilet or get				
		ring garbage in drawers.				
	·	in November 2014. The				
		the following: "BLACK BOX				
		erve for increased mortality				
	in elderly patients with					
		rsening of depression and				
		adverse effects include				
	agitation, anxiety, increased cholesterol,					
	constipation, dizziness, drowsiness. The resident					
	has a behavior sympt	om related to poor memory,				
	wanders, attempts eld	opements, attempts toileting				
	_	in at night and awakes other				
	residents for cares. The	he interventions included:				
	Intervene as necessa	ry to protect the rights and				
	safety of others, appro	oach and speak in a calm				
	manner, divert attention	on, remove from situation				
	and take to an alterna	ate location, provide				
	opportunity for positiv	e interaction and attention.				
	Minimize potential for	residents disruptive				
	behaviors, elopement	t attempts by offering tasks				
	which divert attention	such as scrabble games				
	puzzles and visiting w	vith other ladies. Praise any				
	indication of residents	s progress/ improvement in				
	behavior. Resident p	refers diversional activities				
	as listed above puzzle	es, scrabble.				
	·					
	The care plan identifie	ed the following behaviors:				
	-BEHAVIOR #1 elope	ment attempts: likes				
	scrabble, puzzles with	n other ladies. Target				
	behaviors for PRN Xa					
	-BEHAVIOR #2 Storin	ng garbage in dresser				
		ser drawers once every shift				
	for garbage or food.	•				
	-BEHAVIOR #4 awaki	ing other residents				
		et up at night. Check resident				
		er to take resident on a walk				
	outside. Redirect.	The state of the s				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3) DATE			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00078	B. WING		02/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	FARBROOK 305 3RD	AVENUE SOUTH	WEST		
	WARTEN GOODETT - GE	CLEARB	ROOK, MN 5663	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page 48		21535			
	included the following behavior symptom rel wanders, attempts elso other residents goes i residents for cares. The same as above where and interventions there section of the care plate aforementioned problems included: check resident has potential dementia, less than 5 included: check resident has physician programments.	ated to poor memory, openent, attempts toileting in at night and awakes other he care plan is virtually the exit lists the same problems re is nothing new in this an just a repeat of the em and intervention. The for elopement related to minute recall. Interventions ent every 30 minutes.				
	indicated Seroquel was behaviors that include care of other residents help the nurses in the residents. The physic R48 had no hallucinary physician progress not 12/18/14, which ident prescribed the antipsy behaviors that include some behaviors where care of the patient, like feed them, entering in etc." The physician with helping." but does not behaviors occurred, non-pharmacological successful.	as started because R48 had ad wanting to assist in the is in the facility as well as facility care for the ian progress note indicated tions or delusions. The next of the provided was dated iffed that R48 was yethotic medication for each "continues to have the she tends to interrupt the etransferring them, trying to other residents' rooms, and "Seroquel seems to be at identify how often the inen-pharmacological and if those interventions were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ED	MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00078	B. V	VING		02/20/2015
	ROVIDER OR SUPPLIER	.EARBROOK	STREET ADDRESS 305 3RD AVENU CLEARBROOK,	E SOUTH	WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLETE
21535	and the NPN dated 1 Seroquel had been re no physician progres rationale for stopping nor for restarting the	2/4/14, identified the estarted, however there is note that explained the the medication on 11/1 medication on 12/4/14.	was e 17/14,	535		
	on 12/4/14, Seroque	sician orders revealed t el 25 milligrams (mg) (ar tion) was restarted for iors.				
	Further review of R48's medical record revealed that monthly summaries of behavior were completed for the day and night shift from 9/1/14-1/24/15, and included the following:					
	identified R48 had be included delusions (nare firmly held, contrasection of the report is restless at times and quickly will settle down gets distracted talking activity. Seems to be documentation had no behavior was occurripharmacological and	non-pharmacological tempted to remove or re	ed or this			
	9/17/14, identified R4 symptoms exhibited documentation had it	nursing documentation of the had mood and behave during the night shift. The not identified what the low frequently they occur	rior ne			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING: _			
		00078	B. WING		02/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COOD CA	MADITAN COCIETY CI	SARRESON 305 3RD A	VENUE SOUTH	IWEST		
GOOD SA	MARITAN SOCIETY - CL	CLEARBR	OOK, MN 5663	34		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page	2.50	21535			
	The boxes that identification interventions included puzzles, reading mate Pharmacological intervaliable." Under the was identified that R4 roommate." Under the	fied non-pharmacological I "phone calls to daughter, erials and TV programs." Eventions were "PRN Xanax Exection for sleep patterns it				
	identified R48 had be included delusions. The report identified "becon evening wanting to put into other residents rowalking up and down kitchen wanting to he times when told she is toilet transfer states the often not successful reterm memory. The dot identified how often the and what type of phan non-pharmacological attempted and if they "Some decrease in be Seroquel. Will cont to documentation dated mood and behaviors the night shift. The dot identified what the be frequently they had or monthly nursing docuidentified non-pharmacincluded "Redirect to	hallwaysgoing to the lp,,, becomes agitated at s not to help either residents his is her house an she can ere,,,needs redirection that is elated to poor and short formentation had not his behavior was occurring reacological and interventions were were successful. Also noted enaviors noted with start of monitor. Night shift monthly 11/17/14, identified R48 had symptoms exhibited during formentation had not haviors were or how courred. The boxes on the mentation form that acological interventions bedroom, offer activity" and eventions were identified as:				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00078	B. WING		02	2/20/2015
	ROVIDER OR SUPPLIER	LEARBROOK 305	REET ADDRESS, CITY, STATE 3 3RD AVENUE SOUTHV EARBROOK, MN 56634	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From pag	ge 51	21535			
	dated 12/24/14, ider symptom. Night shif dated 12/18/14, ider and behavior symptout had not identified how frequently they that identified non-pand pharmacological blank. Further docurappeared to rest core	hly nursing documentation ntified again no behavior to monthly documentation ntified that R48 had mood oms exhibited during the night discourred and the boxes harmacological interventions all interventions were left mentation identified R48 mfortably through the night. documentation noted.	-			
	dated as completed had no behavioral or documentation identiand paced up and diredirect most of the included Seroquel's monthly nursing documentally they had identified non-pharm pharmacological interpretation identified non-pharmacological interpretation identified non-pharm	hly nursing documentation on 1/24/15, revealed R48 remood symptoms. The diffied R48 got very anxious own the hallways, unable to time. New medications tarted on 12/18/14. Night shift umentation completed 48 had mood and behavior during the night but had not ehaviors were or how occurred and the boxes that nacological interventions and erventions were left blank. On identified R48 appeared tough the night.				
	reports were review the following was ide					
		narmacist recommendations odate care plan to reflect non				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00078	B. WING		02	20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH ROOK, MN 5663				
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21535	the Seroquel after the place. If medication is trazodone 12.5 mg Bl Please document nor failed and perform qu analysis at least quar determine triggers of re-assess/update carwas no indication that recommendation had entirety. The Seroque 11/17/14, however trastarted in it's place, a	o try, consider discontinuing e non- pharm interventions in s needed, consider ID instead of Seroquel. In pharm interventions which alitative and quantitative terly of this information to the behaviors and e plan as needed." There is this pharmacy been acted on in its el had been discontinued on azodone had not been	21535				
	recommendations for "Discussed need to conterventions and targous psychotropics with DO aware. Utilize antipsy reasons for behaviors documenting interventionally and the behaviors patterns, # of times, coaround the behaviors needed continues from 2/18/2015 11:20 a seated in the common holding her purse. R4 was getting ready to gwas a few blocks away was just working herestill had a car in the g	are plan non pharm get behaviors for ON and staff. They are chotic when all other s are ruled out. Be sure stions failed and perform at least quarterly for other pertinent information . Update care plan as					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ` ′	(X3) DATE SURVEY COMPLETED	
			D. MANING			
		00078	B. WING		02/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CL	EARBROOK	VENUE SOUTH			
	I	CLEARBE	ROOK, MN 5663	34		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page	e 53	21535			
	the nursing home now retired. R48 stated the practical nurse (LPN)	ed she was working here in w only part time as she was at she was a licensed and liked visiting with the them as much as she				
	she had verbally expr starting antipsychotic first doing a complete then identifying and e non-pharmacological pharmacist stated that the antipsychotic medical elopement attempts a other residents in the stated that R48 had be the facility working as for over 40 years). The R48 did not have an a use of the antipsycho stated she had also e of nursing (DON). The had explained to the antipsychotic medical indication for its use of and the facility would behavior and develop interventions and deter failed including the us pharmacological mediantipsychotic medical she had included the	interventions. The at the indications for using dication for R48 included and attempting to care for facility (the pharmacist also been a former employee of a licensed practical nurse are pharmacist confirmed adequate indication for the tic medication Seroquel and explained this to the director are pharmacist revealed she facility staff that using tion without an adequate could be a chemical restraint need to assess R48's a non-pharmacological ermine that all of them had see of more appropriate				
		.m. nursing assistant (NA)-F				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00078	B. WING		02	/20/2015
	PROVIDER OR SUPPLIER	305 3R	ADDRESS, CITY, STATE			
	MARTIAN GOOLLI - GE	CLEAR	BROOK, MN 56634			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	and R48 was easily rehelping residents too hard for R48 to remet working here in the nestated R48 was usual her a cup of coffee or common lounge area out so that she could. On 2/20/15 at 9:33 a. been an employee of 40 years. The DON's Seroquel for indication elopement from the fassist other residents not provide a compre R48's behaviors and non-pharmacological those that had failed DON confirmed R48 eloped from the faciliti medication to deter e other residents was not the serious confirmed R48.	edirected if she started much. NA-F stated it was mber that she was not ursing home anymore. NA-F lly redirected easily by giving setting her out in the where other residents hang converse with them. m. the DON stated R48 had the nursing home for over stated R48 was receiving ns which included acility and attempting to . The DON stated she could hensive assessment of	21535			
	nurse (LPN)-C stated evening that included residents. LPN-C stated anyone, and didn't rear a behaviorand R48 LPN-C also stated R4 people and there were a result of R48 trying R48 was easy to redi	17 a.m. licensed practical R48 had behaviors in the trying to help other ted R48 would never harm ally think of R48's actions as would never hurt anyone. 48 liked to be around other e no residents in danger as to be helpful. LPN-C stated rect by asking her to have a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00078	B. WING		02/20/2015		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
GOOD SA	GOOD SAMARITAN SOCIETY - CLEARBROOK 305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE		
21535	Continued From page	e 55	21535				
	other residents.						
	An antipsychotic use not provided.	policy was requested and					
	administrator or design policies and provide suse of antipsychotic radministrator or design	OD OF CORRECTION: The gnee could review and revise staff education related to the needication. The gnee could develop an der to ensure compliance.					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-One					

Minnesota Department of Health

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