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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BZIY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5368

On February 18, 2015, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 23, 2014. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of January 14, 2015. Based on our visit, we have determined that the facility had corrected the deficiencies issued pursuant to our PCR, completed on December 23, 2014, as of January 14, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 14, 2015.

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

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 31, 2015 be rescinded. (42 CFR 488.417 (b))

Since Mandatory denial of payment for new Medicare and Medicaid admissions never went into effect, the facilty would not be subject to a two year loss of NATCEP.

Refer to the CMS 2567b for health only.

Effective January 14, 2015 the facility is certified for 119 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245368

March 9, 2015

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Dear Ms. Jokinen:

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

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

Effective January 14, 2015 the above facility is certified for:

119 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 119 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: .

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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 2, 2015

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368025

Dear Ms. Jokinen:

On December 30, 2014, we informed you that the following enforcement remedy was being imposed:

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

On December 30, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 31, 2015. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of December 30, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on October 31, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 23, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On February 18, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 14, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 23, 2014, as of January 14, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 14, 2015.

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 31, 2015 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 31, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 31, 2015, is to be rescinded.

In our letter of December 30, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 31, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 18, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

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

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

5368r2_15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **01/14/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/14/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **01/14/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/14/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	03/02/2015	32601	02/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/31/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BZIY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 12/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5368

On December 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2014.

We presumed, based on your plan of correction, that the facility had corrected these deficiencies as of December 9, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 31, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

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

F0176 -- S/S: D -- 483.10(n) -- Resident Self-Administer Drugs If Deemed Safe

As we notified the facility in our letter of November 18, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2015. In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance.

Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify the facility of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 31, 2015. (42 CFR 488.417 (b))

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 30, 2014

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368025

Dear Ms. Jokinen:

On November 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 23, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 9, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 31, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

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

F0176 -- S/S: D -- 483.10(n) -- Resident Self-Administer Drugs If Deemed Safe

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

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

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

However, as we notified you in our letter of November 18, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2015.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 31, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 31, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 31, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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

APPEAL RIGHTS

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	R 12/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 12/22/14 - 12/23/14. The certification tags that were corrected can be found on the CMS2567B. Also there were tag that were not found corrected and one new tag was issued at the time of onsite PCR which are located on the CMS2567. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of nebulizer treatments (a drug delivery device used to administer medication in the form of a mist	F 176	F176 - D 1. Corrective Action: A. RN- B on 12/22/14 reassessed Resident (R30) for any negative outcome due to extended length of nebulizer	1/14/15

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

Electronically Signed | 12/30/14

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F 176	Continued From page 1 inhaled into the lungs) for 1 of 1 resident (R30) observed self administering a nebulizer treatment. R30's quarterly Minimum Data Set (MDS) dated 11/24/14, indicated R30 was cognitively intact and had diagnoses including Alzheimer's disease and congestive heart failure. R30's Self Administration of Medication Assessment dated 8/26/14, indicated R30 may not keep medication and self administer at bedside. R30's undated care plan directed staff no self administration of medications due to R30's recent decline in condition. The care plan indicated nursing staff would safely administer and observe R30 taking designated medications daily. R30's Medication Administration Record dated 12/1/14-12/31/14, identified an order dated 12/16/14, for R30 to receive albuterol sulfate nebulization solution 2.5 milligrams (mg)/3 milliliters (ml) 0.083% 1 vial inhale orally via nebulizer every four hours while awake for shortness of breath related to congestive heart failure. On 12/22/14, at 3:26 p.m. licensed practical nurse (LPN)-B was observed to enter R30's room and set up R30's nebulizer treatment. R30 was observed to be resting in bed, positioned on her back. LPN-B then applied the mask delivering the nebulized medication to R30's face and secured it with a strap behind R30's head, turned off the light and left the room. R30 was continuously observed alone in her room with the nebulizer treatment on until 3:55 p.m.	F 176	treatment, no harm noted. IDT discussed Self Administration of nebulizer for resident (R30) and determined re-assessment for self-administration of medication, RN-B assessed for safety with nebulizer and eye drops, resident (R30) demonstrated ability, provider updated and order obtained 01/06/15. On 12/22/14, LPN -B transcribed own medication □ treatment error and was re-educated 1:1 by RN-B and DON. 2. Corrective Action as it applies to Other Residents: A. 100% review of all others who receive nebulizer treatments. B. Completion of new self-administration for nebulizer treatments on all those who are prescribed nebulizers to determine safety. C. Providers updated, orders obtained and Team updated through 24 hour report. D. Written Education for Nursing Team Members 12/22/2014. 3. Date of Completion: 01/14/15 4. Reoccurrence will be prevented by: A. Nursing Team reeducated on self-administration assessment to determine safety, five rights of medication administration and the Self-Administration policy in written format 12/22/14. A mandatory meeting for all Nursing team members is scheduled the week of 01/12/15. B. Observation through direct audit will be conducted twice per shift for one week,	

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F 176	Continued From page 2 -At 3:55 p.m. nursing assistant (NA)-C looked into the room briefly and then continued down the hallway. R30 was continuously observed until 4:10 p.m. On 12/22/14 at 4:10 p.m. LPN-B was observed walking away from the unit when the surveyor intervened. LPN-B stated she was going on her break. When asked, LPN-B stated she usually left R30's nebulizer treatment on for 5-10 minutes and confirmed it had been on for 40 minutes. LPN-B immediately went to R30's room and discontinued the treatment. LPN-B stated she usually gave R30 her treatment sooner to the time she got up for supper so that if she got busy the NAs would take the treatment off of R30 for her. On 12/23/14 at 2:59 p.m. registered nurse (RN)-B confirmed R30's nebulizer treatment should have been discontinued after 10 minutes. RN-B further stated she had thought self-administration of medications only included pills but after this incident had discussed the situation with the director of nursing (DON) and had determined that in order to be left unattended there should have been a designation in R30's chart that addressed this. RN-B confirmed R30's chart did not contain a designation allowing for R30 to be left unattended during a nebulizer treatment. RN-B also confirmed R30's care plan directed no self administration of medications and R30 should not have been left unattended during her nebulizer treatment. The Albuterol Sulfate Inhalation Solution 0.083% Prescribing Information from Ritedose Pharmaceuticals, LLC identified administration instructions that included regulate flow rate to suit	F 176	then weekly x 4, then monthly with review at the of completion by the observer with immediate education for any deviation from protocol. Nurse Managers will collect and review completed observations 3 times per week. Completed data/analysis to be routed monthly to DON. 5. The Correction will be monitored by: A. DON or designee (QC □RN). B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 176	Continued From page 3 the particular nebulizer so that albuterol inhalation solution will be delivered over approximately 5 to 15 minutes.	F 176		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions for repositioning and pressure relieving devices were followed or 1 of 4 residents (R159) identified with pressure ulcers; for 1 of 3 residents (R27) who were directed to be on an ambulation program; and 1 of 1 resident (R30) who self-administered a medication who had been deemed not appropriate to self-administer medication. Findings include: PRESSURE ULCER PREVENTION: R159 was not repositioned every hour, nor had a pressure relieving cushion in her wheelchair as directed by her care plan. R159's Grand Village Diagnosis Report dated [undated] identified R159's diagnoses as chronic kidney disease, obesity, urge incontinence, memory loss, hypertension (high blood pressure), spondylolisthesis (a condition in which one bone in your back slides forward over the bone below it), and heart failure.	{F 282}	F282 -D 1. Corrective Action: A. RN- A on 12/23/14 reassessed Resident (R159) for any negative outcome due to extended length of sitting in wheel chair and recliner with no observed off- loading. DON conducted an internal investigation to determine if deviation in plan off care (No pressure relieving cushion in wheel chair or recliner, no positioning or offloading within assessed hour need, undocumented dressing changes had occurred) had resulted in actual harm, investigation concluded noted healing. DON instructed Nurse Managers to validate orders within new electronic health record to confirm display accuracy on eMAR/eTAR. B. RN-B on 12/23/14 conducted interview with NA-D regarding Resident (R27) notification of change in restorative program (ambulation), from the 6/10/14 recommendations Amb along handrail in hallway with distance as tolerates - approx	1/14/15

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{F 282}	Continued From page 4 R159's quarterly Minimum Data Set (MDS) dated 11/18/14, indicated R159 had severe cognitive impairment and required extensive assist with bed mobility, transferring and toileting. In addition, identified that R159 had a stage 2 pressure ulcer (a pressure wound that had partial thickness loss of the skin with a red-pink wound, without dead tissue) and recommended R159 be on a turning and repositioning program, have a pressure relieving device in her chair and pressure ulcer care to be completed. R159's Short Term Care Plan dated 12/16/14, identified a problem of an unstagable pressure ulcer to R159's left buttock. The approaches identified, directed staff to repositioned R159 every one hour, place a cushion in her wheelchair and in her recliner, place an air mattress on her bed, and follow the lean wound protocol for treating her wound. On 12/23/14, at 7:45 a.m. R159 was observed seated in her wheelchair at the dining room table. At 8:30 a.m. R159 propelled her wheelchair away from the dining room table and into her room. The nursing assistant (NA)-A followed R159 into her room and asked R159 if she needed to go to the bathroom. R159 stated she didn't and then NA-A asked R159 if she wanted to be transferred into her recliner. R159 responded that she did. At 8:34 a.m. NA-A placed a transfer belt around R159 and directly transferred her into her recliner beside her bed. R159 was not offloaded (relieving the pressure to an area for one full minute) during this transfer. At this time, it was observed that R159 did not have a pressure relieving cushion in the wheelchair she had just been transferred from. NA-A confirmed that there had not been a cushion in R159's wheelchair, nor	{F 282}	10□ □ 6x□s a week. Documentation noted to include resident desire to decline ambulation; functional ability with transfers and ROM remains unchanged. On 12/23/14 Physical and Occupational Therapy orders were obtained for mobility and transfers to determine appropriate programming within resident functional ability and desire. C. RN- B on 12/22/14 reassessed Resident (R30) for any negative outcome due to extended length of nebulizer treatment, no harm noted. IDT discussed Self Administration of nebulizer for resident (R30) and determined re-assessment for self-administration of medication, RN-B assessed for safety with nebulizer and eye drops, resident (R30) demonstrated ability, provider updated and order obtained 01/06/15. On 12/22/14, LPN -B transcribed own medication □ treatment error and was re-educated 1:1 by RN-B and DON. 2. Corrective Action as it applies to Other Residents: A. 100% review of all others who are assessed with Braden less than 18, restorative therapy, and receive nebulizer treatments. B. Completion of new skin assessment as indicated by visual inspection, noting adherence to care plan intervention; NA-D to review all current Restorative programming with Nurse Mangers to determine functional ability and desire, re-implement Nursing to Therapy Referral with noted change in function and or desire; self- administration assessments	

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{F 282}	Continued From page 5 was she aware if R159 needed one. NA-B entered R159's room and confirmed R159 should have a cushion in her wheelchair and stated that yesterday when therapy brought her back they must have brought her back in the wrong wheelchair. At 8:40 a.m., NA-B verified that R159 had been up since 7:00 a.m. seated in the wheelchair without a pressure relieving cushion. In addition, licensed practical nurse (LPN)-A was unsure if R159 should have a pressure relieving cushion in her wheelchair. NA-B located R159's wheelchair with a cushion in a storage area at the end of the unit and switched it out with the wheelchair that had no cushion. At 8:56 a.m. registered nurse (RN)-A stated she would be measuring R159's wound today. RN-A was unable to articulate what offloading was and/or if R159 should have a pressure relieving cushion in her chair. R159 remained seated in her recliner until 9:17 a.m. when she put her call light on and requested to use the bathroom. At 9:20 a.m. LPN-A placed a transfer belt around R159; transferred her into her wheelchair with the pressure relieving cushion; and transported her into the bathroom and on to the toilet (2 hours and 20 minutes - the time R159 had remained without being offloaded). On 12/23/14, at 1:56 p.m. the director of nursing (DON) confirmed her expectation for offloading was the resident should be offloaded for a couple of minutes. The DON confirmed R159's care plan should be followed to include repositioning every one hour and assuring she had a cushion in her wheelchair. The DON agreed waiting two hours and 20 minutes to reposition R159 was too long. The Skin Assessment and Care policy dated 11/2013, indicated the purpose of the policy was to prevent skin breakdown and provide early	{F 282}	all those who are prescribed nebulizers to determine safety. C. Providers updated, orders obtained as needed and Team updated through 24 hour report. D. Written Education for Nursing Team Members 12/22/2014. 3. Date of Completion: 01/14/15 4. Reoccurrence will be prevented by: A. Nursing Team reeducated on pressure relieving cushion in wheel chair or recliner, positioning or offloading within assessed need, documented dressing changes, self-administration assessment to determine safety, five rights of medication administration and corresponding policies in written format 12/22/14. A mandatory meeting for all Nursing team members is scheduled the week of 01/12/15. B. Observation through direct audit will be conducted twice per shift for one week, then weekly x 4, then monthly with review at the of completion by the observer with immediate education for any deviation from protocol. Nurse Managers will collect and review completed observations 3 times per week. Completed data/analysis to be routed monthly to DON. 5. The Correction will be monitored by: A. DON or designee (QC □RN). B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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{F 282}	Continued From page 6	{F 282}		

intervention and treatment for existing skin problems. In addition, the resident who had a pressure ulcer should have received the necessary treatment and services which promoted healing, prevented infection and prevented new sores from developing. The policy directed staff to assure pressure reduction or offloading was conducted as ordered; any dressing changes and treatments should be noted; and redistribution of pressure, pressure redistributing surfaces and an individualized repositioning plan should be developed and followed.

The Care Plan - IDT policy dated 5/2013, indicated the care plans are updated on an ongoing basis to meet the needs of the resident. The care plan is used by all personnel involved in the care of the resident.

AMBULATION:

R27 was not provided ambulation services as directed by the care plan.

R27's care plan dated 11/17/14, directed staff R27 was to ambulate along handrail in hallway with distance as tolerated (approximately 10 feet) 6 times per week. The care plan also identified R27 ambulated with nursing rehab.

On 12/22/2014, at 2:16 p.m. R27 was observed seated in her wheelchair outside the nurses' station. R27 then wheeled herself independently down the hall utilizing her left hand and foot. R27's right hand was contracted and rested on a 1/2 size padded table attached to her wheelchair. R27's right foot rested on a foot rest attached to the wheelchair.

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{F 282}	Continued From page 7 R27 was not observed ambulating at any time during the survey from 12/22/14 at 2:16 p.m. until 12/23/14 at 3:00 p.m. On 12/23/14, at 3:00 p.m. R27 stated she did not walk, however did attend exercises which was enough. On 12/23/2014, at 3:15 p.m. nursing assistant (NA)-D stated R27 was supposed to be on a walking program but she always refused. NA-D stated she performed passive range of motion exercises to R27's upper and lower extremities, however, did not ambulate her. NA-D stated R27 was too scared to ambulate and she had tried several approaches, without success, to ambulate R27. On 12/23/2014, at 3:26 p.m. registered nurse (RN)-B confirmed R27's care plan directed staff to ambulate R27 in the hallway but indicated the task was not included in the restorative tasks section of the computer. RN-B denied knowledge the ambulation had been discontinued. RN-B stated R27 should still be receiving these services. RN-B stated if she had been told R27 was refusing ambulation she would have requested a PT/OT [physical therapy/occupational therapy] evaluation and followed up with the issue. SELF-ADMINISTRATION OF MEDICATIONS: Nursing staff did not safely administer and observe R30 taking her nebulized medication as directed by the care plan.	{F 282}		

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{F 282}	Continued From page 8	{F 282}		

R30's undated care plan directed staff no self administration of medications due to R30's recent decline in condition. The care plan indicated nursing staff would safely administer and observe R30 taking designated medications daily.

R30's Medication Administration Record dated 12/1/14-12/31/14, identified an order dated 12/16/14, for R30 to receive albuterol sulfate nebulization solution 2.5 milligrams (mg)/3 milliliters (ml) 0.083% 1 vial inhale orally via nebulizer every four hours while awake for shortness of breath related to congestive heart failure.

On 12/22/14, at 3:26 p.m. licensed practical nurse (LPN)-B was observed to enter R30's room and set up R30's nebulizer treatment. R30 was observed to be resting in bed, positioned on her back. LPN-B then applied the mask delivering the nebulized medication to R30's face and secured it with a strap behind R30's head, turned off the light and left the room. R30 was continuously observed alone in her room with the nebulizer treatment on until 3:55 p.m.
-At 3:55 p.m. nursing assistant (NA)-C looked into the room briefly and then continued down the hallway. R30 was continuously observed until 4:10 p.m.

On 12/22/14 at 4:10 p.m. LPN-B was observed walking away from the unit when the surveyor intervened. LPN-B stated she was going on her break. When asked, LPN-B stated she usually left R30's nebulizer treatment on for 5-10 minutes and confirmed it had been on for 40 minutes. LPN-B immediately went to R30's room and discontinued the treatment. LPN-B stated she usually gave R30 her treatment sooner to the

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{F 282}	Continued From page 9 time she got up for supper so that if she got busy the NAs would take the treatment off of R30 for her. On 12/23/14 at 2:59 p.m. registered nurse (RN)-B confirmed R30's care plan directed no self administration of medications and R30 should not have been left unattended during her nebulizer treatment.	{F 282}		
{F 311} SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services according to the assessed need for 1 of 3 residents (R27) reviewed for ambulation. R27's undated Admission Record identified R27 with diagnoses that included hemiplegia (paralysis of one side of the body) affecting the dominant side due to cerebrovasuclar disease, and abnormality of gait. R27's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated R27 had moderate cognitive impairment, was non-ambulatory, and required extensive assist of one for transfers and toilet use. The MDS also identified R27 had functional limitation in range of motion with impairment of both the upper and lower extremity on one side. The MDS further indicated R27's most recent	{F 311}	F311 -D 1. Corrective Action: A. RN-B on 12/23/14 conducted interview with NA-D regarding Resident (R27) notification of change in restorative program (ambulation), from the 6/10/14 recommendations Amb along handrail in hallway with distance as tolerates - approx 10□ □ 6x□s a week. Documentation noted to include resident desire to decline ambulation; functional ability with transfers and ROM remains unchanged. On 12/23/14 Physical and Occupational Therapy orders were obtained for mobility and transfers to determine appropriate programming within resident functional ability and desire. 2. Corrective Action as it applies to Other	1/14/15

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{F 311}	Continued From page 10 physical therapy ended on 6/10/14 and a restorative nursing program was not performed during the assessment period. R27's PT - Therapist Progress & Discharge Summary dated 6/10/14, indicated post discharge recommendations for caregiver follow through included continuation of established restorative nursing program. R27's Restorative Nursing Program (effective date 6/11/14) included recommendations to ambulate R27 along handrail in the hallway with distance as tolerated, approximately 10 feet, 6 times per week. R27's care plan dated 11/17/14, directed staff R27 was to ambulate along handrail in hallway with distance as tolerated (approximately 10 feet) 6 times per week. The care plan also identified R27 ambulated with nursing rehab. On 12/22/2014, at 2:16 p.m. R27 was observed seated in her wheelchair outside the nurses' station. R27 then wheeled herself independently down the hall utilizing her left hand and foot. R27's right hand was contracted and rested on a 1/2 size padded table attached to her wheelchair. R27's right foot rested on a foot rest attached to the wheelchair. R27 was not observed ambulating at any time during the survey from 12/22/14 at 2:16 p.m. until 12/23/14 at 3:00 p.m. On 12/23/14, at 3:00 p.m. R27 stated she did not walk, however did attend exercises which was enough.	{F 311}	Residents: A. 100% review of all others who are in restorative therapy. B. NA-D to review all current Restorative programming with Nurse Mangers to determine functional ability and desire, re-implement Nursing to Therapy Referral with noted change in function and or desire. 3. Date of Completion: 01/14/15 4. Reoccurrence will be prevented by: A. Nursing Team reeducated to include Team Leaders gather data from nursing notes, bi-weekly charting, weekly charting, and update Nurse Manager with changes observed. Nurse Manager will further evaluate and if deemed necessary seek MD/NP order for Therapies to evaluate and treat. Any time a resident declines to participate in their scheduled restorative program, resident will be re-approached by the team leader. If a resident declines to participate for the team leader, a progress note will be made stating the residents decline and why to include education for risk of not attending and encouragement efforts to promote participation. Restorative programming and corresponding policy in written format 12/22/14. A mandatory meeting for all Nursing team members is scheduled the week of 01/12/15. B. Observation through direct audit will be conducted twice per shift for one week, then weekly x 4, then monthly with review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	R 12/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 311}	Continued From page 11 On 12/23/2014, at 3:15 p.m. nursing assistant (NA)-D stated R27 was supposed to be on a walking program but she always refused. NA-D stated she performed passive range of motion exercises to R27's upper and lower extremities, however, did not ambulate her. NA-D stated R27 was too scared to ambulate and she had tried several approaches, without success, to ambulate R27. On 12/23/2014, at 3:26 p.m. registered nurse (RN)-B confirmed R27's care plan directed staff to ambulate R27 in the hallway but indicated the task was not included in the restorative tasks section of the computer. RN-B denied knowledge the ambulation had been discontinued. RN-B stated R27 should still be receiving these services. RN-B stated if she had been told R27 was refusing ambulation she would have requested a PT/OT [physical therapy/occupational therapy] evaluation and followed up with the issue. On 12/23/2014, at 3:39 p.m. NA-D stated R27 had never walked since transferring from physical therapy (PT) to restorative nursing in June. NA-D also stated she didn't know how PT got her to walk as she was so afraid. The Restorative Care policy dated December 2014, indicated team leaders gathered data from nursing notes, bi-weekly charting, weekly charting, and updated the clinical care coordinator (CCC) with changes observed. The CCC would further evaluate and if deemed necessary seek physician or nurse practitioner order for PT/OT to evaluate and treat. The policy also identified any time a resident declined to participate in their scheduled restorative program,	{F 311}	at the of completion by the observer with immediate education for any deviation from protocol. Nurse Managers will collect and review completed observations 3 times per week. Completed data/analysis to be routed monthly to DON. 5. The Correction will be monitored by: A. DON or designee (QC □RN). B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	R 12/23/2014

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{F 311}	Continued From page 12 the resident would be re-approached by the team leader. If a resident declined to participate for the team leader, a progress note would be made stating the resident's decline and why. If the resident was in Level II (Restorative Nursing Assistants - Restorative Care Program) a call must be place to the RNAR.	{F 311}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: F 314 Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R159) with a pressure ulcer, was consistently provided pressure relieving interventions and wound care treatment to ensure pressure ulcer healing. Findings include: R159's Grand Village Diagnosis Report dated [undated] identified R159's diagnoses as chronic kidney disease, obesity, urge incontinence, memory loss, hypertension (high blood pressure), spondylolisthesis (a condition in which one bone in your back slides forward over the bone below it), and heart failure.	{F 314}	F314 -D 1. Corrective Action: A. RN- A on 12/23/14 reassessed Resident (R159) for any negative outcome due to extended length of sitting in wheel chair and recliner with no observed off- loading. DON conducted an internal investigation to determine if deviation in plan off care (No pressure relieving cushion in wheel chair or recliner, no positioning or offloading within assessed hour need, undocumented dressing changes had occurred) had resulted in actual harm, investigation concluded noted healing. DON instructed	1/14/15

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{F 314}	Continued From page 13 R159's quarterly Minimum Data Set (MDS) dated 11/18/14, indicated R159 had severe cognitive impairment and required extensive assist with bed mobility, transferring and toileting. In addition, identified that R159 had a stage 2 pressure ulcer (a pressure wound that had partial thickness loss of the skin with a red-pink wound, without dead tissue) and recommended R159 be on a turning and repositioning program, have a pressure relieving device in her chair and pressure ulcer care be completed. On 12/23/14, at 7:45 a.m. R159 was observed seated in her wheelchair at the dining room table. At 8:30 a.m. R159 propelled her wheelchair away from the dining room table and into her room. The nursing assistant (NA)-A followed R159 into her room and asked R159 if she needed to go to the bathroom. R159 stated she didn't and then NA-A asked R159 if she wanted to be transferred into her recliner. R159 responded that she did. At 8:34 a.m. NA-A placed a transfer belt around R159 and directly transferred her into her recliner beside her bed. R159 was not offloaded (relieving the pressure to an area for one full minute) during this transfer. At this time, it was observed that R159 did not have a pressure relieving cushion in the wheelchair she had just been transferred from. NA-A confirmed that there had not been a cushion in R159's wheelchair, nor was she aware if R159 needed one. NA-B entered R159's room and confirmed R159 should have a cushion in her wheelchair and stated that yesterday when therapy brought her back they must have brought her back in the wrong wheelchair. At 8:40 a.m., NA-B verified that R159 had been up since 7:00 a.m. seated in the wheelchair without a pressure relieving cushion. In addition, licensed practical nurse (LPN)-A was unsure if R159 should have a pressure relieving	{F 314}	Nurse Managers to validate orders within new electronic health record to confirm display accuracy on eMAR/eTAR. 2. Corrective Action as it applies to Other Residents: A. 100% review of all others who are assessed with Braden less than 18. B. Completion of new skin assessment as indicated by visual inspection, noting adherence to care plan intervention. C. Providers updated, orders obtained as needed and Team updated through 24 hour report. D. Written Education for Nursing Team Members 12/22/2014. 3. Date of Completion: 01/14/15 4. Reoccurrence will be prevented by: A. Nursing Team reeducated on pressure relieving cushion in wheel chair or recliner, positioning or offloading within assessed need, documented dressing changes, corresponding policies in written format 12/22/14. Licensed Nurse in-service held 01/06/15 which included additional resources http://www.kci1.com/KCI1/woundmanagement for identification of various wounds. A mandatory meeting for all Nursing team members is scheduled the week of 01/12/15. B. Care Plan interventions are communicated to NA's via 24 Hour report and Point of Care (POC). Nursing team re-educated at mandatory meeting the week of 1/12/15 to facility policy and procedure regarding care plan compliance	

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	245368	A. BUILDING _____ B. WING _____	R 12/23/2014

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{F 314}	Continued From page 14 cushion in her wheelchair. NA-B located R159's wheelchair with a cushion in a storage area at the end of the unit and switched it out with the wheelchair that had no cushion. At 8:56 a.m. registered nurse (RN)-A stated she would be measuring R159's wound today. RN-A was unable to articulate what offloading was and/or if R159 should have a pressure relieving cushion in her chair. R159 remained seated in her recliner until 9:17 a.m. when she put her call light on and requested to use the bathroom. At 9:20 a.m. LPN-A placed a transfer belt around R159; transferred her into her wheelchair with the pressure relieving cushion; and transported her into the bathroom and on to the toilet (2 hours and 20 minutes - the time R159 had remained without being offloaded). On 12/23/14, at 9:25 a.m. 159's pressure ulcer was assessed by LPN-A and registered nurse (RN)-A. R159's pressure ulcer was observed to be located on her left buttock. The pressure ulcer was uncovered with no dressing; the wound was red-pink in color and; no foul odor or drainage was noted. RN-A measured the pressure ulcer and confirmed the size of the pressure ulcer was 0.8 centimeters (cm) in length, 0.6 cm in width and 0.2 cm in depth. RN-A verified the pressure ulcer was a stage 2. R159's physician telephone orders dated 10/28/14, directed staff to implement the Grand Village lean wound care protocol. ECUMEN LEAN WOUND SYSTEM, STANDING ORDERS GUIDELINE [undated] directed staff to conduct weekly wound rounds and documentation; complete the braden (tool used to assess a resident' s level of risk for developing a pressure ulcer); develop a skin integrity care plan; and to conduct wound care every three days by	{F 314}	and the expectation that care plans will be adhered to. C. Observation through direct audit looking for decreased immobility, cognitive impairment, medications, co-morbid conditions, healed ulcers,refusal of treatment, impaired circulation, nutritional status, exposure of skin to urine and feces, moisture will be communicated through Interact Stop and Watch tool. Observations will also include that of direct care to ensure care plan compliance. Audits will be conducted twice per shift for one week, then weekly x 4, then monthly with review at the of completion by the observer with immediate education for any deviation from protocol. Nurse Managers will collect and review completed observations 3 times per week. Completed data/analysis to be routed monthly to DON. 5. The Correction will be monitored by: A. DON or designee (QC □RN). B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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{F 314}	Continued From page 15	{F 314}		

irrigating the ulcer with normal saline and applying Silverstat (a wound care gel), and cover the wound with a bandage.

R159's BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK dated 8/21/14, indicated R159 was at risk for developing a pressure ulcer and pressure relieving devices should be implemented in the R159's chair and bed.

R159's Short Term Care Plan dated 12/16/14, identified a problem of an unstagable pressure ulcer to R159's left buttock.The approaches identified directed staff to repositioned R159 every one hour, place a cushion in her wheelchair and in her recliner, place an air mattress on her bed, and follow the lean wound protocol for treating her wound.

R159's Skin Ulcer Data Collection indicated the following measurements of R159's pressure ulcer on her left buttock:
· 10/28/14 - length 2.5 centimeters (cm) by 0.5 cm in width
· 11/3/14 - length 2.5 cm by 0.5 cm in width
· 11/11/14 - length 0.8 cm by 0.5 cm in width
· 11/17/14 - length 1.2 cm by 0.8 cm in width
· 11/25/14 - length 1 cm by 0.9 cm in width
· 11/30/14 - wound not measured
· 12/3/14 - length 1.0 cm by 0.7 cm in width and 0.05 cm in depth
· 12/23/14 - length 0.8 cm by 0.6 cm in width and 0.2 cm in depth

R159's Weekly Wound Observation Tool indicated the following measurements of R159 s pressure ulcer on her left buttock:
· 11/17/14 - length 1.1 cm by 0.8 cm in width

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{F 314}	Continued From page 16 and 0.05 cm in depth · 12/8/14 - length of 0.8 cm by 0.6 cm in width and 0.1 cm in depth · 12/16/14 - length of 0.9 cm by 0.7 cm in width and 0.05 cm in depth On all of the above noted Weekly Wound Observation Tool's, the preventive measures directed the staff to reposition R159 off her wound every one hour, air mattress to her bed, and place a pressure relieving cushion in her wheelchair and recliner. R159's INTERDISIPLINARY PROGRESS NOTES from 10/29/14 - 11/11/14, lacked documentation of wound care being completed. R159's TREATMENT RECORD dated 12/1/14 - 12/31/14, lacked documentation that wound care had been completed during this time. On 12/23/14, at 10:35 a.m. RN-B confirmed her expectations were that the recommendations which were identified on the weekly wound observation tools would be on the care plan and followed. On 12/23/14, at 1:24 p.m. LPN-A verified according to the lean wound care protocol R159 was supposed to have wound care done every three days. LPN-A confirmed R159 did not have a dressing on her wound when she assessed her wound at 9:25 a.m. today, nor did she do any treatment to R159's wound today. LPN-A confirmed she should have redressed R159's wound this morning when she observed the wound was uncovered. LPN-A was unable to verify the last time R159's wound care had been completed.	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 17 On 12/23/14, at 1:45 p.m. RN-B verified R159 had a current order, per the lean wound care protocol, which directed staff to conduct wound care and change the dressing on R159's left buttock every three days and when needed. RN-B verified the order had been incorrectly entered into the computer and had not flowed over to the medication treatment record to prompt the nursing staff when to conduct the dressing changes on R159's wound. RN-B was unable to confirm when the last time R159's wound care, including a dressing change had been conducted. On 12/23/14, at 1:56 p.m. the director of nursing (DON) confirmed her expectation for offloading was the resident should be offloaded for a couple of minutes. The DON confirmed R159's care plan should be followed to include repositioning every one hour and assuring she has a cushion in her wheelchair. The DON agreed waiting two hours and 20 minutes to reposition R159 was too long. In addition, R159's wound care should be completed and documented as completed as directed by the physician. The Skin Assessment and Care policy dated 11/2013, indicated the purpose of the policy was to prevent skin breakdown and provide early intervention and treatment for existing skin problems. In addition, the resident who had a pressure ulcer should have received the necessary treatment and services which promoted healing, prevented infection and prevented new sores from developing. The policy directed staff to assure pressure reduction or offloading was conducted as ordered; any dressing changes and treatments should be noted; and redistribution of pressure, pressure	{F 314}		

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{F 314}	Continued From page 18 redistributing surfaces and an individualized repositioning plan should be developed and followed. The Care Plan - IDT policy dated 5/2013, indicated the care plans were updated on an ongoing basis to meet the needs of the resident and to be used by all personnel involved in the care of the resident.	{F 314}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	12/23/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **12/09/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **12/09/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/09/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/09/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/09/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/09/2014**
ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **12/09/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/09/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/09/2014**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **12/09/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/09/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/09/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	12/30/2014	32601	12/23/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/31/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BZIY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds 119 (L18)

13.Total Certified Beds 119 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 12/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6535

November 18, 2014

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368025

Dear Ms. Jokinen:

On October 30, 2014, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

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 December 9, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 9, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 30, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Compliance Monitoring Division
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5368s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Approved w addendum 12/16/14 LB	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	F 156 -D 1. Corrective Action: A. Social Services Director called R50 on 10/31/14 leaving a message to return her call if R50 had any questions or concerns regarding the Medicare Denial signed on day of discharge. 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for Medicare Non-Coverage Notification/demand Bill/Benefit Exhaust claims was reviewed. B. Review of standard expectation with Skilled Care Team completed on 10/31/14. C. Mandatory Education for all Team Members 12/03/14. 3. Date of Completion: 12/09/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shauna Jokinen — TITLE: Executive Director/Administrator — (X6) DATE: 11/26/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	4. Reoccurrence will be Prevented by: A. Discharge Planner will track, document and communicate with Skilled Care Team per standard. B. Review of upcoming discharges will be conveyed at IDT during morning stand up meetings Monday through Friday. 5. The Correction will be Monitored by: A. DON or designee. B. DON will report summary of Medicare Non-Coverage Notification/demand Bill/Benefit Exhaust to QAPI Committee.	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required uniform denial letter upon termination of all Medicare Part A skilled services 48 hours prior to discontinuation of the services for 1 of 4 residents (R50) reviewed for beneficiary appeal rights review. Findings include: R50 was admitted to the facility on 5/2/14, and discharged from Medicare Part A on 6/12/14, and discharged to home on 6/13/14. The facility provided R50 the Medicare A uniform denial letter on 6/13/14, the day of discharge, not 48 hours prior to the end of covered services as required. On 10/31/14, at 10:10 a.m., the Discharge	F 156		

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F 156	Continued From page 3 Specialist (DC) confirmed R50 was not provided the required form 48 hours prior to the end of skilled services On 10/31/14 at 1:30 p.m. the administrator verified R50 was not provided the required forms 48 hours prior to the discontinuation of Medicare services as required. A facility policy titled, "Medicare Non-Coverage Notification/demand Bill/Benefit Exhaust claims" with a Revision date of 10/2007, indicated the facility had the responsibility of notifying Medicare beneficiaries whenever Medicare Part A would not be the source of payment for their nursing facility costs. The policy further indicated the denial notice must be in writing and must be issued in a 48 hours prior to the end of coverage.	F 156		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	F278 - D 1. Corrective Action: A. RN 10/31/14 reassessed Resident (R24) to validate functional ability with limited ROM. MDS Nurse submitted a modification to reflect accuracy for Resident (R24) with ARD of 09/28/14, on 10/31/14. 2. Corrective Action as it applies to Other Residents: A. The procedure for coding of MDS has been reviewed. B. The RAI manual is available for reference. C. Mandatory Education for all Team Members 12/03/14. 3. Date of Completion: 12/09/14	

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F 278	Continued From page 4 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's Minimum Data Set (MDS) reflected the current range of motion abilities and diagnosis status for 1 of 1 resident (R24) reviewed for assessment accuracy. Findings include: R24's undated Client Diagnoses Report indicated R24's diagnoses included dementia, degenerative joint disease (DJD), aphasia, arthritis, osteoporosis and hypertension. R24's quarterly Minimum Data Set (MDS) dated 9/28/14, indicated R24 was incontinent of bowel and bladder, was non ambulatory and required extensive staff assist for bed mobility, transfers, dressing, eating and personal hygiene. The MDS lacked identification of R24's contracture / impairment of range of motion in bilateral upper extremities. The MDS also lacked identification of R24's diagnoses of dementia and DJD.	F 278	4. Reoccurrence will be prevented by: A. IDT Team reeducated assessment, coding accuracy on 10/31/14 and upon hire, annually, and as needed. B. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. Reoccurrence will be Prevented by: A. DON or designee will audit one record per week to assure assessments are comprehensive and coding reflects accuracy. B. Education and immediate correction will ensue for all identified not meeting comprehensive standards. 6. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 278	Continued From page 5 On 10/29/14, at 7:15 a.m. nursing assistant (NA)-I and a nursing student were observed to transfer R24 into a wheelchair via a mechanical lift. NA-I was observed to put a sweater on over R24's head and then slide R24's arms into the sleeves. R24 was observed to be unable to fully extend the right arm and left arm and elbow. NA-I stated R24's right arm was contracted and she needed to be real careful because R24 bruised easily. On 10/31/14, at 9:00 a.m. registered nurse (RN)-D verified R24's MDS was not accurate and lacked indicated of R24's bilateral upper extremity impairment and the dementia and DJD diagnoses. A policy related to accuracy of MDS coding was requested and no coding policy was provided.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	F279-D 1. Corrective Action: A. Care plans of Residents (R90) dialysis updated 10/31/14, (R91) isolation updated 10/30/14, (R146) skin integrity impairment were updated 10/29/14. 2. Corrective Action as it applies to Other Residents: A. The policy Care Plan –IDT was reviewed with IDT. B. All care plans will be reviewed to assure dialysis, isolation and skin integrity are included. C. Mandatory Education for all Team Members 12/03/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 6 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan included appropriate interventions for monitoring daily fluid intake for 1 of 1 resident (R90) receiving dialysis. In addition, 1 of 2 residents (R91) who were in contact isolation for clostridium difficile (C-diff) and 1 of 3 residents (R146) who had developed pressure ulcers. Findings include: R90's comprehensive care plan lacked direction for staff to monitor daily and/or total R90's 24 hour fluid intake to maintain her 1200 milliliters (ml) fluid restriction guidelines. R90's Client Diagnosis Report [undated] identified R90's diagnoses as end stage renal disease (ESRD), chronic obstructive pulmonary disease (lung disease) and received dialysis services. R90's care plan dated 10/2014, indicated R90 had an alteration of health status due to ESRD and received dialysis treatments three times a week. The care plan also indicated R50 had an alteration in nutritional status with a potential for changes in oral intake. However, the care plan lacked reference to monitoring and/or following R90's daily 1200 ml fluid restriction. On 10/29/14, at 12:42 p.m. the registered nurse	F 279	3. Date of Completion: 12/09/14. 4. Reoccurrence will be Prevented by: A. DON or designee will audit one record per week to assure care plans are complete. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	10/30/2014

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F 279	Continued From page 7 (RN) at the dialysis unit confirmed she was familiar with R90 and her care. The dialysis RN verified R90 was on a daily 1200 ml fluid restriction and was unsure why it had not been addressed on R90's care plan. The dialysis RN stated R90's fluid restriction was a crucial part of her dialysis care. On 10/29/14, at 1:06 p.m. RN-A stated she was unaware R90 was on a fluid restriction and confirmed staff were not monitoring R90's daily fluid intake nor was this information currently available on her care plan. RN-A confirmed R90's fluid restriction information should have been a part of her care plan. R91's comprehensive care plan lacked reference that R91 was on contact precautions for c-diff (a bacterium which causes inflammation of the colon). R91's Client Diagnosis Report [undated] identified R91's diagnosis as pneumonia, cerebral vascular accident (stroke), and c-diff. R91's care plan dated 9/2014, identified a problem area for altered elimination, however the care plan lacked direction for staff to follow contact precautions for the diagnosis of c-diff. R91's Interdisciplinary Progress Notes dated 10/14/14, indicated R91 was positive for c-diff and was placed on contact precautions. On 10/30/14, at 12:04 p.m. RN-C confirmed R91 was on contact precautions for a diagnosis of c-diff. RN-C verified R91's comprehensive care	F 279		

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F 279	Continued From page 8 plan and/or short term care plan did not address the c-diff diagnosis nor a directive to staff to follow contact precautions specific for c-diff. RN-C confirmed it would be appropriate for R91's care plan to include this information. On 10/31/14, at 9:52 a.m. the director of nursing (DON) confirmed her expectations were for staff to develop, follow and revise each resident's care plan to meet the individual needs of each resident. R146's comprehensive care plan lacked reference that R146 had developed five stage two pressure ulcers (partial thickness skin loss involving epidermis, dermis or both) and interventions for the direction of care in order to provide interventions to heal and prevent further development of pressure ulcers. R146's Client Diagnosis Report signed 9/24/14, identified R146's diagnoses as chronic systolic heart failure, anxiety, hypertension and Parkinson's disease. R146's care plan dated September 2014, indicated R146 was at high risk for pressure and moisture related breakdown and had a physical mobility deficit related to increased weakness and ongoing heart related issues. The care plan indicated R146's skin would be free from pressure or moisture related skin conditions. The care plan did not identify any pressure relieving interventions. R146's interdisciplinary progress note dated 10/28/14 indicated R146 had five open areas on	F 279		

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F 279	Continued From page 9 her bilateral buttocks near the coccyx area. On 10/30/14, at 8:34 a.m. RN-A confirmed she was aware of R146's pressure ulcers and that R146's comprehensive care plan did not address the pressure ulcers nor directives to staff to provide interventions to heal/prevent R146's pressure ulcers. RN-A confirmed the care plan should identify pressure relieving measures and pressure ulcer treatments. On 10/30/14 at 9:17 a.m. the DON confirmed her expectations were for staff to develop, follow and revise each resident's care plan to meet the individual needs of each resident. The Care Plan-IDT policy dated 5/2013, indicated the care plan was developed to help attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and should be updated on an ongoing basis to meet the individual needs of the resident and was to be used by all staff involved in the care of the resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	F280 -D 1. Corrective Action: A. RN on 10/31/14 reassessed Resident (R24) to validate functional ability with limited ROM. RN on 10/30/14 reassessed Resident (R126) with noted change and Physical Therapy orders obtained. 2. Corrective Action as it applies to Other Residents: A. Reviewed functional assessment and in house-transfer form with Nurse Managers. B. Second validation of level one therapy processing implemented for DON or designee to use to validate care delivery to assure care plans are being followed. C. Mandatory Education for all Team Members 12/03/14.	

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F 280	Continued From page 10 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include an ambulation program for 1 of 1 resident (R126) in the sample who required an ambulation program. In addition, the facility failed to revise the care plan to include contractures for 1 of 1 resident (R24) who had contractures. Findings include: R126 was on an restorative ambulation program and the care plan did not address this. R126's admission Minimum Data Set (MDS) dated 9/20/14, indicated R126's diagnoses included weakness and congestive heart failure. The MDS also indicated R126 had cognitive impairment, walked with staff assistance in own room only once or twice and had not walked outside of the room during the MDS seven day reference period. The MDS also indicated R126 was receiving physical therapy (PT) services. R126's The Rehab Care PT/OT	F 280	3. Date of Completion: 12/09/14 4. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. 5. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the care observation results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 280	Continued From page 11 Recommendation to Caregivers form, dated 10/14/14, indicated R126 was to ambulate with a rolling walker to and from meals and the bathroom with assist of one staff and a gait belt, as tolerated. On 10/30/14, at 11:40 a.m. registered nurse (RN)-D stated R126's ambulation program was never set up therefore was not addressed on the care plan. RN-D added, on 10/14/14, R126 was moved from the Moose Unit to the River Unit and somehow the program got missed. R24's care plan was not revised to include left arm/elbow contracture. R24's Client Report [undated] indicated R24's diagnoses included dementia, degenerative joint disease (DJD), aphasia, arthritis and osteoporosis. R24's quarterly MDS dated 9/28/14, indicated R24 had impaired cognition, was non ambulatory and required extensive staff assist for bed mobility, transfers, dressing, eating and personal hygiene. R24's current care plan dated 10/2014, lacked indicated R24 had upper extremity contractures. On 10/29/14, at 7:15 a.m. nursing assistant (NA)-I and a nursing student were observed to transfer R24 into a wheelchair via a mechanical lift. NA-I was observed to put a sweater on over R24's head and slide R24's arms into the sleeves. R24 was observed to be unable to fully	F 280		

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F 280	Continued From page 12 extend the right arm and left arm and elbow. NA-I stated R24's right arm was contracted. On 10/31/14, at 9:00 a.m. registered nurse (RN)-D verified R24's care plan lacked indication of the upper extremity contractures. The facility's Care Plan policy dated 8/2003, indicated care plans were updated on an ongoing basis to meet the needs of residents.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a call light and wheelchair foot rests for 1 of 1 resident (R126) according to the care plan. Findings include: R126's care plan dated 10/2014, indicated R126 had impaired physical mobility, weakness and received physical therapy services for strengthening. The care plan indicated R126 was to have a call light within reach and foot rests on the wheelchair for transportation to long distant areas. On 10/27/14, at 4:30 p.m. R126 stated she did	F 282	F282 -D 1. Corrective Action: A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained. 2. Corrective Action as it applies to Other Residents: A. Reviewed functional assessment and in house-transfer form with Nurse Managers. B. Second validation of level one therapy processing implemented for DON or designee to use to validate care delivery to assure care plans are being followed. C. Mandatory Education for all Team Members 12/03/14. 3. Date of Completion: 12/09/14	

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F 282	Continued From page 13 not have a call light to use in her room / by her bed but had one in the bathroom that she could use, if needed. On 10/28/14, at 9:30 a.m. R126 was observed in her room, seated in the wheelchair. A call light was not observed in her room nor within reach of R126 to use in case of needed assistance. On 10/29/14, at 9:00 a.m. R126's room was again observed to be without a call light next to the bed nor in the room. On 10/29/14, at 1:20 p.m. licensed practical nurse (LPN)-F stated R126's care plan was correct in directing staff to provide R126 a call light / cord when in her room. LPN-F verified R126's room did not have a call light / cord available for R126 to use if needed. At the time of this interview, nursing assistant (NA)-H was observed to wheel R126 from her room to the rehab room which was located at the far end of the facility. R126 did not have leg rests for lower extremity support on the wheelchair. On 10/29/14, at 2:35 p.m. registered nurse (RN)-F stated she would expect R126's wheelchair to have leg rests on when being transported long distances. RN-F verified R126's care plan was correct and also stated R126 should have been provided with a call light and foot rests on the wheelchair. The facility's Care Plan policy dated 8/2003, indicated the resident and/or their representative, along with the entire care team was involved in the care planning process. The policy also	F 282	4. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. 5. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the care observation results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 282	Continued From page 14 indicated resident care would be planned to help attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor daily fluid intake for 1 of 1 resident (R90) who had chronic kidney disease, was receiving dialysis and on a prescribed daily fluid restriction. In addition, the facility failed to ensure a urinary catheter was irrigated according to physician orders for 1 of 3 residents (R224) reviewed with a urinary catheter. Findings include: R90's 1200 milliliter (ml) fluid restriction order had not been carried through from the dialysis unit to the facility. R90's Client Diagnosis Report [undated] identified R90's diagnoses as end stage renal diseases (ESRD), currently on dialysis and chronic obstructive pulmonary disease (lung disease).	F 309	F309 -D 1. Corrective Action: A. RN 10/31/14 reviewed Resident (R90) care plan and updated fluid restrictions. Delayed specialized catheter supplies for Resident (R224), noted 10/31/14 successful irrigation. 2. Corrective Action as it applies to Other Residents: A. Spoke with Nurse Managers and directed a reminder be provided to the nursing team to review and update plan of care PRN. Instructed Nurse Managers – Clinical Leads to contact provider to seek advisement with delayed supplies. B. The policy Care Plan –IDT was reviewed with IDT. Standard updated to include validation of supplies required and to contact provider with any delay to seek advisement, DON or designee to use to validate care delivery to assure care plans are being followed. C. Mandatory Education for all Team Members 12/03/14.	

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F 309	Continued From page 15 R90's quarterly Minimum Data Set (MDS) dated 7/15/14, indicated R90 was cognitively intact, required supervision with eating and was receiving dialysis treatment. R90's care plan dated 10/2014, identified a problem area for alteration of health status due to her ESRD and was receiving dialysis treatments three times a week. However, the care plan lacked reference to monitoring and/or following R90's daily 1200 ml fluid restriction. On 10/29/14, at 12:12 p.m. R90 was observed seated in her room in a wheelchair. Two blue mugs were observed situated on her bedside tables. She confirmed one mug had apple juice in it and the other water. R90 stated she was on a fluid restriction, however was unaware of the total amount of fluid she could consume daily. She stated she tried to do her best, but it was hard because she got thirsty. R90 stated the nurses at the dialysis unit frequently (about once a week) said she had came in for her treatment with more fluid than she should. The Dialysis Communication Reports were reviewed and the following concerns were noted during dialysis treatments: · Communication Report dated 8/12/14, indicated R90 was heavy on this day. The dialysis unit wanted the facility to remind R90 to limit fluids. R90 was over 2.0 kilograms (kg) over her dry weight (the amount of body weight without extra fluid). · Communication Report dated 8/19/14, revealed R90 had high fluid gains the last few treatments. The dialysis unit directed the facility to reinforce fluid restrictions and to review how to	F 309	3. Date of Completion: 12/09/14 4. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. Provider update and recommendations made will be transcribed per protocol. 5. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the data from care plan reviews and order changes due to unavailability of supply initially ordered; communicate the information to the QAPI Committee on a quarterly basis for further direction.	

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F 309	Continued From page 16 measure fluid intake. · Communication Report dated 10/18/14, indicated R90 was hypotensive (low blood pressure) during the treatment and the facility was to encourage R90 to adhere to her fluid restriction. · Communication Report dated 10/21/14, indicated the facility was to please encourage R90's fluid restriction. · Communication Report dated 10/28/14, revealed the facility was to please monitor fluids and to assist R90 with fluid and dietary restrictions for renal failure. On 10/29/14, at 11:58 a.m. dietary aide (DA)-A confirmed R90 was on a renal diet, however stated he was not aware of the amount of fluid she could have offered to her during her meal times. On 10/29/14, at 12:30 p.m. licensed practical nurse (LPN)-B stated R90 drank what she wanted and confirmed the facility was not monitoring her total daily fluid intake. On 10/29/14, at 12:42 p.m. the registered nurse (RN) at the dialysis unit confirmed she was familiar with R90 and her care. The dialysis RN verified R90 was on a daily 1200 ml fluid restriction and she was unsure why it had not been addressed on R90's care plan. The dialysis RN confirmed R90's weight gains had varied from 2-3 kg, and the less R90 gained the better because she didn't tolerate a lot of excess fluid well. The dialysis RN confirmed R90 had come in for her dialysis treatments over 3 kg, three times over the last month. The dialysis RN verified R90's fluid restriction was a crucial part of her dialysis care and that the facility really needed to	F 309		

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F 309	Continued From page 17 be monitoring it closely as they do not want R90 to end up in fluid overload. On 10/29/14, at 1:06 p.m. RN-A stated she was unaware R90 was on a fluid restriction and they currently had not been monitoring R90's daily fluid intake. RN-A verified she had not been routinely reviewing the Dialysis Communication Reports, however stated it was her expectation for staff to bring to her attention communication concerns between the dialysis unit and the facility such as the repeated concern for R90's need to follow her fluid restriction. RN-A stated she would contact the dialysis unit and obtain clarification. On 10/30/14, at 8:46 a.m. nursing assistant (NA)-C confirmed the blue mugs held 240 ml of fluid and they were refilled and replaced in each resident room at least three times a day, if not more frequently. NA-C stated R90 liked her coffee and frequently asked for coffee and apple juice throughout the day; which would be given to her. On 10/30/14, at 9:25 a.m. RN-A stated the facility had verified with the dialysis unit that R90 should have been on and monitored for a daily 1200 ml fluid restriction. No policy and/or procedure related to dialysis care were provided. R224 was not provided with catheter irrigation services as ordered by the physician. R224's admission Minimum Data Set (MDS)	F 309		

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F 309	Continued From page 18 dated 10/11/14, indicated R224 was cognitively intact and had an indwelling urinary catheter. R224's Client Diagnosis Report dated 10/16/14, identified R224 had diagnoses that included a stroke and bladder outlet obstruction. R224's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/16/14, indicated R224 had a diagnosis of bladder outlet obstruction and had a Foley catheter. The CAA identified R224 had been hospitalized for urinary tract infection (UTI) and had an ER visit for bladder spasms. The CAA also indicated R224 would be referred for an appointment with a urologist. R224's The Physician Orders dated 9/26/14, to 10/31/14, included an order dated 10/23/14, for hand irrigation of catheter with sterile water until clear daily and as needed for urinary retention. On 10/27/14, at 6:30 p.m. R224 was observed in bed with the head of the bed elevated 90 degrees. R224 was eating supper with his wife's (FAM)-A assistance. R224 was awake and alert. FAM-A indicated R224 was to have his catheter irrigated daily and had been waiting since 10/23/14 to get it done. FAM-A stated the facility did not have the supplies they needed to irrigate R224's catheter. On 10/28/14, at 11:00 a.m. R224's Treatment Record dated October 2014, was reviewed and included an order dated 10/23/14. The ORDER TEXT column identified hand irrigation of catheter with sterile water. The HOUR column indicated QD PM [every evening]. The date fields for 10/23, 10/24,10/25, 10/26, and 10/28, were blank.	F 309		

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F 309	Continued From page 19 On 10/29/14, at 2:25 p.m. FAM-A stated R224 was at a urologist appointment on 10/23/14, where the physician identified he wanted R224's catheter irrigated everyday. FAM-A stated she provided many of R224's cares, however denied irrigating his catheter. FAM-A stated it had been done once on the evening of 10/27/14, since R224's return from the urologist. On 10/29/14, at 2:47 p.m. licensed practical nurse (LPN)-H stated R224's catheter irrigation was to be done everyday and the Treatment Record indicated it was to be done on the evening (PM) shift. LPN-H indicated the order and a clarification of the order was received on 10/23/14. LPN-H confirmed the catheter was not irrigated until 10/27/14, as the facility did not have the supplies to do it. LPN-H stated they did not get the supplies until 10/27/14. LPN-H also stated she had not irrigated the catheter on 10/28/14. On 10/30/2014, at 3:18 p.m. registered nurse (RN)-C stated there was a delay in receiving the equipment from the pharmacy to irrigate R224's catheter as a special adaptor was required to connect to the catheter to flush it which had been ordered. RN-C indicated the pharmacy did not have the required adaptor in stock and confirmed it was 4 days before the catheter could be irrigated. RN-C also confirmed a treatment was missed on 10/28/14 and the lack of catheter irrigation put the resident at risk for obstruction. On 10/31/14, at 10:42 a.m. director of nursing (DON) stated she would would have expected R224's catheter to have been irrigated as ordered, or if unable to do so, the physician should have been contacted for further orders.	F 309		

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F 309	Continued From page 20 The Medication/Treatment Administration policy dated November 2013 indicated all medications/treatment were to be administered as prescribed.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary treatment/services for 1 of 1 resident (R126) in the sample for ambulation. Findings include: R126's admission Minimum Data Set (MDS) dated 9/20/14, indicated R126's diagnoses included weakness and congestive heart failure. The MDS indicated R126 had cognitive impairment, walked with staff assistance in own room only once or twice and had not walked outside of the room during the MDS seven day reference period. The MDS also indicated R126 was receiving physical therapy (PT) and occupational therapy (OT) services. R126's Care Area Assessment (CAA) for falls, dated 9/26/14, indicated R126 had been admitted to the facility due to increased weakness, a change in cognition and had a history of falls. The CAA also indicated R126 had previously been	F 311	F311 -D 1. Corrective Action: A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained. 2. Corrective Action as it applies to Other Residents: A. Reviewed functional assessment with Nurse Managers. B. Second validation of level one therapy processing implemented for DON or designee to use to validate care delivery to assure care plans are being followed. Internal transfer form to be completed. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14 5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, ambulation program is being provided to assure care plans are being followed.	

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F 311	Continued From page 21 able to walk with a walker and was presently participating in PT and OT services. R126's Activity of Daily Living (ADL) CAA dated 9/26/14, indicated R126 required extensive assist with ADL's, transfers and mobility. R126's care plan dated 10/2014, indicated R126 had impaired physical mobility, was admitted to the facility related to increased weakness, and was working with PT for strengthening. The care plan also indicated R126 was ambulating with PT, and that PT would update nursing when R126 was able to walk on the unit, with nursing staff. R126's PT Discharge Summary dated 10/14/14, indicated PT for R126 had been, that R126 was able to ambulate safely for 60 feet with a 2-wheeled walker and CGA (contact guard assist) on even surfaces. The summary indicated R126 had increased her functional independence with ambulation but had plateaued, and was no longer making remarkable gains therefore PT had been discontinued for R126, and the resident was to participate in the restorative program provided by nursing. A Rehab Care PT/OT Recommendation to Caregivers form, dated 10/14/14, indicated R126 was to ambulate with a rolling walker to and from meals/bathroom with assist of one staff and a gait belt, as tolerated. During observations on 10/27/14, at 4:30 p.m. R126 was in her room, seated in a wheelchair. At that time R126 was asked whether she walked, R126 stated she did not walk and staff did not help her walk.	F 311	6. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the ambulation monitoring results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 311	Continued From page 22 On 10/29/14, at 7:10 a.m. R126 was observed seated her wheelchair at the dining table. When asked, R126 stated staff had not walked her to breakfast. At 11:35 a.m. R126 was observed in her wheelchair using her feet to wheel herself to the dining table for lunch. At 12:25 p.m. R126 was observed to self propel her wheelchair to wheel herself away from the dining room back to her room. Staff did not offer to ambulate R126. On 10/30/14, at 8:35 a.m. R126 was observed in the dining room, seated in the wheelchair while eating breakfast. When asked, R126 again stated she had not walked yesterday and had not walked yet today. On 10/30/14, 8:45 a.m. nursing assistant (NA)-G was asked by the surveyor if she could ambulate R126. NA-G was observed to place a gait belt on R126 and cued her to grab on to the dining room chair. R126 was heard to state, "I will do anything to get out of here." At that time, licensed practical nurse (LPN)-F stated two days ago staff had asked therapy for a walker to use when walking R126 but had not received one yet. LPN-F advised NA-G to wait with walking R126 until therapy had provided a walker. LPN-F stated R126 could walk behind the wheelchair but that stated she (LPN-F) would prefer staff wait to have a walker available. At 8:52 a.m. a front wheeled walker was brought to the unit and set beside R126. At 9:00 a.m. NA-G was observed to attempt to walk R126 with a gait belt and the front wheeled walker. R126 was observed to walk with NA-G and the walker approximately 25-30 feet before R126 was heard to state, "I have to sit down, it is just is no use." During this observation, NA-G verified that R126 had not walked to meals the day before, however	F 311		

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F 311	Continued From page 23 had walked behind her wheelchair from her room to the tub room which was about 30 feet. On 10/30/14, at 11:40 a.m. registered nurse (RN)-D verified there was no ambulation documentation in R126's care tracker from 10/14/14 through 10/29/14. RN-D stated if R126 was walking, she would expect to see NA documentation related to distance walked and whether R126 had tolerated walking. RN-D stated the care tracker should have been set up with R126's ambulation program, as well as with a specific place for the NA's to document her progress, however RN-D stated the program had never been set up. RN-D stated R126 had been transferred on 10/14/14, from the Moose unit of the facility to the River unit, and somehow R126's ambulation program was never set up. RN-D confirmed PT had first provided R126 with a walker to ambulate on 10/30/14. On 10/30/14 at 12:00 p.m., NA-G stated to RN-D and the surveyor that she had documented R126's refusal to ambulate in the behavior section of the care tracker and had documented R126 had refused to walk four times yesterday. However, no documentation was located in the electronic record. On 10/30/14 at 12:05 p.m., RN-D reviewed R126's care tracker documentation history and verified the record contained no documentation regarding R126's ambulation since 10/14/14, when R126 had been discharged from PT. RN-D also verified R126 was unable to ambulate the 60 feet she had been able to walk when discharged from PT. RN-D stated she would have R126 re-evaluated by PT due to the decline in her ambulation ability.	F 311		

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F 311	Continued From page 24 On 10/31/14, at 9:15 a.m. RN-D stated R126's ambulation program had now been set up in the care tracker, and stated PT would be re-evaluating R126 that morning. On 10/31/14 at 9:30 a.m., PT-B verified R126's PT discharge notes indicated R126 had been walking 60 feet. PT-B verified that if R126 was walking only 30 feet now, that would indicate a decline. PT-B stated PT-A would re-evaluate R126 that day because PT-A was the therapist who had previously worked with R126. On 10/31/14 at 11:35 a.m., PT-A stated he had completed R126's PT re-evaluation and stated R126 was able to ambulate 10 feet twice. PT-A stated he would provide therapy services for R126 due to weakness and the decline in her ambulation ability. PT-A stated it was real unfortunate R126's rehab program had not been set up for her so she could have maintained her ability to walk a greater distance. The facility's policy, Restorative Care dated 1/2009, indicated the purpose was directed towards assisting each resident to achieve and maintain their highest level of self-care through position, range of motion and ambulation. The policy indicated PT would determine goals and level of restorative care upon discharge from therapy. The policy indicated the ambulation program would be placed under the restorative plan on the care plan and would be updated with the goals and interventions.	F 311		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 25 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions including comprehensive assessment, notification of the physician, and pressure redistribution devices, in order to promote healing and prevent further development of pressure ulcers for 1 of 3 (R146) residents reviewed for pressure ulcers. R146 experienced actual harm due to development of multiple stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both.) Findings include: R146's quarterly Minimum Data Set (MDS) dated 8/27/14, indicated R146 had intact cognition, required extensive assist of two staff for bed mobility and transfers and was at risk for developing pressure ulcers. The MDS also indicated R146 had no pressure ulcers. A corresponding note related to the MDS dated 8/27/14, indicated R146 had an area that was prone to reopening and indicated staff would apply protective ointment to the area and alert nursing to any changes.	F 314	F314 -G 1. Corrective Action: A. On 10/29/14 RN reassessed Resident (R146) with skin condition change and Therapy orders were obtained 10/30/14. 2. Corrective Action as it applies to Other Residents: A. Reviewed skin assessment with Nurse Managers. B. All records reviewed for those identified with a Braden less than 18. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14 5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, review skin data collection.	

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F 314	Continued From page 26 R146's Diagnosis Report dated 9/24/14, indicated R146's diagnoses included: chronic systolic heart failure, anxiety, Parkinson's disease, anemia, diabetes mellitus and edema. R146's care plan dated September 2014, indicated R146 was at high risk for pressure and moisture related breakdown and had a physical mobility deficit related to increased weakness and ongoing heart related issues. The care plan indicated R146's skin would be free from pressure or moisture related skin conditions. The care plan had no pressure ulcer prevention interventions nor pressure ulcer treatments identified. R146's weekly skin assessment form indicated R146 had a pressure ulcer on the right buttock midway between the coccyx and leg crease and the following measurements were documented: -7/18/14, ulcer measured 0.4 centimeter (cm) x 1.4 cm, open area. dressing applied, to be changed every three days. -8/13/14, ulcer measured 2.1 cm x 0.8 cm, dressing applied, change every day and as needed. Review of R146's Skin Ulcer Data Collection Forms revealed the following entries: -8/27/2014, a pressure ulcer, location not identified, No measurement was indicated. However, indicated the wound bed was epithelialized with macerated edges/surrounding skin. No odor. No further information was provided.	F 314	6. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the impaired skin integrity findings weekly at IDT and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 314	Continued From page 27 -9/11/14, right buttock pressure ulcer measured 1.2 cm x 0.5 cm with an epithelialized / granulated wound bed, no pain, no odor. -10/2/2014, the right buttock ulcer measured 0.4 cm x 0.5 cm, the left buttock ulcer was identified and measured 0.4 cm x 0.5 cm., rolled edges, epithealized wound bed, no pain, no odor. -10/8/2014, the right buttock ulcer measured 0.2 cm x 0.3 cm, the left buttock ulcer measured 0.5 cm by 0.7 cm. The remainder of the form was blank with no further information / wound description provided. -10/14/14, the right buttock ulcer measured 1.0 cm x 1.0 cm, the left buttock ulcer measured 0.6 cm by 1.2 cm. with minimal bloody drainage and redness around the edges. A written entry on the same form dated 10/14/14, indicated some bloody drainage, ulcers were painful when cleaned and dressed. -10/21/2014, the right buttock ulcer measured 1.0 cm by 1.0 cm and an additional right buttock ulcer measured 0.5 cm by 0.5 cm. The left buttock ulcer measured 0.7 cm by 1 cm. with minimal bloody drainage, slough present, redness around edges, no odor and no pain. A written entry on the same form dated 10/21/14, indicated small open areas one on left and two on the right with small amount bleeding and yellow slough on right wound. -10/22/14, coccyx pressure ulcer on the right buttock measured 1.0 cm by 1.0 cm, the lower second pressure ulcer on the right buttock measured 0.6 cm by 1.2 cm, the pressure ulcer on the left buttock measured 0.5 cm by 0.5 cm.	F 314		

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F 314	Continued From page 28 and an open area on the center of the coccyx area,by the tail bone measured 0.2 cm by 0.3 cm. The rest of the form was blank with no further information / description of the ulcers was indicated. On 10/29/14, RN-A completed a Skin Ulcer Data form for R146 and the following five stage two pressure ulcers were identified: ·upper left of coccyx measured 0.7 X 1.2 cm with a depth of 0.2 cm. The wound had minimal serous drainage with 50% slough and 50% granulation. The outer edges of the wound were red. No odor or pain was noted. The section which indicated if signs of progress toward healing and if not contact the physician was blank. ·upper right of coccyx ulcer measured 0.6 X 0.3 cm with a depth of 0.2 cm with minimal serous drainage, 50% slough and 50% granulation, redness around the edges, no odor and indicated R---had pain at the site. The section which indicated if signs of progress toward healing and if not contact the physician was blank. ·lower right of coccyx ulcer measured 1.5 X 1.0 cm with a depth of 0.2 cm. with minimal serous drainage, 50% slough, 40% granulation and 10% eschar (dead tissue), redness around the edges, pain at site and no odor. The section which indicated if signs of progress toward healing was present and if not contact the physician within 2-3 weeks was blank. ·lower left of coccyx ulcer measured 1.5 X 1.3 cm with a depth of 0.2 cm. with minimal serous drainage, 50% slough, 50% granulation, redness	F 314		

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F 314	Continued From page 29 around edges, had pain at site and no odor present. ·center of the coccyx ulcer measured 0.5 cm X 0.3 cm with a depth of 0.1 cm with minimal serous drainage, 10% slough, 90% granulation and redness around the edges. There was no evidence that a comprehensive skin assessment had been completed following the development of the above pressure ulcers. On 10/28/2014, at 11:40 a.m. R146 was observed in the dining room, seated in her wheelchair. No pressuring distribution cushion was observed on the seat of the wheelchair. On 10/29/14, at 12:36 p.m. licensed practical nurse (LPN)-A stated when a resident developed an ulcer or any kind of open area, the nurse would initiate a skin ulcer data form, obtain measurements, obtain a pressure ulcer wound kit and would inform the registered nurse (RN) who was responsible for monitoring pressure ulcers. LPN-A stated wounds were measured weekly on Tuesdays and if it was determined the wound was not healing or worsening, the RN would make the call as to the next step in the treatment process. At this time, LPN-A was observed to complete R146's coccyx dressing change. LPN-A verified R146 had five stage two pressure ulcers on her coccyx area: two on the right buttock, one in the center of the coccyx and two on left buttock. When asked whether the RN had assessed R146's ulcers, LPN-A stated, "I don't know." When asked if R146 utilized a wheelchair pressure redistribution device, LPN-A stated, "I think she does." LPN-A proceeded to look around R146's room and stated, "I guess not." When	F 314		

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F 314	Continued From page 30 asked if R146 would benefit from the use of a pressure relieving cushion in both the recliner and wheelchair, LPN-A replied, "Oh absolutely." LPN-A stated she was not aware if R146 had been assessed for the use of a pressure redistribution device. On 10/29/14, at 1:52 p.m. R146 was observed in her room, seated in the recliner. When asked if she had a cushion for the wheelchair seat, R146 stated, "no I don't." When asked if her bottom hurt while seated in the wheelchair or recliner, R146 stated, "yes it does hurt, it hurts all the time." When asked if she had been assessed by anyone for pressure redistribution devices for both the wheelchair or recliner, R146 stated, "No they have never done that." On 10/29/14 at 2:20 p.m., when asked whether R146 utilized a pressure redistribution device in the wheelchair, nursing assistant (NA)-A stated "I am not sure, I thought she had one." However, after looking, NA-A verified R146 did not currently have a cushion to help prevent pressure ulcers in her wheelchair. NA-A further stated, "I think it would probably help her." On 10/29/14 at 4:13 p.m., RN-A stated skin assessments had not been completed for R146 following the development of any of the five pressure ulcers R146 had developed. RN-A further stated, "I know that she had a cushion at one time, even though it is not on the care plan. I called her daughter, and the daughter stated she did have a cushion at one time but we're not sure when it disappeared." On 10/30/14 at 8:34 a.m., RN-A stated she had implemented a pressure redistribution device last	F 314		

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F 314	Continued From page 31 night. However, at that time RN-A and the surveyor observed R146 to be seated in her wheelchair in the dining room without a pressure relieving device in the wheelchair. RN-A verified this observation. In addition, when asked, RN-A verified she had not notified R146's medical doctor about the development of the five pressure ulcers. RN-A stated R146 had been seen by the nurse practitioner, however during review of the record, there was no documentation to indicate whether the pressure ulcers were ever brought up or discussed during those visits: 10/10/14, 10/16/14 and 10/21/14. RN-A also verified she had not completed a comprehensive skin assessment when R146 had developed the five pressure ulcers, and stated she was unaware an assessment was supposed to be completed following the development of pressure ulcers. On 10/30/14, at 9:17 a.m. the director of nursing (DON) stated it was the facility's policy and protocol to complete a comprehensive skin assessment with the development of a pressure ulcer. The DON stated she was unaware the assessments had not been done when R146 developed the pressure ulcers. The DON also stated it was her expectation the RN would contact a resident's medical provider when an ulcer was not healing. The DON confirmed she would expect a wheelchair pressure redistribution device be implemented when a resident had a pressure ulcer. During the conversation, the DON verified the appropriate skin assessments and interventions were not completed/implemented for R146 and stated, "we can only go forward from here." The DON verified the facility's policy was not followed. The DON provided documentation of steps the facility had implemented on 10/30/14, which consisted of a	F 314		

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	245368	A. BUILDING _____ B. WING _____	10/30/2014

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F 314	Continued From page 32 request for Occupational and Physical therapy to evaluate and provide treatment related to the need for wheelchair and bed positioning interventions for pressure reduction, transfers and comfort measures. In addition, on 10/30/14, a notice was sent to R146's medical doctor which requested an evaluation of the worsening stage two ulcers, and a Braden Scale (pressure sore risk assessment) was completed. The resident's Braden score was identified as 13, which indicated R146 was at moderate risk for pressure ulcer development. The facility's policy titled, Skin Assessment and Care revised November 2013, included: "Each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to skin care; a resident who enters the facility without pressure ulcers does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." The policy further included, "A registered nurse must complete a skin assessment if a new pressure ulcer develops. The assessment must include a review of the resident's tissue tolerance to pressure."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 33 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a call light and foot rests according to the assessed need for 1 of 1 resident (R126) in order to minimize the risk of falls or injury. Findings include: R126's Fall Risk Assessment dated 9/15/14, indicated R126 was at high risk for falls. The assessment indicated staff would encourage R126 to use the call light for assistance, would check R126 frequently and provide one staff assistance for activities of daily living (ADL) and walking. R126's admission Minimum Data Set (MDS) dated 9/20/14, indicated R126's diagnoses included weakness and congestive heart failure. The MDS also indicated R126 had cognitive impairment, walked with staff assistance in own room only once or twice and had not walked outside of the room during the seven day reference period. The MDS also indicated R126 was receiving physical therapy (PT) services. R126's Falls Care Area Assessment (CAA) dated 9/26/14, indicated R126 was admitted to the facility due to increased weakness, a change in cognition and a history of falls. The CAA also indicated R126 had previously been able to walk	F 323	F323 -D 1. Corrective Action: A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained. 2. Corrective Action as it applies to Other Residents: A. Reviewed fall assessment, need for foot pedals on wheel chair and call light expectation with Nurse Managers B. Direct Observations will continue DON or designee to use to validate care delivery to assure safety interventions are being followed. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14 5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed.	

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F 323	Continued From page 34 with a walker and was presently participating in PT and occupational therapy (OT). R126's ADL CAA dated 9/26/14, indicated R126 required extensive assist with ADL's, transfers and mobility. R126's care plan dated 10/2014, indicated R126 had impaired physical mobility, was admitted to facility related to increased weakness and was in PT for strengthening. The care plan indicated R126 was to have a call light within reach and foot rests were to be used for long distances when in the wheelchair. On 10/27/14, at 4:30 p.m. R126 stated she did not have a call light in her room nor by her bed but stated there was a call light in the bathroom that she could use. On 10/28/14, at 9:30 a.m. R126 was observed in her room seated in a wheelchair. No call light / call cord was observed in her room. On 10/29/14, at 9:00 a.m. R126 was observed in her room. No call light was observed in the room. On 10/29/14, at 1:20 p.m. licensed practical nurse (LPN)-F verified R126's room did not have a call light/cord for her to use to summon assistance. LPN-F also indicated R126's care plan was correct and stated R126 should have a call light available for use in the room. At the time of the interview, nursing assistant (NA)-H was observed wheeling R126 to the rehab room located at the far end of the facility. R126's feet / legs were observed unsupported as the wheelchair foot rests were not on.	F 323	6. The Correction will be Monitored by: A.DON or designee. B. The Nurse Managers will summarize the care observation results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 323	Continued From page 35 On 10/29/14, at 2:35 p.m. registered nurse (RN)-F stated she would expect R126's wheelchair to have foot rests on when being transported long distances. RN-F stated R126's care plan was correct and was not followed. The facility policy, Call Lights, dated 8/2003, indicated all staff were responsible for answering call lights. However, R126 was not provided with a call light. No facility policy was provided related to wheelchair foot rests.	F 323	F332- D 1. Corrective Action: A. On 10/29/14 RN reassessed Resident (R3) with no negative outcome identified. 2. Corrective Action as applies to other residents; A. Team educated on medication/treatments administration. B. Medication errors issued to the individual involved with administering medications at the inaccurate time. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14 5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe medication/treatment protocol is being followed.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents (R3) whose medication administration was observed. The facility had 2 medication errors in 27 opportunities resulting in an error rate of 7.4% Findings include: On 10/29/2014, at 8:35 a.m. licensed practical nurse (LPN)-E was observed to administer medications to R3. LPN-E administered levothyroxine 75 micrograms (mcg), Prilosec OTC (omeprazole) 20 milligrams (mg), eleven other oral medications (aspirin, fenofibrate, Lyrica, lisinopril, Certavite, vitamin C, ferrous	F 332		

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F 332	Continued From page 36 gluconate, metformin, sertraline, atenolol, and baclofen) and one injectible medication (Novolog). At the time of administration, R3 was finishing the breakfast meal. R3's Physician Orders dated 9/28/14 - 11/06/14, included the following orders: -8/29/14, Synthroid (levothyroxine) 0.075 mg take 75 mcg by mouth before breakfast -8/29/14, omperazole 20 mg take 1 capsule by mouth two times daily before meals. R3's Medication Record dated 10/01/14 - 10/31/14, identified Synthroid 0.075 mg was to be given before breakfast at 7:00 a.m. and omeprazole 20 mg was to be given before meals at 8:00 a.m. and 4:00 p.m. On 10/29/2014, at 1:29 p.m. LPN-E confirmed R3's levothyroxine and Prilosec should have been given before R3 had eaten. LPN-E stated she had many interruptions in the morning and was late giving the medication. On 10/30/2014, at 3:50 p.m. registered nurse (RN)-C confirmed R3's levothyroxine and omeprazole should have been given prior to his eating breakfast. On 10/31/14, at 10:42 a.m. director of nursing (DON) confirmed she would have expected R3's medications to be given before meals as ordered by the physician. The Medication/Treatment Administration policy dated November 2013, indicated all medications/treatment were to be administered as prescribed.	F 332	6. The Correction will be Monitored by: A.DON or designee. B. The Nurse Managers will summarize the medication/treatment observation results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 356 F 356 SS=C	Continued From page 37 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the nurse posting was accurate regarding the actual	F 356 F 356	F356- D 1. Corrective Action: A. On 10/27/14 the receptionist updated the informational sheet in the glass cabinet located outside the LSW office which included location of posted Nursing hours. 2. Corrective Action as applies to other residents; A. Policy revision to include posting the following information: ▪ Facility name ▪ The current date ▪ The total number and actual hours worked by the following categories of licensed staff directly responsible for resident care per shift: o Registered Nurses o Licensed Practical Nurses o Certified Nursing Aides ▪ Resident Census 3. Mandatory Education for all Team Members 12/03/14.	

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F 356	Continued From page 38 number of licensed staff on duty for 4 of 4 days reviewed. This had the potential to affect all 100 residents residing in the facility as well as visitors who may wish to view this information. Findings include: During the initial tour on 10/27/14, at 1:00 p.m. a nurse staff posting informational sheet was observed located inside an encased glass cabinet outside of the social workers office and also in the Lodge community that directed residents and staff to the Woods nursing station area to find the daily nurse staff posting information. However, the nurse staff posting was observed located on the wall to the side of the social workers office and not in the Woods station as indicated. The nurse staff posting was observed to lack the actual number of licensed and unlicensed staff working. On 10/27/14, at 1:54 p.m. licensed practical nurse (LPN)-C confirmed the daily nurse staff postings were not in the woods nursing station, they were posted by the social workers office. On 10/28/14, at 8:10 a.m. the nurse staff posting was observed posted in the same location. The posting lacked the actual number of licensed and unlicensed staff working. On 10/29/14, at 7:10 a.m. the nurse staff posting was observed posted in the same location. The posting lacked the actual number of licensed and unlicensed staff working. On 10/30/14, at 8: 10 a.m. the nurse staff posting was observed posted in the same location. The posting lacked the actual number of licensed and	F 356	4. Date of Completion: 12/09/14 5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, validate protocol is being followed. 6. The Correction will be Monitored by: A.DON or designee. B. The scheduler will summarize the results and present the information to the QAPI Committee on a quarterly basis for further direction.	

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F 356	Continued From page 39 unlicensed staff working. On 10/30/14, at 2:23 p.m. the director of nursing (DON) stated the scheduler initially filled out the staff posting information and then if they received a call in, whoever received the call, was responsible to update the staff posting. The DON confirmed the nurse staff posting for 10/27, 10/28, 10/29, and 10/30, did not reflect the number of licensed and unlicensed staff working each shift. The DON verified some of the start times for staff were 5:30 a.m. and 11:30 a.m. The DON confirmed these start times were not reflected on the nurse staff posting. In addition, the DON confirmed the information posted in the encased glass cabinets was incorrect and the only posting of nurse staffing hours were on the wall outside of the social workers office. No policy related to nurse staff posting was provided.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	F371-F 1.Corrective Action: A. On 10-30-14 DM obtained T-strips and confirmed appropriate temperature. 2. Corrective Action as it applies to Other Residents: A. The standard of practice for food distribution and maintain sanitary conditions will continue to be followed. B. The standard was reviewed with team on 10/30/14. 3. Mandatory Education for all Team Members 12/03/14.	

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F 371	Continued From page 40 review the facility failed to ensure dishes were washed in a sanitary manner which had the potential to affect all 102 residents residing in the facility and were served meals on the unsanitized dishes. Findings include: On 10/30/14, at 1:45 p.m. the dishwasher was observed as dinner meal dishes were being washed. During the rinse cycle, the dishwasher temperature gauge was observed to read 170 degrees. At this time the dietary manager (DM) stated the rinse water temperature was required to be at 180 degrees for sanitation purposes. Review of the facility's dishwasher rinse temperature logs from 10/1/14-10/30/14, revealed the following: -10/1/14, One out of seven recorded rinse temperatures was below the required 180 degree temperature at 150 degrees. -10/10/14, two out of five recorded rinse temperatures were below the required 180 degree temperature at 175 degrees and 178 degrees. -10/14/14, three out of 10 recorded rinse temperatures were below the required 180 degree temperature at 172-178 degrees. -10/20/14, two of eight recorded rinse temperatures were below the required 180 degree temperature at 178 degrees. -10/23/14, four out of 10 recorded rinse	F 371	4. Date of Completion: 12/09/14 5. Reoccurrence will be prevented by: A. Periodic surveillance of dishwasher temperature will be conducted. 6. The Correction will be monitored by: 1. DM or designee. 2. DM will report summary of compliance findings to QAPI Committee.	

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F 371	Continued From page 41 temperatures were below the required 180 degree temperature at 160 to 174 degrees, respectively. -10/25/14, four out of the eight recorded rinse temperatures were below the required 180 degree temperature at 172-178 degrees. -10/26/14, two out of 10 recorded rinse temperatures were below the required 180 degree temperature at 178 degrees. -10/27/14, eight of the 13 recorded rinse temperatures were below the required 180 temperature and ranged from 150-179 degrees. -10/28/14, five of the 11 recorded rinse temperatures were below the required temperature and ranged from 178-179. On the temperature log, a note was written which indicated maintenance had checked the heat booster on Wednesday morning with wash temperature of 150 degrees and rinse temperature of 181 degree. -10/29/14, five out of the 12 recorded rinse temperatures were below the required 180 temperature and ranged from 176-178 degrees. -10/30/14, three out of the five recorded rinse temperatures were below the required 180 degree temperature and ranged form 164-179 degrees. On 10/30/14, following the review of the temperature logs at approximately 1:50 p.m. the DM stated she had reviewed the temperature log readings and stated she was aware the rinse water was not getting up to the required 180	F 371		

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F 371	Continued From page 42 degrees for adequate sanitation. The DM also stated when temperatures were below the required temperature staff were directed to contact the maintenance person who had informed us the dishwasher was functional. The DM stated Eco Lab was last at the facility to review the dishwasher on 9/30/14, and reported 180 degrees on the dishwasher rinse water. The DM stated the facility was not planning to repair the dishwasher because they were expecting a new machine in December 2014. On 10/30/14, at 3:00 p.m. the director of nursing (DON) stated the facility had not had any facility wide infectious outbreak. At 3:05 p.m. the DM consulted with Eco Lab who questioned if the dishwasher water temperature gauges were bad and in need of replacement. At 4:15 p.m. Eco lab personal attempted to get a digital temperature reading for the rinse water, however, the temperature only reached 170 degrees. He stated the rinse water gauge needed to be replaced and he would order the piece for the facility. At 4:45 p.m. the DM, dietician and Eco Lab staff were advised the dishwasher could not be used until the dish washer was working correctly in order to ensure sanitization of the dishes. On 10/31/14, at 8:00 a.m. the DM stated she obtained T-strips and a thermometer for obtaining accurate temperature readings of the dishwasher rinse water. At this time the DM ran a tray with a container of forks with a T-strip attached to a fork tine. The T-strip turned black which indicated the rinse water was the appropriate temperature. The	F 371		

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F 371	Continued From page 43 thermometer was placed in the dishwasher and had a 180 degree reading. At that time the DM advised the dietary staff the dishwasher could be used for resident dishes. The facility's Dishwasher Operation and Principles policy dated 3/05, indicated dishes would be properly racked and the dishwasher would be operated according to standards. The policy indicated final rinse water temperature on the dishwasher should be 180-190 degrees.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	F425 - D 1.Corrective Action: A. Resident (R90) care plan and Resident (R230) Delay in receiving prescribed medications, omission errors processed. 2. Corrective Action as it applies to Other Residents: A. Spoke with Nurse Managers and directed a reminder be provided to review process of ordering medications in timely manner to ensure delivery. Instructed Nurse Managers – Clinical Leads to contact provider to seek advisement with delayed script processing. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14	

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F 425	Continued From page 44 by: Based on interview and document review the facility failed to ensure medication refills were obtained in a timely manner to meet the needs of 2 of 2 residents (R230, R90) who required as needed (PRN) pain and anti-spasmodic medications. Findings include: A Consultant Pharmacist's Medication Review dated September 2014, identified as a facility summary, indicated the medical director had concerns signing for narcotics. The review also indicated the medical director was concerned regarding new resident admissions and prescription narcotic availability. The pharmacist's implementation timeline directed a physician need not be contacted but nursing staff should address as soon as possible. R230 was prescribed PRN medications for muscle spasms and pain and the medications were not available for use as prescribed. R230's undated Client Diagnosis Report indicated R230 had diagnoses that included chronic back pain, multiple compression fractures, left total knee replacement and muscle spasms. R230's admission Minimum Data Set (MDS) dated 10/19/14, indicated R230 was cognitively intact and reported almost constant pain which made it hard to sleep at night and caused her to limit her day-to-day activities. The MDS indicated R230 reported a pain level of 8 on a 0-10 scale. R230's Psychotropic Drug Use Care Area	F 425	5. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, verify process delivery. Provider update and recommendations made will be transcribed per protocol. 6. The Correction will be Monitored by: A. DON or designee. B. The Nurse Managers will summarize the data from pharmacy deliver sheets and order changes due to unavailability of medication initially ordered; communicate the information to the QAPI Committee on a quarterly basis for further direction.	

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F 425	Continued From page 45 Assessment (CAA) dated 10/19/14, indicated R230 was taking Valium (a medication to treat anxiety, muscle spasms and other conditions) prior to admission to the facility due to muscle spasms. The CAA indicated the current dosage of antianxiety medication was effective in minimizing R230's muscle spasms. R230's Pain CAA dated 10/19/14, indicated R230 was at an increased risk for uncontrolled/unmanaged pain and currently had orders and was receiving PRN Norco (narcotic pain reliever for moderate to moderately severe pain), PRN tramadol (analgesic for moderate to severe pain), PRN Valium, daily scheduled Zanaflex (muscle relaxant) and daily scheduled morphine sulfate (narcotic analgesic for moderate to severe pain) injection via implanted infusion pump. The CAA also indicated R230 would request pain medications as needed from staff, and though R230 had verbal complaints of pain daily, the current pain regimen was effective in managing R230's pain R230's Physician Orders dated 10/12/14, included orders for diazepam (Valium) 2 milligrams (mg.) 1 tablet PRN by mouth every 4 hours for muscle spasms and hydrocodone bitartrate/acetaminophen (Norco) 325 mg - 7.5 mg 1 tab by mouth every 4 hours for pain. On 10/28/2014, at 1:26 p.m. R230 was observed in her room, seated in her wheelchair. Her demeanor was calm and there were no non-verbal indicators of pain such as grimacing or guarding observed. R90 stated she had been out of Valium and hadn't had any in two days because the pharmacy hadn't sent any. R230 stated she had muscle spasms frequently and	F 425		

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F 425	Continued From page 46 had been uncomfortable without her Valium. R90 stated when she had a spasm her body clenched and she often cried out in pain. R90 was observed to clench her fists and stiffen her entire body and face as she spoke to the surveyor. On 10/29/14, at 2:47 p.m. licensed practical nurse (LPN)-H stated R230 was admitted to the facility on a Sunday and received a 30 day supply of Valium which ran out on Sunday (10/26/2014). LPN-H stated the pharmacy needed a physician signed prescription in order to refill the medication. At that time the Medication Record dated 10/12/14 - 10/31/14, was reviewed with LPN-H. LPN-H confirmed Valium was not available for R230 beginning 10/26/2014, and the emergency kit did not contain Valium so R230 had not received the medication. LPN-H stated they now had the medication and R230 had received it Tuesday evening (10/28/14) however, she had not initialed the record to indicate she had. LPN-H also stated R230 was currently out of Norco as well, but they were able to take the medication out of the emergency kit. LPN-H stated they still had not received R230's Norco from the pharmacy yet. On 10/30/2014 at 9:13 a.m. LPN-G stated the facility had an ongoing problem receiving refills of narcotics. LPN-G stated they let the pharmacy know as soon as possible when a refill was needed but would often have to wait as the pharmacy required a physician signed prescription for the refill therefore the refill of the medication would be delayed. LPN-G also stated there were times when residents required pain medications that were not available and he had needed to call the on-call physician for a one time order so he could then use the medication from	F 425		

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F 425	Continued From page 47 the emergency kit. On 10/30/14, at 10:09 a.m. nursing assistant (NA)-D stated R230 complained of cramps intermittently everyday. NA-D stated R230 did well once she was moving around but would cry out loudly which could be heard at the nurses desk when she was moved. On 10/30/14, at 12:05 p.m. R230 again stated she had not received valium for two days (10/27/14, and 10/28/14,) and did experience pain and spasms during those two days. R230 indicated she was given pain medication during that time which did help but did not provide the same amount of relief the Valium did. Review of R230's record revealed the following: The Interdisciplinary Progress Note (IPN) dated 10/28/14, indicated R230 had been requesting her diazepam or Valium 2 mg for muscle spasms. The IPN indicated a call had been placed to both Walgreen's pharmacy and Thrifty White Pharmacy to determine which pharmacy would be responsible to refill the prescription. Thrifty White Pharmacy indicated they would contact the primary physician to get the medication refilled. The IPN also indicated R230 was notified regarding the calls placed to refill her medications. The IPN further indicated R230 had Norco given at 8:40 a.m. and again at 12:40 p.m. for muscle spasms and pain rated at 10/10 and 8/10. R230's Individual Narcotic Record, page 130, identified R230's diazepam 2 mg supply was at zero after the dose given on 10/26/14, at 9:30	F 425		

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F 425	Continued From page 48 p.m. The Individual Narcotic Record, page 143, identified 30 tablets of diazepam 2 mg were received on 10/28/14. The Record did not identify the time the tablets were received. R230's Individual Narcotic Record, page 142, identified R230's hydrocodone/APAP 7.5/325 mg (Norco) supply was at zero after the dose given on 10/28/14, at 9:45 p.m. The Individual Narcotic Record, page 148, identified 30 tablets of hydrocodone/APAP 7.5/325 mg (Norco) were received on 10/30/14. The Record did not identify the time the tablets were received. The Emergency Kit Narcotic Log for the Lodge unit identified R230 received Norco dispensed from the emergency kit on 10/29/14, at 4:50 p.m. and on 10/30/14, at 12:45 a.m. and 10:30 a.m. On 10/30/14, at 3:10 p.m. registered nurse (RN)-C stated they had struggled with PRN narcotic refills since the rule for requiring a written script went into effect. RN-C stated this issue was a project they were working on with Quality Assurance and their medical director. RN-C also stated they were using their emergency kit too much to the point they were emptying out their emergency kit when individual resident's medications were not available. RN-C agreed lack of medication availability could have a negative impact on the residents' quality of life. R230's Medication Record dated 10/12/14 - 10/31/14, and Individual Narcotic Record pages 130, 143, 142 and 148 were reviewed with RN-C. RN-C verified R230 went without her Valium from 9:30 p.m. on 10/26/14 until 8:00 p.m. on 10/28/14.	F 425		

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F 425	Continued From page 49 On 10/31/14, at 9:30 a.m. Packing Slips dated 10/28/14, and 10/30/14, which indicated dates medications were delivered to the facility by the pharmacy, were reviewed with pharmacist (RPH)-A. RPH-A confirmed on 10/28/14, R230's diazepam would have been delivered no sooner than 6:30 p.m. RPH-A also confirmed there was one medication delivery on 10/30/14, which included R230's Norco which would have been delivered no sooner than 6:30 p.m. (Review of the Individual Narcotic Record, Packing Slips and interview with RPH-A verified R230's diazepam was unavailable from 10/26/14, at 9:30 p.m. until at least 6:30 p.m. on 10/28/14, and Norco was unavailable from 10/28/14, at 9:45 p.m. until at least 6:30 p.m. on 10/30/14,) R90's PRN pain medication was not available for use. R90's undated Client Diagnosis Report indicated R90 had diagnoses that included right hip hemiarthroplasty (replacement of one half of the hip joint) and back pain. R90's quarterly MDS dated 7/15/14, indicated R90 was cognitively intact and reported almost constant pain which made it hard to sleep at night and caused her to limit her day-to-day activities. R90 described her pain as severe. R90's Pain CAA dated 4/14/14, indicated R90 was admitted to the facility after sustaining a right hip fracture. The CAA identified R90 had a diagnosis of chronic pain and was on scheduled medication for pain, as well as, PRN narcotics.	F 425		

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F 425	Continued From page 50 The CAA also identified R90 was aware to alert staff when she needed PRN pain medication. The CAA further identified R90 was at risk for unrelieved pain and staff was to observe for signs and symptoms of pain and administer pain medication as prescribed and needed. Review of R90's record revealed the following: The IPN dated 4/7/14, identified R90 had pain and was taking oxyodone 5 mg (a narcotic pain medication for moderate to severe pain) 1-2 tabs every three hours as needed. The IPN dated 4/13/14, at 2:57 p.m. identified two oxycodone 5 mg tablets were taken from the emergency kit for R90's pain. The IPN dated 4/13/14, at 6:28 p.m. identified R90's daughter brought in a prescription of PRN oxycodone 5 mg. The IPN indicated verification of proper labeling and identification of the medication was performed and the medication was counted and entered into the narcotic log. The IPN dated 4/13/14, at 9:27 p.m. indicated R90 had PRN Tylenol 650 mg for pain at 4:40 p.m. The IPN indicated R90's daughter got her prescription filled and brought it in. The IPN dated 4/15/14, at 6:42 p.m. indicated a fax was sent to R90's physician to get a hard script and refills for R90's oxycodone. The IPN dated 4/16/14, indicated R90's daughter reported concerns with personally having to get narcotic medications refilled and stated R90 had run out and the daughter had to then bring in a	F 425		

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F 425	Continued From page 51 prescription to get filled for the facility. R90's Physician Orders dated 10/13/14 ,-11/13/14, included an order dated 10/13/14, for hyrdocodone/APAP 325-5 mg take 1-2 tablets every 6 hours as needed for severe pain. The Woods narcotic E-Kit [emergency kit] log identified R90 received hydrocodone/APAP 5 mg/325 mg dispensed from the emergency kit on 8/20/14, at 8:00 p.m. On 10/29/14, at 2:47 p.m. RN-A confirmed there was a delay receiving medications from the pharmacy when a written prescription was required. RN-A confirmed when this occurred, staff would take the medication from the emergency kits. On 10/31/2014, at 9:47 a.m. RPH-B stated during her first visit to the facility on 9/10/14, the medical director had approached her with concerns regarding the PRN narcotic refill process. RPH-B stated responses from the providers were not happening in a timely manner. RPH-B indicated the medical director had been filling the prescriptions and he was no longer comfortable doing this. RPH-B also stated it was her understanding having the medical director sign the prescriptions had been an attempt at a solution for residents receiving their refills in a timely fashion but the medical director had not been aware of the volume of prescriptions involved prior to agreeing to the solution. RPH-B indicated she had talked with RPH-A who confirmed there was an on-going issue. RPH-B stated there had been no work done regarding the problem and indicated she was waiting for notification on when the quality assurance	F 425		

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F 425	Continued From page 52 meeting was going to be to discuss how they were going to resolve the issue. At this time, during review of R230's diazepam and Norco refill issues with RPH-B, RPH-B stated she had believed the problem to be related to paperwork and had not realized residents were not receiving their medication. RPH-B confirmed R230 not receiving her medications was an issue and concern. RPH-B also identified it was a concern if the facility was routinely utilizing their emergency kit to dispense medications they could not obtain as use of the emergency kit in this fashion could be a Board of Pharmacy issue and the facility could have emergency kit privileges taken away. RPH-B also stated it could be narcotic diversion. On 10/31/2014, at 10:28 a.m. director of nursing (DON) confirmed the facility should have had R230's Valium and Norco available for her use. DON stated she considered this an omission error. DON also confirmed it was an issue to have to use the emergency kit for residents' prescribed medications. A medication refill/ordering policy was requested but none was provided.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	F441 - D 1.Corrective Action: A. Resident (R170) to ensure appropriate infection control measures during dressing change, policy reviewed to be accurate with best practices.	

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F 441	Continued From page 53 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were provided during wound care for 1 of 2 residents (R170) observed during a dressing change. Findings include:	F 441	2. Corrective Action as it applies to Other Residents: A. The procedure for wound dressing changes has been reviewed. 3. Mandatory Education for all Team Members 12/03/14. 4. Date of Completion: 12/09/14 5. Reoccurrence will be prevented by: A. NSG Team reeducated with policy and procedure, LEAN Wound protocol upon hire, annually, and as needed. B. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. C.DON or designee will audit one record per week to assure technique is compliant with best practices. D.Education and immediate correction will ensue for all identified not meeting comprehensive standards. 6. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 441	Continued From page 54 R170's Client Diagnosis Report [undated] identified R170's diagnoses as unstageable pressure ulcer on her left heel, anemia and dementia. R170's admission Minimum Data Set (MDS) dated 7/17/14, indicated R170 had moderate cognitive impairment, had one unstageable pressure ulcer and was at risk for the development of pressure ulcers. R170's Physician Orders dated 10/7/2014, directed staff to complete wound care and change the dressing on R170's left heel every two days. On 10/29/14, at 8:29 a.m. licensed practical nurse (LPN)-D gathered the wound care supplies and entered R170's room. LPN-D was observed to place a towel on an over bed table, wash her hands, set out and open the wound care supplies. Nursing assistant (NA)-B entered the room and washed her hands. LPN-D was observed to donne a pair of gloves. While NA-B elevated and held R170's left foot, LPN-D was observed cut and remove R170's soiled heel dressing. LPN-D proceeded to remove her gloves and immediately donned a new pair. LPN-D cleansed the wound with saline wash, removed her gloves and donned a new pair. She then applied Vaseline around the wound with a Q-tip, removed her gloves and donned a new pair. LPN-D then applied algisite (a wound dressing), covered it with foam dressing, wrapped the wound, removed her gloves and secured the wrap with tape. Both LPN-D and NA-B were observed to wash their hands. On 10/29/14, at 8:46 a.m. LPN-D confirmed she	F 441		

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F 441	Continued From page 55 had not washed her hands or utilized hand sanitizer between the removal of the soiled dressing, cleansing and application of the new dressing. On 10/29/14, at 10:54 a.m. the director of nursing (DON) confirmed the facility's infection control standard precautions policy did not address washing ones hands after the removal of a soiled dressing and prior to the donning of a new pair of gloves and applying a clean dressing. The Infection Control - Standard Precautions policy dated 10/2012, directed staff to remove gloves promptly after use and to wash hands immediately to avoid transfer of microorganisms. A copy from a resource book on Changing a Wound Dressing [undated] was provided; however did not address the need to wash ones hands after removal of a soiled dressing and prior to the donning of a new pair of gloves and applying a clean dressing.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain 2 of 3 neighborhood ice machines in a clean and sanitary manner. This had the potential to affect	F 465	F465 - E 1.Corrective Action: A. Facility cleaned ice machines, replaced ceramic tiles and obtained covered wastebaskets. 2. Mandatory Education for all Team Members 12/03/14.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 56 33 of 100 residents residing in the facility and recieved ice from the machines. In addition the facility failed to maintain ceramic tiles in the dish room and have covered wastebaskets by the sinks in the kitchen. Findings include: On 10/30/14, at 11:300 a.m. a kitchen tour was conducted with the dietary manager (DM). The follow findings were observed: 1. Both hand washing sinks in the kitchen were noted to have waste baskets with no covers. The DM verified the findings and stated she would order waste baskets with covers. 2. upon entering the dish room, two ceramic wall tiles were observed cracked and missing pieces ceramic. The DM stated she contacted maintenance about two weeks ago and would contact them again regarding the broken tiles. 3. An ice machine on both the Woods and Spruce neighborhood kitchens were observed to have a thick white coating on the back splash, around the ice release spots and on the base of the machines. At that time the cook verified the ice machines were in need of cleaning. The DM stated the ice machines were not on a cleaning schedule but now would be. The facility's Holding, Transferring and Disposing of Garbage policy dated 3/05, indicated trash receptacles would be covered with lid at all times.	F 465	3. Date of Completion: 12/09/14 4. Reoccurrence will be prevented by: A. DM will conduct random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5 The correction will be monitored by: A. DM	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 57 An ice machine cleaning policy was requested but not provided by the facility.	F 465		

Addendum to Plan of Correction for Grand Village 245368 (original signed and dated 11/26/14)

(revisions are in *bold italics)*

F280 -D

1. Corrective Action:
   A. RN on 10/31/14 reassessed Resident (R24) to validate functional ability with limited ROM. RN on 10/30/14 reassessed Resident (R126) with noted change and Physical Therapy orders obtained.
   B. RN reviewed plan of care and made revisions for limited range of motion for resident (R24) and updated care plan to include ambulation program for resident (R26).
   C. RN updated nursing team care plan revisions through 24 hour report.

2. Corrective Action as it applies to Other Residents:
   A. Reviewed functional assessment and in house-transfer form with Nurse Managers.
   B. Second validation of **skilled therapy recommendations** processing implemented for DON or designee to use to validate care delivery to assure care plans are updated with revisions as identified through assessment. ***RN will cross reference recommendations from skilled therapy to assure orders were processed.***
   C. Mandatory Education for all Team Members 12/03/14.

3. Date of Completion: 12/09/14

4. Reoccurrence will be Prevented by:
   A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed.
   B. DON or designee will review all in-house transfer forms for care plan adherence and revision.
   C. DON or designee will review care plans for updates and revisions as assessed by interdisciplinary team randomly but at least 2 times a week.

5. The Correction will be Monitored by:
   A. DON or designee.
   B. The Nurse Managers will summarize the care observation results, care plan review results and present the information to the QAPI Committee on a quarterly basis for further direction.

F282 -D

1. Corrective Action:
   A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained.
   B. RN reviewed and updated care plan to include ambulation program for resident (R26).
   C. RN updated nursing team on care plan revisions through 24 hour report. Call light policy was reviewed. Confirmed for Resident (R126) footrests are required on wheelchair for transportation to long distance areas.

2. Corrective Action as it applies to Other Residents:
   A. Reviewed functional assessment and in house-transfer form with Nurse Managers. ***House wide audit completed to verify call light availability and use of footrests.***

B. Second validation of skilled therapy processing implemented for DON or designee to use to validate care delivery to assure care plans are being revised with assessed changes.

C. Random direct observations in and out of patient/resident room to observe for call light placement and use of footrests to assure care plan adherence. Random, direct observations for visual placement of footrests to assure care plan adherence as assessed and care planned.

D. On 10/31/14 all team members where educated on call light necessity. Any discrepancy would be reported to team leader and through interdisciplinary team until issue is resolved.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:

A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed.

B. ***RN will cross reference recommendations from skilled therapy to assure orders were processed.***

6. The Correction will be Monitored by:
   A. DON or designee.
   B. The Nurse Managers will summarize the care observation results and present the information to the QAPI Committee on a quarterly basis for further direction.
   C. ***Nurse mangers will complete random direct observations in and out of patient/resident room to observe for call light placement and use of footrests to assure care plan adherence. Random, direct observations for visual placement of footrests to assure care plan adherence as assessed and care planned.***

F309 -D

1. Corrective Action:

A. RN 10/31/14 reviewed Resident (R90) care plan and updated fluid restrictions, ***implemented fluid intake clinical monitoring to be within provider recommendations of 1200 ccs***. Delayed specialized catheter supplies for Resident (R224), were obtained and noted on 10/31/14 successful irrigation.

2. Corrective Action as it applies to Other Residents:

A. Spoke with Nurse Managers and directed a reminder be provided to review and update plan of PRN. Instructed Nurse Managers – Clinical Leads to contact provider to seek advisement with delayed supplies.
   a. Contact provider
   b. Document that a call was placed to provider.
   c. Await a return phone call from provider for advisement.
   d. If no return call within 1 hour, place call to provider again. Continue to make hourly phone calls to provider until advisement for alternate medication or supply is made.

B. The policy Care Plan –IDT was reviewed with IDT. ***The Admission standard was updated to include*** validation of supplies required and to contact provider with any delay to seek advisement, DON or designee to use to validate care delivery to assure care plans are being

followed. *Team Leaders conduct weekly visual checks of inventory on hand within community and submit request for supplies from large supply room.*

C. Based on assessment and/or provider order clinical monitoring will be implemented as indicated for intake and output.

D. Mandatory Education for all Team Members 12/03/14.

3. Date of Completion: 12/09/14

4. Reoccurrence will be Prevented by:

A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. Provider update and recommendations made will be transcribed per protocol, ***changes to original orders will be reviewed and a determination made on utilization.***

B. DON or designee will randomly but at least two times a week review documentation for intake and output.

5. The Correction will be Monitored by:

A. DON or designee.

B. The Nurse Managers will summarize the data from care plan reviews, intake/output, and order changes due to unavailability of supply initially ordered; communicate the information to the QAPI Committee on a quarterly basis for further direction.

F311 -D

1. Corrective Action:

A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained. ***Care plan was updated to reflect ambulation program.***

2. Corrective Action as it applies to Other Residents:

A. Reviewed functional assessment with Nurse Managers.

B. Second validation of skilled therapy processing implemented for DON or designee to use to validate care delivery to assure care plans are being followed. Internal transfer form to be completed ***for ongoing care delivery from one community to another. All ambulation programs were reviewed and validated.***

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:

A. DON or designee will randomly, but at least two times a week, will observe ambulation program is being provided to assure care plans are being followed.

6. The Correction will be Monitored by:
   A. DON or designee.
   B. The Nurse Managers will summarize the ambulation monitoring results and present the information to the QAPI Committee on a quarterly basis for further direction.

F314 -G

1. Corrective Action:
A. On 10/29/14 RN reassessed Resident (R146) with skin condition change and Therapy orders were obtained 10/30/14.
B. Care plan was revised to reflect pressure relieving devices gel cushion to be used in both wheelchair and recliner. Pressure relieving mattress to bed. Resident (R146) encouraged to offload at minimum hourly while awake.

2. Corrective Action as it applies to Other Residents:
A. Reviewed skin assessment with Nurse Managers, 100% audit of all braden and TTT completed with revisions to care plan as needed.
B. All records reviewed for those identified with a Braden less than 18. ***Tissue tolerance test were completed, care plans reviewed to ensure accuracy. Individualized repositioning programs validated. Conveyed to nursing via 24 hour report.***
C. Pressure relieving devices validated.
D. Direct observations will be conducted to ensure pressure relieving interventions are in place and effective.
E. Stop and Watch early warning tool. Changes will be reported via Stop and Watch early warning tool.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:
A. DON or designee will randomly, but at least two times a week, review skin data collection, stop and watch early warning tool.
B. Update care plan interventions. Educate team through 24 hour report with changes made to promote healing and or prevention of impaired skin integrity.

6. The Correction will be Monitored by:
   A. DON or designee.
   B. The Nurse Managers will summarize the impaired skin integrity findings weekly at IDT and present the information to the QAPI Committee on a quarterly basis for further direction.

F323 -D

1. Corrective Action:

A. On 10/30/14 RN reassessed Resident (R126) with noted change and Physical therapy orders were obtained.

B. Call light provided.

2. Corrective Action as it applies to Other Residents:

A. Reviewed fall assessments, need for foot pedals on wheel chair and call light expectation with Nurse Managers

B. Direct Observations will continue. DON or designee to validate care delivery to assure safety interventions are being followed.

C. Hourly rounding will continue, and shift to shift walk through.

D. All team members where educated on call light necessity. Any discrepancy would be reported to team leader and through interdisciplinary team until issue is resolved.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:

A. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed.

B. Nurse mangers will complete random direct observations in and out of patient/resident room to observe for call light placement and use of footrests to assure care plan adherence. Random, direct observations for visual placement of footrests to assure care plan adherence as assessed and care planned.

6. The Correction will be Monitored by:

A.DON or designee.

B. The Nurse Managers will summarize the care observation results and present the information to the QAPI Committee on a quarterly basis for further direction.

F332- D

1. Corrective Action:

A. On 10/29/14 RN reassessed Resident (R3) with no negative outcome identified.

B. MAR reviewed and revised to reflect medications to be taken before breakfast as prescribed.

C. Medication error issued to the individual involved.

2. Corrective Action as applies to other residents;

A. Team educated on medication/treatments administration ***including the 5 Rights.***

B. Medication errors issued to the individuals involved with administering medications at the inaccurate times.

C. Medication/Treatment Administration Policy was reviewed. Pharmacy consult updated and provided an audit tool for medication pass observations. Determination to measure performance will be calculated. Pharmacy consult will provide reports quarterly.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:
A. DON or designee will randomly, but at least two times a week, observe medication/treatment protocol being followed.

6. The Correction will be Monitored by:
A. DON or designee.
B. The Nurse Managers will summarize the medication/treatment observation results and present the information to the QAPI Committee on a quarterly basis for further direction.

F371-F
1. Corrective Action:
A. On 10-30-14 DM obtained T-strips and confirmed appropriate temperature.
B. Replacement temperature gauge was installed.

2. Corrective Action as it applies to Other Residents:
A. The standard of practice for food distribution and maintain sanitary conditions ***will continue to be followed and monitored by the DM. The standard was reviewed with the dietary team who operate the dishwasher and random temperature checks will continue.***
B. The standard was reviewed with team on 10/30/14.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be prevented by:
A. Periodic surveillance of dishwasher temperatures will be conducted.
B. Analysis of temperature findings will be reviewed by DM or designee. Variances will be immediately corrected.

6. The Correction will be monitored by:
1. DM or designee will randomly but at least 2 times per week verify proper temperature.
2. ***DM*** will report summary of compliance findings to QAPI Committee ***on a quarterly basis.***

F425 - D
1.Corrective Action:
A. Resident (R90) care plan and Resident (R230) Delay in receiving prescribed medications, **resulted** in omission errors processed for nurses involved.

B. Thrifty White notified of Rxs required for resident (R90) and (R230).

2. Corrective Action as it applies to Other Residents:
A. Spoke with Nurse Managers and directed a reminder be provided to review process of ordering medications in timely manner to ensure delivery. Instructed Nurse Managers – Clinical Leads to contact provider to seek advisement with delayed script processing.
B. Medication Refill/Ordering protocol was reviewed. Instructed Nurse Managers – Clinical Leads to contact provider to seek advisement with medications.

- *a. Contact provider*
- *b. Document that a call was placed to provider.*
- *c. Await a return phone call from provider for advisement.*
- *d. If no return call within 1 hour, place call to provider again. Continue to make hourly phone calls to provider until advisement for alternate medication and or script is provided.*

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be Prevented by:
A. DON or designee will randomly, but at least two times a week, verify process delivery. Provider update and recommendations made will be transcribed per protocol.

6. The Correction will be Monitored by:
A. DON or designee.
B. The Nurse Managers will summarize the data from pharmacy deliver sheets and order changes due to unavailability of medication initially ordered; communicate the information to the QAPI Committee on a quarterly basis for further direction.

F441 - D

1. Corrective Action:
A. Resident (R170) to ensure appropriate infection control measures during dressing change, policy reviewed to be accurate with best practices. ***Nursing team directed to remove gloves promptly after use and wash hands immediately to avoid transfer of microorganisms.***
B. Education provided to all nursing team members via 24 hour report to adhere to infection control practices while providing wound care. Policy Infection Control Standard Precautions was reviewed.

2. Corrective Action as it applies to Other Residents:
A. The procedure for wound dressing changes has been reviewed.
B. Education and periodic surveillance implemented to monitor infection control practices.

3. Mandatory Education for all Team Members 12/03/14.

4. Date of Completion: 12/09/14

5. Reoccurrence will be prevented by:
A. NSG Team reeducated with policy and procedure, LEAN Wound protocol upon hire, annually, and as needed.
B. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion.

6 Reoccurrence will be Prevented by:
A. DON or designee will directly observe dressing change technique is compliant with best practices.
B. Education and immediate correction will ensue for all identified not meeting comprehensive standards infection control practices.

7. The Correction will be Monitored by:
A. DON or designee.
B. The QAPI Committee will review the surveillance results on a quarterly basis and provide further direction, as needed.

F465 - E

1. Corrective Action:
A. Facility cleaned ice machines, ceramic tiles are on order through flooring company and covered wastebaskets are ordered.
B. DM or designee will sanitize machines daily. Machines will be delimed/descaled 1 time per week. On monthly cleaning schedule observations will be made for damaged ceramic tiles and covered wastebaskets.

2. Mandatory Education for all Team Members 12/03/14.

3. Date of Completion: 12/09/14

4. Reoccurrence will be prevented by
A. DM will conduct random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion.

Approved 12/16/14 LB

Shawna Bkinen, Executive Director, Revised 12/15/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(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	INITIAL COMMENTS FIRE SAFETY 01 Main Building (1900, 1972, 1992 and 2000 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 01 Main Building was found 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 18 New Health Care. Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

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K 000	Continued From page 1 original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is Met.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Sub-Acute 2004 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 02 Sub-Acute 2004 Building was found 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 18 New Health Care. Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

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K 000	Continued From page 1 original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		