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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CF6S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245373**

2.STATE VENDOR OR MEDICAID NO.
(L2) **537342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

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 **01/02/2014** (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 **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 :
Denise Erickson HFE NEII 02/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/20/2013 (L33)

DETERMINATION APPROVAL

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

CCN: 24-5373

On February 1, 2014 health and life safety code conducted Post Certification Revisit (PCR) and verified correction of deficiencies issued pursuant to the October 25, 2013 extended survey. As a result of the extended survey, Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified, resulting in an extended survey and remedies recommended to the CMS Region V Office. Since the facility attained compliance, this Department is discontinuing the Category 1 remedy of State monitoring, effective Decem ber 7, 2013. In addition, we are recommending the following to the CMS Region V Office for imposition:

• Per day civil money penalty remain in effect (42 CFR 488.430 through 488.444)

The facility is subject to a two year loss of NATCEP, effective October 25, 2013 due to the extended survey resulting in SQC. Refer tot the CMS

2567b for both health and life safety code.

Effective December 7, 2013, the facility is certified for 40 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5373

March 8, 2014

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minneosta 56572-0645

Dear Ms. Garrity:

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 December 7, 2013 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2014

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

RE: Project Number S5373026
Substantial Compliance Deficiencies F503, F509 and F519-All Corrected

Ms. Garrity:

On February 1, 2014, this Department sent you the results of the Post Certification Revisit (PCR) conducted on December 23, 2013. Three deficiencies at the time of the October 25, 2013 standard survey were cited at a scope and severity level of "C" (Substantial Compliance):

- **0503-Lab Svcs - Fac Provided, Referred, Agreement**
- **0509-Diagnostic Svcs - Meet Hospital Requirements**
- **0519-Transfer Agreement With Hospital**

The District office that conducted the survey provided additional communication and confirmed they verified correction of all deficiencies, including the "C" level deficiencies listed above. Enclosed you will find a CMS 2567b revisit form with the following deficiencies corrected, as of December 1, 2013:

- **0503-Lab Svcs - Fac Provided, Referred, Agreement-12/01/2013**
- **0509-Diagnostic Svcs - Meet Hospital Requirements-12/01/2013**
- **0519-Transfer Agreement With Hospital-12/01/2013**

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

Sincerely,

Mark Meath

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

Enclosure(s)

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing	12/23/2013

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/01/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **12/07/2013**
ID Prefix **F0503** Reg. # **483.75(i)(1)(i-iv)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0509** Reg. # **483.75(k)(1)(i-ii)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0519** Reg. # **483.75(n)** LSC	Correction Completed **12/01/2013**
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	MM/GA	03/28/2014	31256	12/23/2013
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
10/25/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing	12/23/2013

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/01/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/01/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **12/07/2013**
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	MM/GA	02/01/2014	31256	12/23/2013
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
10/25/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing **01 - MAIN BUILDING 01**	1/2/2014

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0038	Correction Completed **11/25/2013**	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
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:
	MM/PS	02/01/2014	03006	01/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
10/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

February 1, 2014

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

Re: Enclosed Reinspection Results - Project Number S5373026

Dear Ms. Garrity:

On December 23, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 25, 2013, with orders received by you on November 18, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5373r14lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00442	A. Building B. Wing	12/23/2013

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **12/01/2013**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **12/01/2013**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **12/01/2013**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	Correction Completed **12/03/2013**	ID Prefix **21165** Reg. # **MN Rule 4658.0675 Subp. 7** LSC	Correction Completed **12/03/2013**	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	MM/GA	02/01/2014	31256	12/23/2013
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
10/25/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CF6S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245373**
2.STATE VENDOR OR MEDICAID NO.
(L2) **537342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

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 **10/25/2013** (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 **40** (L18)

13.Total Certified Beds 40 (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
	40			
(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 :
Denise Erickson, HFE NEII 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/18/2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5373

An extended survey was completed at Pelican Valley Health Center on October 25, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of J. The IJ was abated on October 25, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety.

As a result of the survey findings, this Department imposed State Monitoring effective November 18, 2013.

In addition, this Department recommended the enforcement remedy listed below to the CMS RO:

- Per day civil money penalty.

The facility is subject to a two year loss of NATCEP, effective October 25, 2013 due to the extended survey.

Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6664

November 13, 2013

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5373026

Dear Ms. Garrity:

The above facility was surveyed on October 21, 2013 through October 25, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIS TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health 1505 Pebble Lake Road, Suite #300 Fergus Falls, Minnesota 56537-3858.

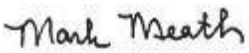
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140.

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

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

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

Sincerely,



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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5373s14lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted as the facility was found to be in an immediate jeopardy (IJ) on 10/23/13, at 5:25 p.m. at F323 due to failure to assess residents at risk for falls and effectively implement interventions. The IJ was removed on 10/25/13, at 10:24 a.m..	F 000		
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	F 279	F279 Pelican Valley Health Center ensures that the results of the assessment are used to develop, review and revise the resident's plan of care. Resident # R1's comprehensive plan of care was reviewed and revised with regards to dialysis services/care. At this time no other residents are receiving dialysis services. The Director of Nursing will have a meeting with nursing staff to review the facility policy regarding care plans and adherence to the individual resident plans of care, specifically with regards to dialysis. The Director of Nursing or designee will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee will review audits and make recommendations as needed.	12/1/13.

OK c addendum 12/10/13 bc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/26/13

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.

RECEIVED
DEC 03 2013
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 279	Continued From page 1 §483.25; and any services that would otherwise 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 interview and document review, the facility failed to develop a comprehensive care plan related to care and precautions of dialysis access for 1 of 1 residents (R1) receiving dialysis. Findings include: R1 had diagnoses including chronic kidney failure, with placement of a dialysis PermaCath and initial dialysis treatment on 10/18/13. The admission Minimum Data Set (MDS) dated 10/7/13, identified R1 was cognitively intact and required assistance with all activities of daily living. Further, the MDS identified R1 was unsteady with transitioning from various surfaces and required one person assistance with bathing. Review of the interdisciplinary progress notes revealed a note on 10/18/13, which identified placement of a dialysis PermaCath. There was no documentation found regarding the location of the PermaCath, instructions for care, or emergency care. Review of R1's October, 2013 treatment record revealed the lack of documentation of monitoring done of the dialysis PermaCath site.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 279	Continued From page 2 The care plan, revised 10/18/13, identified R1 had chronic kidney disease with recent exacerbation and fluid retention. The approaches listed were to have labs and vitals as ordered and coordinate cares with dialysis unit, keep M.D. and family updated and observe for changes in condition and keep M.D. current. However, the care plan lacked approaches to address care and precautions to use with the dialysis access, emergency procedures related to the dialysis catheter and dialysis therapy. During an interview on 10/24/13, at 10:16 a.m. licensed practical nurse (LPN)-A confirmed R1 had recently started dialysis, stated she was aware R1 had a catheter for dialysis treatments. She stated she would expect staff to keep the dressing covering the dialysis site dry. During an interview on 10/24/13, at 11:25 a.m. registered nurse (RN)-B confirmed R1 had started dialysis therapy in the recent past. She confirmed R1's care plan did not include approaches/interventions for care of dialysis access care. The care plan did not address the location and type of dialysis access that R1 had, and did not include precautions to follow for the care of the catheter. RN-B stated the facility had not had a dialysis patient in a while, and would have to research what to do if severe weather caused a missed dialysis treatment. The facility policy titled Care Planning IDT, revised December 2009, identified the care plan was developed to assure continuity of care to meet the individual needs of each resident.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 3 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 implement the plan related to appropriate use of personal alarms for 4 of 4 residents (R40, R34, R31, R39) identified with frequent falls. Findings include: R40's personal safety alarm unit was not securely attached rendering inoperable. The care plan, revised 10/19/13, identified R40 had potential for injury (falls) related to impaired cognition and mobility due to cerebrovascular accident, multi infarct dementia with unpredictable activity/ behaviors, and history of falls. The care plan listed various interventions which included: clip alarm on in bed, and clip alarm while in chair, to alert staff of needs. During observation on 10/23/13 at 8:45 a.m., R40 was alone in her room, lying in bed, yelling out loudly, with her bed in a low position, her left leg was hanging over the side of the bed onto the floor. R40 wore a black fabric sling on her right arm and her left hand was clutching her right arm while she was rocking her torso back and forth in bed, attempting to get of of bed. A metal clip was attached to R40's left shoulder of her gown and	F 282	F282 Pelican Valley Health Center ensures that services are provided by qualified persons in accordance with each resident's written plan of care. Residents # R40, R34, R31, and R39 care plans were reviewed and revised to reflect appropriate implementation of personal alarms. All other residents currently using personal alarms were also reviewed. Education was provided immediately to all staff providing cares to residents in regards to appropriate use of alarms. The facility policy regarding use of alarms was reviewed and revised. The Director of Nursing or her designee will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee will review audits and make recommendations as needed.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 4 the cord of the clip was laying over the top of the pillow. R40 continued to attempt to get out of bed, with her leg hanging out of bed and continued to rock back and forth until 8:49 a.m. when the surveyor notified staff. Nursing assistant (NA)-B came to R40's room to assist R40. No alarms were sounding during the entire observation. On 10/23/13 at 12:15 p.m., NA-B confirmed R40 was to have a clip alarm on when she is in bed or in a chair. NA-B stated R40 does try to get out of bed and does try to transfer herself daily. NA-B confirmed that the clip is to be hooked to R40's clothing towards her shoulder area and that she would either hook the alarm box to the wheelchair or lay it on the bed on the far side of the pillow. NA-B confirmed that R40's clip alarm was not sounding when she was attempting to self transfer on 10/23/13 at 8:45 a.m. During continuous observation on 10/23/13 from 10:14 a.m. to 10:24 a.m., NA-A assisted R40 to transfer into a recliner in the lounge at 10:14 a.m. NA-A attached the metal clip of the alarm to R40's left shoulder and placed the alarm box on the left arm of the recliner and immediately walked out of the lounge. The personal safety alarm box was not affixed to a stationary surface. On 10/23/13 at 10:20 a.m., NA- A confirmed that R40 was to have a clip alarm on while in the chair or recliner, and confirmed she had rested the alarm box on the arm of the recliner. NA-A stated, "we don't have anything to hook it to." At 10:24 a.m., NA-A reentered the lounge and moved the personal safety alarm from the left	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 5 arm of the recliner to the back of R40's wheelchair and secured the alarm box with a large metal clip. Then NA-A proceeded to hook the small metal clip of the alarm to R40's right shoulder. NA-A then exited the area. Prior to this, R40's personal safety alarm was not attached securely to an affixed object for ten minutes while R40 sat in the recliner unsupervised. During continuous observation on 10/23/13 from 11:12 a.m. to 11:26 a.m., R40 was seated in a recliner in the lounge area, with her wheelchair sitting next to the recliner and the alarm box attached to the back of the wheelchair with a large metal clip. The small metal clip at the end of the string, from the box was observed laying in the seat of the wheelchair, not attached to the resident. At 11:26 a.m. on 10/23/13, the clip alarm continued to be observed on the seat of R40's wheelchair next to the recliner, not clipped to R40's shirt. During interview with NA-B at that time, NA-B confirmed the clip alarm was not attached to R40. NA-B proceeded to hook the clip of the alarm to the back of R40's right shoulder, while the alarm box remained attached to the back of R40's wheelchair. R40's clip alarm had not been appropriately attached to her shirt for fourteen minutes while she sat in recliner unsupervised. On 10/23/13 at 11:30 a.m., registered nurse (RN)-A confirmed R40's current care plan directed staff to have a clip alarm on R40 while in bed or in a chair. RN-A confirmed R40 self transferred at times, and was confused. RN-A confirmed R40 sustained fractures after her falls	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 6 on 8/15/13 and 10/19/13. RN-A stated the usual practice was to attach the clip to R40's clothing towards her shoulder area and alarm box to be attached to the wheelchair or it rested on the bed above the pillow. RN-A stated "alarm is not securely attached to anything." R34's personal safety alarm unit was not securely attached rendering inoperable. The care plan, revised 10/4/2013, identified R34 was at risk for falls related to impaired mobility, pain, dementia, arthritis and would forget limitations. R34's care plan directed facility staff to assist with transfers, and toileting. The care plan further directed R34 was to have a "clip alarm" in place when in bed and in the chair. During observation on 10/22/2013, at 1:17 p.m., R34 was observed seated in a brown overstuffed recliner lift chair in the facility TV lounge. The chair was fully reclined and R34's feet were on the foot rest. A metal clip on a cord was attached to the back of R34's sweater, however, the white alarm box with UMP lettering was loosely placed above R34's head on the top edge of the back of the recliner and was not affixed to the fabric of the recliner and could move freely from the chair. During continuous observation from 1:17 p.m., to 4:01 p.m., R34 was seated in the TV room in the recliner chair with the alarm box loosely resting on the top edge of the chair above her head. At 1:50 p.m., R34 repositioned herself to the right to see the TV, the alarm box continued in	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 7 the same position, loosely resting, and not affixed to the chair. The alarm did not sound. At 2:38 p.m., R34 was resting in the chair, the alarm box remained resting on top of the recliner headrest, not affixed to the chair. At 2:56 p.m. NA-C briefly approached R34 and then proceeded to walk out of the lounge area. NA-C did not check the alarm box which remained resting on top of the recliner headrest, not affixed to the chair. At 4:01 p.m., LPN-B and the surveyor examined R34's clip alarm box and LPN-B confirmed that the box was not affixed to R34's chair. LPN-B further confirmed that usual practice would be to clip the alarm box to a surface which would allow the magnetic clip to detach if R34 attempted to transfer independently. On 10/23/2013, during continuous observation from 7:03 a.m. to 8:50 a.m., R34 was lying in her room in bed on her left side. R34's personal safety alarm was clipped to the back of her nightgown, however, the alarm box was loosely resting on the mattress above the pillow, and was not affixed to any surface to allow the magnetic tab to detach and trigger the personal safety alarm if R34 attempted to transfer independently. At 7:07 a.m., RN-A approached R34 with a morning medication. RN-A raised the head of the bed for R34 to take the medication and the alarm box slid down the head of the bed. RN-A then placed the alarm box under R34's pillow, however the alarm box was not affixed to any surface. At 7:18 a.m., NA-H stated R34 did frequently attempt to get out of bed independently and the	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 8 personal safety clip alarm was utilized to alert facility staff if R34 was attempting to get out of bed or the chair independently. From 7:03 a.m., until 8:50 a.m., R 34 remained in bed, with the personal safety alarm resting loosely on the mattress not affixed to any surface. At 9:00 a.m., R34 was seated in the dining room in her wheel chair, there was no personal safety alarm affixed to the wheel chair or to R34's clothing. At 9:04 a.m., R34 was seated in the wheel chair at a dining table, however, the safety alarm was not present, not attached to R34's clothing or wheelchair. The ADON was present in the dining room, getting food items from the steam table. At 9:04 a.m., during interview, ADON indicated she was not aware R34's safety alarm was not in place. She confirmed R34 was to have a personal safety alarm attached at all times when in the chair or in bed. ADON immediately left the dining room and returned with R34's safety alarm box and proceeded to attach the clip to R34's clothing and the alarm box to the back of the wheel chair. R31's personal safety alarm unit was not securely attached rendering inoperable.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 9 The care plan revised 8/25/13, identified R31 to be at risk for falls with numerous fall interventions which included signal light within reach and reinforce use, non-slip mat at bedside, motion alarm at night to alert staff of needs, staff to anticipate needs and clip alarm in when in wheelchair. During an observation on 10/23/13, at 10:44 a.m. NA-G assisted R31 to sit in a recliner and place both feet on the raised foot rest. NA-G covered R31's lap and arms with a blanket, attached a metal clip with cord attached to her shirt then proceeded to place alarm box on the seat of the recliner next to R31's thigh. NA-G walked away from the area. The personal clip fall alarm was not securely attached to a stationary surface. During observation on 10/23/13, at 10:54 a.m. R31 sat forward in the recliner and began moving the blanket away from her legs stating "I needed to go see." During this movement the clip alarm box fell out of the chair, and hit the floor. During an interview on 10/23/13, at 1:49 p.m. LPN-A confirmed the clip alarm box was sitting in the recliner next to R31's left side between her thigh and the recliner arm and not attached to a stationary surface. She confirmed the personal During an interview on 10/23/13, at 2:27 p.m. NA-D confirmed the clip alarm is used because R31 will bend over and reach too far, the clip alarm is used because she has done this before and fallen. NA-D stated the clip alarm" goes where she goes" in wheel chair, in bed.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 10 During an interview on 10/23/13, at 4:08 p.m. RN-D confirmed the current care plan for R31 and indicated the clip alarm was started after R31 fell to alert staff of the potential to fall due to leaning over, or attempting to get out of the chair since she was ambulatory in the past. R39's personal safety alarm unit was not securely attached rendering it inoperable and was within the resident's reach. The care plan, revised 10/1/13, identified R39 had potential for injury related to impaired cognition, history of falls with one resulting in fractured right hip, vitamin D deficiency,and need for assist with transfer and ambulation. R39's care plan included various interventions which included call light handy, assist with transfers and walking and clip alarm in bed and while up in wheelchair to alert staff of any potential needs. On 10/23/13, at 8:01 a.m. R39 was observed lying in bed with a "SMART" personal safety alarm unit placed on the mattress next to the pillow on R39's left side. The clip part of the alarm was attached to R39's clothing, however, the unit was not securely attached to a surface. On 10/23/13, at 8:22 a.m. NA-B confirmed the alarm unit had been resting on the mattress, next to the pillow. NA-B indicated that is how staff applied personal safety alarms to all residents when alarms were utilized in bed.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 282	Continued From page 11 On 10/23/13, at 8:25 a.m. RN-A confirmed R39's care plan and confirmed R39 does attempt to sit up at the edge of her bed. RN-A confirmed R39 is at risk for further falls and stated the alarm is to alert staff that she is attempting to get up.	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 develop and implement care planning interventions related to dialysis access care for 1 of 1 resident (R)1 receiving dialysis services. Findings include: R1 had diagnoses which included chronic renal failure and had a dialysis catheter placed on 10/18/13. The admission Minimum Data Set (MDS) dated 10/7/13, identified R1 was cognitively intact and required assistance with all activities of daily living. Further, the MDS identified R1 was unsteady with transitioning from various surfaces and required one person assistance with bathing. The care plan, revised 10/18/13, identified R1	F 309	F309 Pelican Valley Health Center ensures that 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. Resident #R1's care plan was revised relating to dialysis access. The facility policy for dialysis care planning was reviewed and revised. The Director of Nursing will have a meeting with nursing staff to review the policy. The Director of Nursing or her designee will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee will review audits and make recommendations as needed.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 309	Continued From page 12 had chronic kidney disease with recent exacerbation and fluid retention. The approaches listed were to have labs and vitals as ordered and coordinate cares with dialysis unit, keep M.D. and family updated and observe for changes in condition and keep M.D. current. However, the care plan lacked approaches to address care and precautions to use with the dialysis access, emergency procedures related to the dialysis catheter and dialysis therapy. Review of the interdisciplinary progress notes revealed a note on 10/18/13, which identified placement of a dialysis PermaCath. There was no documentation found regarding the location of the PermaCath, instructions for care, or emergency care. Review of R1's October, 2013 treatment record revealed the lack of documentation of monitoring done of the dialysis PermaCath site. During observation on 10/22/13, at 9:32 a.m. R1 showed the surveyor her gauze covered dialysis port on the upper right side of her chest. The center of the gauze had a half dollar size brown to red color area in the middle that did not saturate through the dressing. R1 confirmed that she had started dialysis recently and indicated she had received bathing assistance by facility staff. During an interview on 10/24/13, at 10:11 a.m. nursing assistant (NA)-F confirmed she assisted R1 with a bath today. She stated she had not covered the dressing on R1's chest and it had gotten wet with the spray of the shower. NA-F stated she had asked a nurse prior to giving the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 309	Continued From page 13 bath and the nurse had stated it was ok to get the dressing wet. During an interview on 10/24/13, at 10:16 a.m. licensed practical nurse (LPN)-A confirmed R1 had recently started dialysis, stated she was aware R1 had a catheter for dialysis treatments. She stated she would expect staff to keep the dressing covering the dialysis site dry. During an interview on 10/24/13, at 11:25 a.m. registered nurse (RN)-B confirmed R1 had started dialysis therapy in the recent past. She confirmed R1's care plan did not include approaches/interventions for care of dialysis access care. The care plan did not address the location and type of dialysis access that R1 had, and did not include precautions to follow for the care of the catheter. RN-B stated the facility had not had a dialysis patient in a while, and would have to research what to do if severe weather caused a missed dialysis treatment. During an interview on 11/24/13, at 11:32 a.m. RN-A stated R1 was not being treated as a dialysis patient at this time. RN-A stated, they are just getting fluids off at this time, the dietitian had not seen her yet. She stated she believed the shunt had been placed in R1's arm but "not sure." During an interview on 10/24/13, at 3:40 p.m. the director of nursing (DON) confirmed R1's care plan did not address care and precautions to follow for dialysis access and she would need to contact the dialysis unit and medical doctor to "see what we should be doing here." The DON	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 309	Continued From page 14 stated staff would need to call dialysis to find out if the dressing could get wet and she would expect nursing assistants to check with the charge nurse for directions to care for residents when something is new. The DON stated understanding that emergency procedures and specific type cares should be part of the care plan. The DON stated she would clear up any miss understandings today and get the care plan updated.	F 309		
F 323 SS=J	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 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 comprehensively assess residents for risk of falls and effectively implement the application of personal safety alarms resulting in an immediate jeopardy situation for 2 of 4 residents (R40, R34) reviewed at risk for falls. Both R40, R34 sustained actual harm when they sustained fractures following a fall. In addition to the residents in immediate jeopardy, the facility failed to appropriately implement personal safety alarms, which resulted in the potential for harm that was not immediate jeopardy for 2 of 2 residents (R31, R39) with a history of falls	F 323	F323 Pelican Valley Health Center ensures That the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. The comprehensive fall assessments for Resident #R40 and R34 were completed prior to exit and care plans updated. The comprehensive fall assessments for Resident #R31 and R39 were also completed and care plans updated. All current residents with high risk for falls will be assessed and care plans updated as needed. The Director of Nursing reviewed and revised the policy regarding residents risk for falls and use of personal alarms. All staff that provides direct cares to residents was educated immediately on the policy. A monitoring system was implemented to ensure compliance with appropriate use of alarms. The Director of Nursing or her designee will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee will review audits and make recommendations as appropriate.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 15 The immediate jeopardy began on October 23, 2013, due to the systemic failure of the facility to appropriately implement personal safety alarms to prevent falls. The administrator and the director of nursing (DON) were notified on 10/23/2013, at 5:25 p.m. of the immediate jeopardy for R40 and R34. The IJ was removed on 10/25/2013, at 10:24 a.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R40 and R34 due to fractures sustained following falls. Findings include: R40 was assessed by the facility as a high risk for falls related to cognition impairment, impairment of gait and transferring, history of falls, forgets limitations and has unpredictable behaviors. Interventions identified by the facility included the use of a personal safety clip alarm to be used while R40 was in bed or in a chair. However, during observations of R40, the battery operated alarm was not securely attached to an affixed object nor was the clip attached to R40's clothing that would allow the peg to detach to sound the alarm to alert staff. In addition, the facility failed to comprehensively assess R40's risk factors related to falls which would include possible causal factors related to attempts at unsafe independent transfers. R40 had diagnoses of multiple infarct dementia, anxiety, aphasia and insomnia. The significant change Minimum Data Set (MDS) dated 8/29/13, identified R40 was severely cognitively impaired, required extensive assist of two with transfers,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 16 toilet use and bed mobility, and utilized a wheel chair for locomotion on and off the unit. The MDS also indicated R40 had one fall that resulted in a major injury, a pelvic fracture, during the assessment period. The Care Area Assessment (CAA) dated 8/29/13, identified R40 was at high risk for falls related to balance problems during transition, history of falls, use of anti-anxiety medications, anti-depressant medications, and also has unpredictable activity and behaviors. The assessment also revealed a decline in activities of daily living which identified R40 to require more assistance with cares. The CAA also indicated that R40 had a diagnosis of cerebrovascular accident, experienced aphasia and her speech was nonsensical. R40 also had a diagnosis of osteoarthritis that affected her knees and recent pelvic fracture. The care plan, revised 10/19/13, identified R40 had potential for injury (falls) related to impaired cognition and mobility due to cerebrovascular accident, multi infarct dementia with unpredictable activity/ behaviors, and history of falls. The care plan listed various interventions which included: clip alarm on in bed, and clip alarm while in chair, to alert staff of needs. The quarterly fall risk assessment dated 6/30/13, indicated R40 continued to be at risk for factors noted on comprehensive assessment. The fall risk assessment indicated R40 was being managed for behaviors and cognition conditions due to cerebrovascular accident and was tolerating medications well with no adverse effects noted. Mood and cognition was identified	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 17 as stable. However the fall assessment indicated R40 had knee discomfort which affected her gait at times, but also identified R40 was steady and would use handrails in the hallways. Will continue plan of care. The quarterly functional safety assessment dated 6/30/13, identified R40 continued to be independent with supervision for bed mobility, transfers, and ambulation. R40's facility undated nursing assistant (NA) care sheet directed staff to use a clip alarm when R40 was in her wheelchair and in bed at night. A facility incident report dated 8/14/13, at 9:00 a.m. revealed R40 had experienced an unwitnessed fall in the dining room. According to the report, R40 had stood up and attempted to sit down and fell on the floor missing the chair. The report indicated R40 had no injuries, that staff had implemented a toileting plan after a 3 day bowel and bladder collection, and that the resident was to utilize a wheel chair as needed. The report also revealed R40 had risk factors of dementia and macular degeneration, as well as underlying conditions of impaired mobility, impaired vision, depression, change in mood, behavioral issues, and impaired cognition. The post fall plan of action was to assess and observe the resident's normal toileting schedule for the next 3 days and then to implement a specific toileting plan based on the data collected. A facility incident report dated 8/15/13, at 1:00 p.m. revealed R40 was in the dining room attempting to ambulate, knees bent and R40 fell to the ground. The report indicated R40 had	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 18 sustained a bruise to the inside of the wrist from the Watchmate (a Wanderguard bracelet), and had complaints of pain in her shoulder and left leg. Staff implemented a clip alarm to be attached to R40's chair and clipped to the resident to alert staff of R40's attempts to self transfer or ambulate. The report also revealed R40 had risk factors of dementia, knee pain, macular degeneration, impaired mobility, impaired vision, depression, change in mood, behaviors, and impaired cognition. The post fall plan of action indicated a clip chair alarm was placed on R40's wheel chair to help alert staff when the resident attempts to transfer or ambulate by herself. The annual fall risk assessment dated 8/29/13, indicated R40 was at high risk for falls related to a history of falls, secondary diagnosis, impaired gait/transferring, and forgets limitations. The assessment indicated R40 had experienced two recent falls, 8/14/13 and 8/15/13, and that R40 had sustained a pelvic fracture from the fall on 8/15/13. The annual functional assessment dated 8/29/13, indicated R40 was not steady, and was only able to stabilize with human assistance when moving from a seated to standing position, moving on and off toilet, and during surface to surface transfers. R40 had functional limitation in range of motion to lower extremity with impairment on one side due to left pelvic fracture. The assessment identified R40 required extensive assist of two persons to physically assist with her activities of daily living. Furthermore, R40's safety interventions indicated she was to have a clip alarm in the chair and a motion alarm in bed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 19 A facility incident report dated 10/19/13, at 5:30 a.m. revealed R40 was found sitting on the floor next to her bed clutching her right upper arm. The report indicated R40 stated to staff that she had fallen out of bed and landed on her right arm. The report indicated R40 had sustained a 1 inch skin tear on the right elbow and had swelling of the right upper arm. R40 was sent to the clinic and was diagnosed with a fracture of the humerus (upper arm bone). The report also revealed R40 had risk factors of impaired cognition and judgement, impaired safety awareness, as well as underlying condition of knee pain, environmental factors of bed not in low position, impaired mobility, and balance. The post fall plan of action was to keep R40's bed in the low position when R40 was in bed to prevent falls. Interdisciplinary progress notes reviewed from 7/29/13 to 10/21/13 revealed: On 7/29/13, R40 received limited assistance with bed mobility and transfers and she ambulates independently in her room and hall. R40 will utilize a wheel chair during day due to knee pain. On 8/16/13, R40 having severe pain today with any movement, R40 unable to stand or sit on toilet and screamed in pain which seemed to be in both legs, hips and knees. On 8/17/13, R40 continued to have severe pain to her left hip, and having difficulty with transfers and any weight bearing. R40 required two assist with all transfers. R40 sent to clinic to be assessed and possible x-ray. Results from x-ray	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 20 revealed left superior and inferior pelvic fracture. On 8/29/13, R40 has been more dependent with cares and more incontinent due to decline in health and strength. Has severe pain upon any movements of lower extremities. At present time resident is not ambulating due to a fractured pelvis. On 9/29/13, R40 had clip alarm attached to night clothing to alert staff of independently transferring to and from bathroom. Staff to standby to assure safety. R40 will attempt to ambulate in her room, and in the hall independently but staff are alerted by alarm and will assist her depending on her level of pain due to pelvic fracture. At times makes efforts to get up without any assistance, alarm is connected to resident to keep her safe. On 10/19/13, R40 was found sitting on floor next to her bed clutching her right upper arm/shoulder, and was sent to Sanford clinic for x-ray. X-ray results revealed a fracture of the right humeral head. During observation on 10/23/13, at 8:45 a.m., R40 was alone in her room, lying in bed, yelling out loudly, with her bed in a low position, her left leg was hanging over the side of the bed onto the floor. R40 wore a black fabric sling on her right arm and her left hand was clutching her right arm while she was rocking her torso back and forth in bed, attempting to get of of bed. A metal clip was attached to R40's left shoulder of her gown and the cord of the clip was laying over the top of the pillow. R40 continued to attempt to get out of bed, with her leg hanging out of bed and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 21	F 323		

continued to rock back and forth until 8:49 a.m. when the surveyor notified staff. Nursing assistant (NA)-B came to R40's room to assist R40. No alarms were sounding during the entire observation.

On 10/23/13, at 12:15 p.m., NA-B confirmed R40 was to have a clip alarm on when she is in bed or in a chair. NA-B stated R40 does try to get out of bed and does try to transfer herself daily. NA-B confirmed that the clip is to be hooked to R40's clothing towards her shoulder area and that she would either hook the alarm box to the wheelchair or lay it on the bed on the far side of the pillow. NA-B confirmed that R40's clip alarm was not sounding when she was attempting to self transfer on 10/23/13 at 8:45 a.m.

During continuous observation on 10/23/13, from 10:14 a.m. to 10:24 a.m., NA-A assisted R40 to transfer into a recliner in the lounge at 10:14 a.m. NA-A attached the metal clip of the alarm to R40's left shoulder and placed the alarm box on the left arm of the recliner and immediately walked out of the lounge. The personal safety alarm box was not affixed to a stationary surface.

On 10/23/13 at 10:20 a.m., NA- A confirmed that R40 was to have a clip alarm on while in the chair or recliner, and confirmed she had rested the alarm box on the arm of the recliner. NA-A stated, "We don't have anything to hook it to."

At 10:24 a.m., NA-A reentered the lounge and moved the personal safety alarm from the left arm of the recliner to the back of R40's wheelchair and secured the alarm box with a large metal clip. Then NA-A proceeded to hook

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 22 the small metal clip of the alarm to R40's right shoulder. NA-A then exited the area. Prior to this, R40's personal safety alarm was not attached securely to an affixed object for ten minutes while R40 sat in the recliner unsupervised. During continuous observation on 10/23/13, from 11:12 a.m. to 11:26 a.m., R40 was seated in a recliner in the lounge area, with her wheelchair sitting next to the recliner and the alarm box attached to the back of the wheelchair with a large metal clip. The small metal clip at the end of the string, from the box was observed laying in the seat of the wheelchair, not attached to the resident. At 11:26 a.m. on 10/23/13, the clip alarm continued to be observed on the seat of R40's wheelchair next to the recliner, not clipped to R40's shirt. During interview with NA-B at that time, NA-B confirmed the clip alarm was not attached to R40. NA-B proceeded to hook the clip of the alarm to the back of R40's right shoulder, while the alarm box remained attached to the back of R40's wheelchair. R40's clip alarm had not been appropriately attached to her shirt for fourteen minutes while she sat in recliner unsupervised. On 10/23/13, at 11:30 a.m., registered nurse (RN)-A confirmed R40's current care plan directed staff to have a clip alarm on R40 while in bed or in a chair. RN-A confirmed R40 self transferred at times, and was confused. RN-A confirmed R40 sustained fractures after her falls on 8/15/13 and 10/19/13. RN-A stated the usual practice was to attach the clip to R40's clothing towards her shoulder area and alarm box to be	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 23 attached to the wheelchair or it rested on the bed above the pillow. RN-A stated, "Alarm is not securely attached to anything." On 10/23/13, at 1:53 p.m., NA-C confirmed R40's care plan directed staff to use a clip alarm when she is in bed or in a chair. NA-C stated R40 did attempt to self transfer from her wheelchair to the recliner routinely. On 10/23/13, at 2:08 p.m., NA-D confirmed R40 was to have a clip alarm on when she was in bed and in a chair. NA-B stated R40 did try to get out of bed and also did transfer herself. NA-B confirmed the clip was to be hooked to R40's clothing towards her shoulder area and the alarm box was attached to the wheelchair and when in bed the box lays on the bed. NA-D stated, "I don't think it is securely attached." On 10/23/13, at 2:24 p.m., licensed practical nurse (LPN)-A confirmed R40 was to have a clip alarm on while in bed or in a chair because she has fallen in the past. She stated R40 did try to transfer herself occasionally. LPN-A confirmed the clip was to be hooked to R40's clothing and the alarm box either hooked to the wheelchair or when in bed the box is placed on the bed under her pillow. On 10/23/13, at 2:35 p.m., NA-E confirmed R40 was to have a clip alarm on when she is in bed and in a chair. NA-E also confirmed R40 did try to get out of bed herself and did try to transfer herself at least twice a week. On 10/23/13, at 11:16 a.m., the assistant director of nursing (ADON) confirmed it would be	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 24 expected the personal safety alarms would be attached to R40's clothing and the alarm box would be affixed to a secure surface while R40 was in any chair or her bed. The ADON further indicated attaching the alarm box to a secure surface would allow the clip alarm to detach, and trigger the sound of the alarm to alert staff of R40's movements. Review of the facility policy titled Fall Prevention, dated October 2007, included: The facility would provide a safe, comfortable and secure environment for residents, and provide an ongoing system for monitoring residents. Furthermore, the facility would analyze incidents of falls in order to determine causal factors and implement the appropriate interventions. Review of manufacturer's guidelines undated, for the Alert-Mate Alarm model #SAM-1 alarm, also known as a "clip alarm," identified techniques to attach the alarm by using Velcro and to affix the alarm to the bed, chair, wheelchair or night stand out of reach of the resident. The guidelines further indicated a Mate holder could also be used, to insert alarm into holder and attach to bed, chair, wheelchair or nightstand, out of reach of the resident. R34 had been assessed by the facility as high risk for falls, and had a history of a fall with a fracture. Interventions identified by the facility to prevent further falls included the use of a personal safety clip alarm attached to R34's clothing, with the opposite end of the cord magnetically attached to a battery pack alarm	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 25 box, which would then set off a sound, when detached, to alert facility staff if R34 attempted to transfer independently from a chair or bed. However, during observations of R34, the battery pack was not securely affixed to a surface to allow detachment of the magnetized end from the battery pack alarm box to allow the alarm to sound. In addition, the facility failed to comprehensively assess R34's risk factors related to falls which would include possible causal factors related to attempts at unsafe independent transfers. R34 had diagnoses which included dementia, rheumatoid arthritis, osteoporosis and chronic insomnia. The quarterly MDS dated 9/15/2013, identified R34 was severely cognitively impaired, required the extensive assistance for all activities of daily living, and utilized a wheel chair for locomotion. The fall risk assessment dated 4/24/2013, revealed R34 was at high risk for falls related to cognitive impairment, lack of awareness of limitations and impaired gait and transferring. The care plan, revised 10/4/2013, identified R34 was at risk for falls related to impaired mobility, pain, dementia, arthritis and would forget limitations. R34's care plan directed facility staff to assist with transfers, and toileting. The care plan further directed R34 was to have a "clip alarm" in place when in bed and in the chair. R34's facility undated nursing assistant care sheet directed staff to utilize a clip alarm when R34 was in the chair as the resident did not ambulate, and to utilize a clip alarm when R34 was in bed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 26 R34's annual MDS, dated 12/13/2012, revealed a brief interview for mental status was not performed as R34 was rarely understood. The MDS further revealed R34 made poor decisions, required supervision, extensive assistance for all ADL's, and required staff to stabilize her balance during movements from seated to standing, moving on and off the toilet and transferring between bed and a chair. Review of R34's CAA dated 12/13/2012, for activities of daily living, revealed a decline in her general medical condition related to multiple diagnoses and identified R34 required more assistance with cares. The CAA further identified R34 was at high risk for falls related to balance problems, a recent fall and the utilization of anti-anxiety and antidepressant medication. R34's facility fall risk assessment dated 12/13/2012, revealed R34 had a fall 10/25/12, while attempting to get up to the bathroom. The fall assessment dated 1/17/13, identified R34 was at high risk for falls and interventions were to continue with a bowel and bladder plan, assess and manage pain, discontinue use of the remote sensor alarm and utilize a clip alarm when R34 was in bed and when in a chair. The facility incident report, dated 3/8/2013, revealed R34 was found at 8:15 p.m., on the floor by her bathroom door. R34 stated she was looking to go to the bathroom. The report revealed R34 received a 5 centimeter (cm) scratch to her mid back. The intervention initiated was to offer toileting after supper and to anticipate toileting needs. The root cause	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 27 analysis of the fall identified the following: R34 had impaired mobility related to rheumatoid arthritis and was not oriented to her own abilities. She was impulsive and unaware of safety. She needed extensive assist of one for toileting and had a clip alarm to alert staff to independent transfers. The facility incident report, dated 3/30/13, revealed R34 was found resting on the floor in her room on her side with hands tucked under her head. R34 had no apparent injuries. The root cause analysis of the fall identified the following: R34 had dementia that prevented insight into her physical limitations. R34 had arthritis with limited mobility and poor physical strength. The report indicated the clip alarm had been utilized, and a new intervention was to place a foam "noodle" to pad the outer edge of the bed to give the clip alarm "an added chance to catch movement." The facility incident report dated 4/20/13, revealed R34 was found on the floor at 10:30 a.m., in the facility dining room with another resident witness who stated R34 got up and walked to another dining table to help another resident with a tray, turned to go back to the chair, and fell on the floor. The report revealed R34 had severe right hip pain and stated it hurt to touch. Ice was applied to the right hip and Morphine given with scant relief. R34 was subsequently admitted to the local hospital with severe right hip pain and a diagnosis of a right hip fracture. The new intervention was to keep R34 under observation when up. The root cause analysis of the fall identified the following: R34 had dementia with extremely poor short term memory, impaired cognition, and had	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 28 judgement/safety awareness deficit. R34 appeared to forget that she was too weak and it was too painful for her to walk. The fall risk assessment dated 4/24/13, revealed R34 returned from the hospital on 4/22/13 and was at continued high risk for falls, was cognitively impaired and resistive to cares and redirection at times. The assessment identified R34 did not ambulate, transferred with the assist of one to two, and had chronic pain from rheumatoid arthritis. The plan for fall prevention was to continue with previous measures. The facility incident report dated 5/2/13, revealed R34 was found on the floor in her room at 2:10 a.m. There were no injuries noted. The root cause analysis revealed the following: R34 had impaired mobility and pain due to fracture of the right hip on 4/20/13. Her cognition was impaired due to a diagnosis of senile dementia. R34 also had judgement/safety awareness deficit and did not know her own limitations. The intervention initiated was to change R34's bed to one lower to the floor and place a fall mat next to the bed made to absorb impact in the event of another fall, and keep the clip alarm on in bed and chair. The facility incident report dated 9/13/13, revealed R34 fell from a recliner lift chair when another resident attempted to assist her out of the recliner chair. R34 received 2 scratches on her mid back and left buttock and on the left buttock there was a 4 cm pink area. The root cause analysis of the fall revealed the following: R34 had an underlying diagnosis of senile dementia and rheumatoid arthritis and a history of falls making her an increased risk for falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 29 R34 had impaired mobility and balance. R34 had a history of depressive disorder and impaired judgement and safety awareness deficit putting her at risk for falls. The report identified the intervention was to turn up the volume on the chair clip alarm, replace if needed, reinforce toileting and check on R34 when in the recliner. The facility incident report dated 9/18/13, revealed R34 was up in the wheel chair in the TV (television) room in front of the nurses' station when the chair alarm went off and R34 was found kneeling in front of her wheel chair. R34 had no apparent injuries. The root cause analysis of the fall revealed the following: R34 had a diagnosis of senile dementia that put her at risk for falls due to impaired cognition and decreased judgement and safety awareness deficit. R34's rheumatoid arthritis affected her mobility and balance and put her at risk for falls. The plan of action was to reinforce with R34 the need to stay sitting upright, avoid leaning too far forward as she could fall out of her wheelchair/chair. Review of interdisciplinary team progress notes from 1/2013 to 10/2013, revealed the following: 1/3/13- R34 had a decline in general health with low energy level 2/6/13- R34 did not communicate needs. 3/8/13- R34 was found sitting on the floor in her room R34 stated she was looking for the bathroom. A scratch 5 cm long on mid back. 3/30/13- R34 was found on floor in room lying on her side and stated she was trying to get out of	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 30 bed. 4/13/13- R34 was routinely checked during scheduled every two hour rounds and had a clip alarm attached to her night clothes to alert staff of attempt to independently transfer. The progress note further identified R34 would remove the alarm at times. 6/12/13- R34 was unable to verbalize needs, was acting out with anger and aggression and had been irritable. Orders were obtained for an increase in pain medication and to evaluate for improvement in pain and restlessness. 7/17/13- The previous night R34 was found sitting up and removing clip safety alarm. R34 required extensive assistance to ambulate in the bathroom. R34 was never using the call system and staff was required to anticipate needs and provide them due to dementia. A safety alarm was clipped to her nightgown, the bed was in lowest position, and a safety mat was kept on floor next to bed "for her history of restless episodes, climbing out of bed and falling. Will remove the clip alarm and hide it under her pillow. Since it will take her time, staff have been able to assist her as soon as alarm has sounded." 8/13/13- Required extensive assist for all repositioning. Bed was kept in lowest position, a safety mat was placed on the floor and a clip alarm was attached to her nightgown. R34 continued to have a history of sitting up and attempting to transfer self, and a prior history of falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 31 9/13/13- R34 had a fall while attempting to get out of the recliner. Scratches to her skin and back and left buttocks with a pink raised area 4 cm around. No other injuries apparent. 9/15/13- On nights when R34 had poor sleep she was restless, digging in drawers, attempting to get out of bed, transfer to a standing position, angry at staff. R34 had a personal safety clip alarm to alert staff when she was restless. During observation on 10/22/13, at 1:17 p.m., R34 was observed seated in a brown overstuffed recliner lift chair in the facility TV lounge. The chair was fully reclined and R34's feet were on the foot rest. A metal clip on a cord was attached to the back of R34's sweater, however, the white alarm box with UMP lettering was loosely placed above R34's head on the top edge of the back of the recliner and was not affixed to the fabric of the recliner and could move freely from the chair. During continuous observation from 1:17 p.m. to 4:01 p.m. on 10/22/13, R34 was seated in the TV room in the recliner chair with the alarm box loosely resting on the top edge of the chair above her head. At 1:50 p.m., R34 repositioned herself to the right to see the TV, the alarm box continued in the same position, loosely resting, and not affixed to the chair. The alarm did not sound. At 2:38 p.m., R34 was resting in the chair, the alarm box remained resting on top of the recliner headrest, not affixed to the chair.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 32 At 2:56 p.m. NA-C briefly approached R34 and then proceeded to walk out of the lounge area. NA-C did not check the alarm box which remained resting on top of the recliner headrest, not affixed to the chair. At 4:01 p.m., LPN-B and the surveyor examined R34's clip alarm box and LPN-B confirmed that the box was not affixed to R34's chair. LPN-B further confirmed that usual practice would be to clip the alarm box to a surface which would allow the magnetic clip to detach if R34 attempted to transfer independently. On 10/23/13, during continuous observation from 7:03 a.m. to 8:50 a.m., R34 was lying in her room in bed on her left side. R34's personal safety alarm was clipped to the back of her nightgown, however, the alarm box was loosely resting on the mattress above the pillow, and was not affixed to any surface to allow the magnetic tab to detach and trigger the personal safety alarm if R34 attempted to transfer independently: At 7:07 a.m., RN-A approached R34 with a morning medication. RN-A raised the head of the bed for R34 to take the medication and the alarm box slid down the head of the bed. RN-A then placed the alarm box under R34's pillow, however the alarm box was not affixed to any surface. At 7:18 a.m., NA-H stated R34 did frequently attempt to get out of bed independently and the personal safety clip alarm was utilized to alert facility staff if R34 was attempting to get out of bed or the chair independently.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 33 At 7:03 a.m. until 8:50 a.m., R34 remained in bed, with the personal safety alarm resting loosely on the mattress not affixed to any surface. At 9:00 a.m., R34 was seated in the dining room in her wheel chair, there was no personal safety alarm affixed to the wheel chair or to R34's clothing. At 9:04 a.m., R34 was seated in the wheel chair at a dining table, however, the safety alarm was not present, not attached to R34's clothing or wheelchair. The ADON was present in the dining room, getting food items from the steam table. At 9:04 a.m. during interview, the ADON indicated she was not aware R34's safety alarm was not in place. She confirmed R34 was to have a personal safety alarm attached at all times when in the chair or in bed. The ADON immediately left the dining room and returned with R34's safety alarm box and proceeded to attach the clip to R34's clothing and the alarm box to the back of the wheel chair. On 10/23/13, at 9:59 a.m., NA-D stated R34 frequently attempted to get out of bed or get up out of the wheel chair independently. NA-D stated the usual placement of the alarm box for R34's personal safety alarm while in bed was to place the box loosely on the mattress behind R34. NA-D further stated the usual way to place the alarm box when in the recliner chair was to tuck it under a cover on the recliner or clip it to the wheel chair. On 10/23/13, at 10:06 a.m., NA-B stated R34	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 34 frequently attempted to get up from the recliner chair by swinging legs over the edge of the chair. NA-B stated the last time R34 attempted to get out of the chair was approximately 2 weeks prior. NA-B stated R34 also frequently attempted to get out of bed independently, the last time was two days ago. NA-B stated the usual placement of the personal safety alarm box when R34 was in bed was to lay it on the mattress behind R34's head. NA-B indicated the alarm box was not attached to a surface but loosely placed on the mattress. On 10/23/13, at 10:30 a.m., NA-A stated R34 frequently attempts to lean forward in the chair and indicated R34 had an alarm on the wheel chair to alert staff of any attempts to transfer independently. On 10/23/13 at 10:36 a.m., RN-A confirmed R34 was frequently restless at night and made attempts to get out of bed independently. RN-A further indicated R34's attempts to self transfer were the reason for the low bed, floor mat and safety alarm. On 10/23/2013 at 11:16 a.m., during review of R34's fall reports and fall assessments, the ADON confirmed the current care plan for R34 and verified that R34 was to have a personal safety clip alarm attached when in bed or a chair. The ADON further confirmed R34 was at high risk for falls and had fallen and sustained a fracture in the past. The ADON also confirmed it would be expected that the personal safety alarms would be attached to R34's clothing and the alarm box would be affixed to a secure surface while R34 was in any chair or her bed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 35 The ADON indicated this would allow the magnetic tab to detach, and trigger the sound of the alarm to alert staff of R34's movements. On 10/23/13 at 3:55 p.m., the director of nursing (DON) provided installation and instructions for the personal safety alarms. DON confirmed the instructions gave direction to secure the alarm boxes to a stationary surface. Review of manufacturer's guideline instructions for the UMP Standard monitor identified techniques to attach the alarm to a non movable surface, with use of a chair strap and a mounting bracket for the bed. In a post survey telephone response from the manufacturer's representative on 11/5/13 at 4:15 p.m., a representative of the Universal Medical Products company stated the alarm box was to be firmly affixed to a chair or bed to allow the magnetic seal to be broken between the monitor and the magnet. Review of the facility policy titled Fall Prevention, dated October 2007, revealed the facility would conduct ongoing assessments, and provide an ongoing system for monitoring and analyzing incidents of falls in order to determine causal factors and implement appropriate interventions. The immediate jeopardy that began on 10/23/13, at 5:25 p.m., was removed on 10/25/13, at 10:24 a.m., after verification of staff education, training of staff, and reassessment of all residents at risk for falls utilizing alarm devices.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 36 R31's diagnoses included Alzheimer's disease, and osteoporosis. The quarterly MDS dated 8/25/13, identified R31 had severe cognitive impairment, and required extensive assistance with all activities of daily living. Further, the MDS identified R31 had a fall and sustained injury since the previous assessment. The care plan revised 8/25/13, identified R31 to be at risk for falls with numerous fall interventions which included signal light within reach and reinforce use, non-slip mat at bedside, motion alarm at night to alert staff of needs, staff to anticipate needs and clip alarm in when in wheelchair. During an observation on 10/23/13, at 10:44 a.m. NA-G assisted R31 to sit in a recliner and place both feet on the raised foot rest. NA-G covered R31's lap and arms with a blanket, attached a metal clip with cord attached to her shirt then proceeded to place alarm box on the seat of the recliner next to R31's thigh. NA-G walked away from the area. The personal clip fall alarm was not securely attached to a stationary surface. During observation on 10/23/13, at 10:54 a.m. R31 sat forward in the recliner and began moving the blanket away from her legs stating "I needed to go see." During this movement the clip alarm box fell out of the chair, and hit the floor. During an interview on 10/23/13, at 1:49 p.m. LPN-A confirmed the clip alarm box was sitting in the recliner next to R31's left side between her thigh and the recliner arm and not attached to a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 37 stationary surface. During an interview on 10/23/13, at 2:27 p.m. NA-D confirmed the clip alarm is used because R31 will bend over and reach too far, the clip alarm is used because she has done this before and fallen. NA-D stated the clip alarm" goes where she goes" in wheel chair, in bed. The resident incident report, dated 2/18/13, revealed staff heard a "thud" and found R31 in the dining room with a chair and resident on her right side, lying on the floor. The root cause analysis identified R31 had dementia and wanders. The analysis indicated R31 either sat on the arm of the chair and tipped it or leaned over sideways to pick up something from the floor. The form identified R31 was easily agitated and aggressive. Also, it identified resident was unaware of deficit, was cognitively challenged and would sit where she chooses and ambulates about the facility at will. The root cause analysis did not include further interventions to prevent further falls for R31. The resident incident report, dated 7/10/13, revealed R31 was found in blood on floor in front of the closet in her room. R31 sustained a two centimeter (cm) laceration on her left temple which required sutures placed. The root cause analysis identified R31 had Alzheimer's disease, sustained a 2 cm laceration on left temple along with a skin tear on her cheek bone and left elbow. R31 was seen by physician at that time and neuro checks done. The use of a floor mat at the bedside was started while resident in bed was started at that time to prevent further falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 38 Review of the functional/safety assessment dated 8/25/13, identified R31 had altered communication due to Alzheimer's disease, needed extensive assist of one or two for transfers, ambulation, toileting. Review of the falls risk assessment, dated 8/25/13, identified R31 remained at risk for falls and was not always cooperative with ambulation due to impaired cognition. The assessment identified R31 had numerous interventions in place to prevent falls and would continue same plan of care. During an interview on 10/23/13, at 4:08 p.m. RN-D confirmed the current care plan for R31 and indicated the clip alarm was started after R31 fell to alert staff of the potential to fall due to leaning over, or attempting to get out of the chair since she was ambulatory in the past. The Standard Monitor (MDT8400) alarm referred to as a "clip alarm" undated manufacturer's instructions identified techniques to attach the alarm to a non movable surface, with use of a chair strap and a mounting bracket for the bed. R39's personal safety alarm unit was not securely attached and was within the resident's reach. R39's diagnoses included dementia, history of falls, osteoporosis and a surgical repair of a fractured right femur on 3/12/13, after a fall out	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 39 of bed at home. The MDS dated 3/27/13, indicated R39 had severely impaired cognition and required extensive assistance from staff for ADL's. The CAA dated 4/3/13, indicated R39 was dependent in all ADL's related to recent fracture and cognitive deficit, the CAA also indicated that R39 was at risk for falls. The care plan, revised 10/1/13, identified R39 had potential for injury related to impaired cognition, history of falls with one resulting in fractured right hip, vitamin D deficiency,and need for assist with transfer and ambulation. R39's care plan included various interventions which included call light handy, assist with transfers and walking and clip alarm in bed and while up in wheelchair to alert staff of any potential needs. The Resident Incident Report dated 4/23/13, staff heard a loud noise and found R39 sitting on the floor in the middle of the resident's room. R39 indicated she hit her head when she fell, no injury noted. The root cause analysis identified R39 had impaired mobility and balance due to right femur fracture. R39 also had impaired cognition, judgement/safety awareness deficit due to a diagnosis of dementia. Interventions put in place at that time included to wear gripper socks while in bed, and have clip alarm on while in bed or wheelchair since R39 in not aware of own limitations. The Resident Incident Report, dated 5/6/13, revealed R39 had rolled out of bed onto the floor. The root cause analysis identified R39 had history of dementia with impaired cognition and a judgement/safety awareness deficit and impaired mobility. Interventions put in place at that time.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 40 were to continue alarms to wheelchair and bed, bed in lowest position and a padded mat on floor next to bed. Also, R39 was to sit in wheelchair or when by nurses desk in a recliner so staff could keep an eye on her. The fall risk assessment dated 9/27/13,identified R39 remained at risk for alls related to history of falls, secondary diagnosis, use of assistive devices, weak gait/transferring and forgot limitations. The plan at that time was to continue fall interventions as direction on the care plan. On 10/23/13, at 8:01 a.m. R39 was observed lying in bed with a "SMART" personal safety alarm unit placed on the mattress next to the pillow on R39's left side. The clip part of the alarm was attached to R39's clothing, however, the unit was not securely attached to a surface. On 10/23/13, at 8:22 a.m. NA-B confirmed the alarm unit had been resting on the mattress, next to the pillow. NA-B indicated that is how staff applied personal safety alarms to all residents when alarms were utilized in bed. On 10/23/13, at 8:25 a.m. RN-A confirmed R39's care plan and confirmed R39 does attempt to sit up at the edge of her bed. RN-A confirmed R39 is at risk for further falls and stated the alarm is to alert staff that she is attempting to get up. On 10/23/13, at 2:24 p.m. NA-B reported that they have assignment sheets that let them know which residents have alarms, then NA-B stated the assignment sheets do not indicate how to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 323	Continued From page 41 apply the alarm or the alarm unit. The undated Smart Caregiver Corporation Installation and Use Instructions indicated to make certain the monitor is securely attached and out of the resident's reach. The effectiveness of this monitoring device relies entirely on the direct supervision and immediate response by the caregiver to this monitor's alert. Failure to compy [sic] with this warning may result in injury or death.	F 323		
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 review, the facility failed to implement sanitary practices to prevent the spread of food born illness related to staff handling ready to eat foods and improper storage of pans in the kitchen. This deficient practice had the potential to affect all 33 residents residing in the facility. Findings include: On 10/24/13, at 8:56 a.m. the cook (C)-A was	F 371	F371 Pelican Valley Health Center ensures that the facility will appropriately store, prepare, distribute, and serve food under sanitary conditions. During the Dept. of Health kitchen tour on 10/24/13, the Dietary Staff failed to properly store 4 large pans. Because of the improper sanitary conditions, all Dietary Staff will review, sign, and follow the Dietary policy: Washing and storage of dishware. The Dietary Manager will conduct random checks on dishware to ensure all dishware is stored appropriately to ensure quality and sanitation. The Quality Assurance Committee will review audits and make recommendations as needed.	12/3/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 371	Continued From page 42 observed in front of the dining room, preparing the breakfast meal. With her bare hands, C-A reached into a carton, cracked open a raw egg and poured the raw egg into a pan of boiling water. She immediately picked into a plastic bag, with her bare hands removed two slices of bread and placed the bread into the toaster. At 8:58 a.m., with her soiled bare hands, C-A removed the two slices of toast and placed them on a plate. She continued to crack raw eggs into a pan of boiling water, remove bread slices out of the bread bag and put into toaster with her bare hands for the entire observation until 9:02 a.m. C-A prepared eggs and toast using her bare hands for the entire observation, without sanitizing her hands or wearing gloves. On 10/24/13, at 9:25 a.m. C-A confirmed she handled the bread and toast with bare hands after cracking raw eggs without washing her hands or applying gloves. C-A stated she typically used tongs for getting bread out of the bag and into and out of the toaster. C-A reported that it is hard to wash your hands after each item that is touched, then stated they would need three staff to be able to do it correctly and they do not have enough staff for that. On 10/24/13, at 3:00 p.m. the kitchen tour revealed a stack of four large pans placed on a lower shelf, when the pans were separated, each pan was dripping with a wet clear liquid. On 10/24/13, at 3:00 p.m. the dietary manager (DM) confirmed that all four pans were put away wet. The DM reported that she would expect the staff to wait until all pans were dry before putting the pans into storage. The DM stated the staff	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 371	Continued From page 43 had not been educated on proper storing of pots and pans in the past. The DM also confirmed handling bread and raw eggs with bare hands was not acceptable. She stated she would expect staff to use gloves when directly handling food items. The policy titled Hand Washing dated 2005, directed staff to wash hands when switching between working with raw food and working with ready to eat food. The facility Employee Sanitary Practices Policy dated 2005, indicated staff were to use utensils to handle food. The facility Washing and Storage of Dishware Policy undated, indicated that dishware should be put away when it is fully dry and has no sign or feeling of wetness.	F 371		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497	F497 Pelican Valley Health Center completes performance reviews for every nursing assistant at least every 12 months and provides education based on these reviews. The Director of Nursing reviewed and revised the facility policy regarding inservice training to ensure continuing competence of nursing assistants. The employees NA-J, NA-H, NA-A, NA-K, NA-L have been contacted by the Director of Nursing and instructed to complete assigned inservice education classes. The Director of Nursing will review all current Nursing Assistants for compliance of completion of assigned inservice education courses. The Director of Nursing or her designee will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee will review audits and make recommendations as needed.	12/7/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 497	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the required 12 hours of continuing education was provided to 5 of 5 nursing assistants (NA-J, NA-H, NA-A, NA-K, NA-L) reviewed. Findings include: On 10/24/2013, review of employee personnel records was conducted with the administrator present. The record review revealed NA-J, NA-H, NA-A, NA-K, NA-L , who had been employed with the facility more than 12 months, had not received the required 12 hours of yearly continuing education. NA-J was hired by the facility on 9/18/12. Review of training records revealed NA-J had received nine hours of continuing education. This was three hours less than the required twelve hours. NA-H was hired by the facility on 6/16/09. Review of training records revealed NA-H had received eight hours of continuing education. This was four hours less than the required twelve hours. NA-A was hired by the facility on 4/27/04. Review of training records revealed NA-A had received five hours of continuing education. This was seven hours less than the required twelve hours. NA-K was hired by the facility on 11/19/80. Review of training records revealed NA-K had	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 497	Continued From page 45 received eight hours of continuing education. This was four hours less that the required twelve hours. NA-L was hired by the facility on 1/30/12. Review of training records revealed NA-L had not received any of the 12 required continuing education. On 10/24/13, at 5:11 p.m., the facility administrator confirmed the above findings and stated the continuing education for nursing assistants had not been tracked according to date of hire for the employee. The Administrator further stated the facility had been using the calendar year to track continuing education for employees and this was incorrect.	F 497		
F 503 SS=C	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.	F 503	F503 Pelican Valley Health Center does not provide laboratory services on site but ensures that services are obtained from a laboratory that meets the applicable requirements. The Administrator has contacted Sanford Health of Pelican Rapids to obtain a written agreement for laboratory services. The Administrator will review all contracts annually to ensure compliance is achieved and maintained.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 503	Continued From page 46 If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, the facility was providing laboratory testing without a written agreement to provide outside laboratory services for residents in the facility. This had the potential to affect all 33 residents residing in the facility. Finding include: An extended survey was conducted on 10/24/13. The facility was unable to provide a written agreement to provide outside laboratory services. The facility received laboratory services from an outside agency. The clinic sent laboratory staff to the facility to do draw lab work and took samples back to the clinic to be tested. On 10/24/13 at 4:05 p.m. the administrator confirmed the facility did not have a written agreement and stated the facility sends residents to the clinic next door or the emergency room.	F 503		
F 509 SS=C	483.75(k)(1)(i-ii) DIAGNOSTIC SVCS - MEET HOSPITAL REQUIREMENTS If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26	F 509	F509 Pelican Valley Health Center does not provide diagnostic services on site but ensures that services are obtained from another provider that meets the applicable requirements. The Administrator has contacted Sanford Health of Pelican Rapids to obtain a written agreement for diagnostic services. The Administrator will review all contracts annually to ensure compliance is achieved and maintained.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 509	Continued From page 47 of this subchapter. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to obtain an written agreement for radiology diagnostic services. This had the potential to affect all 33 residents who resided in the facility. Findings include: An extended survey was conducted on 10/24/13. The facility did not provide its own diagnostic services and received services from an outside agency called Essential Health. The facility was unable to provide a written agreement with a Medicare approved supplier. On 10/24/13 at 4:05 p.m. the administrator confirmed the facility did not have a written agreement for radiology diagnostic and stated the facility sends residents to the clinic next door or the emergency room.	F 509		
F 519 SS=C	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation	F 519	F519 Pelican Valley Health Center ensures that residents needing emergency care are sent to an Emergency Room to receive appropriate treatment. The Administrator has contacted four area hospitals to obtain written transfer agreements with Essentia Health Fargo, Essentia Health St. Mary's Detroit Lakes, Lake Region Hospital Fergus Falls and Sanford Hospital Fargo. The Administrator will review the transfer agreements annually.	12/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 519	Continued From page 48 under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure a written transfer agreement with one or more hospitals. This practice had the potential to affect all 33 residents residing in the facility. Findings include: During the extended survey the facility was unable to provide a written agreement with one or more hospitals, to assure residents would be admitted timely to a hospital when medically appropriate. On 10/25/13, at 9:15 a.m., the administrator	F 519		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 519	Continued From page 49 confirmed the facility did not have an written transfer agreement with a hospital. She stated the facility has transferred residents to three area hospitals in the past.	F 519		

Pelican Valley Health Center ensures that all food be stored, prepared, distributed and served under sanitary conditions to prevent the spread of foodborne illnesses. During the Dept. of Health visit on 10/24/13, the cook was observed using bare hands cracking an egg then immediately reaching into a plastic bread bag and grasped two pieces of bread that were put into a toaster. She continued to do this action several more times while observed during the period without washing hands. Because of the improper sanitary conditions, all Dietary Staff will review, sign and follow the Dietary policies: Hand washing, Use of plastic gloves, and Employee sanitary practice with food handling. The Dietary Manager will continuously observe to ensure proper techniques are used to prevent foodborne illnesses when handling food. Particularly, on days raw eggs are served, Dietary Manager will ensure that proper compliance of food handling is used. The Quality Assurance Committee will review audits and make recommendations as needed. Completion date: 12/13/13.

Addendum to F 323 Plan of Correction as per request of MDH.

All residents at risk for falls will be assessed for appropriate interventions and care plans will be updated. All residents will be reassessed for alternative interventions as needed. Recurrence will be prevented by auditing by the DON or her designee weekly times 4, then monthly and no less often than every three months. All Licensed Nursing Staff was provided education at a meeting by the Director of Nursing on Root Cause Analysis on 10/28/13 with the emphasis on interdisciplinary approach to determining underlying causes of falls in dealing with interventions as well as looking at proactive methods. These include but are not limited to such things as reviewing medications, toileting schedules, activities, behavior interventions, pain management, restorative programs and change in status. Audits have been conducted on residents to determine if alarms have been activated and how often to determine if they are still needed. Five of the 7 tab alarms were eliminated as a result of these findings and alternative interventions identified. Visual audits for current alarms are done every week to check for appropriate placement and functioning. The QA Committee will review audits and make recommendations as needed.

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

F5373022

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pelican Valley Health Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok 12-13-13 RECEIVED DEC 10 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

no opportunity to correct
DC: 12-4-13
EXIT: 10-25-13

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

Executive Director | 11/26/13

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
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Pelican Valley Health Center was constructed at 4 different times and is a 1-story building without a basement. In 1951 the original building was built and was determined to be of Type II(111) construction (it is the lower level of the with a clinic building). In 1969 the majority of the building was constructed to the west and north of the clinic building and was determined to be Type II (000) construction. In 1996 a business office/ family room addition was constructed to the north of the 1969 building and was determined to be Type II (111) construction. A connecting link to the assisted living apartment building to the north was constructed in 2002 north of the 1996 addition and was determined to be Type V (111) construction and is separated from the assisted living with 2-hour fire rated barrier. The building is divided into 3 smoke zones with at least 30 minute fire barriers. The building is completely sprinkler protected in	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection in the 1969 and 1996 building in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 37 at the time of the survey. Because the original 1951 building, and the 1969, 1996 and 2002 additions are completely sprinkler protected and all meet the construction requirements of NFPA 101 "The Life Safety Code" 2000 edition the complex was surveyed as one building (Type II (000)). The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that 2 of 4 exit doors are not in accordance with NFPA 101 The Life Safety Code section 19-2.2.2.3 and the Centers for	K 038	K038 Pelican Valley Health Center ensures that it will protect and follow all Life Safety Code Standards. The locked exit doors will now remain unlocked after a fire alarm, loss of power or sprinkler activation. A manual key switch has been installed to relock the doors. The codes to open the locked exit doors will be kept posted by each door at all times. The Environmental Director will be responsible for keeping these codes posted.	11/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(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 038	Continued From page 3 Medicaid Medicare Services (CMS) informational letter. This deficient practice could effect all 40 residents, any visitors and staff in an emergency situation. Findings include: Observations and an interview with the Director of Maintenance, during the facility tour on October 24, 2013, between 1:00 pm and 2:30 pm revealed that: 1) The south and east exit doors are locked against egress with a key pad release device at each door in accordance with the CMS informational letter, however the sign indicating the code to open the doors had been removed, and 2) It could not be verified that the locks on the exit doors can only be reactivated manually from within the unit after being released by the fire alarm activation, loss of power or sprinkler system activation as required by the Minnesota State Fire Code. These deficient practices were confirmed by the Director of Maintenance and the Administrator during the facility and at the time of exit.	K 038		