ID: CF6S

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

	PART	I - TO BE COMI	PLETED BY T	THE STAT	E SURVEY AGENCY	Fa	cility ID: 00442
MEDICARE/MEDICAID PROVIDER N (L1) 245373 2.STATE VENDOR OR MEDICAID NO. (L2) 537342500	Ю.	3. NAME AND ADD (L3) PELICAN V (L4) 211 EAST M (L5) PELICAN R	ALLEY HEALT		(L6) 56572	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP	PPLIER CATEGOR	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other nplaint
6. DATE OF SURVEY 01/02 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING I	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	40 (L18) 40 (L17)	B. Not in Com	equirements	n	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	6. Scope of Service 7. Medical Directo	PΓ
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 40 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAR See Attached Remarks 17. SURVEYOR SIGNATURE	KS (IF APPLICABLE	SHOW LTC CANCEL Date:	LATION DATE):		18. STATE SURVEY AGENCY AI	PPROVAL	Date:
Denise Erickson HF			02/01/2014 D BY HCFA R	(L19) EGIONAI	OFFICE OR SINGLE STAT	TE AGENCY	(L20)
DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Par 2. Facility is not Eligible	Y	20. COM	IPLIANCE WITH C		21. 1. Statement of Financi		-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension	DATE E SANCTIONS	24. LTC AGREEMI ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	INVOLUNTA 05-Fail to Med	et Health/Safety et Agreement
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)			00-Active	
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (12/20/2013	OF APPROVAL DA	(L33)	DETERMINATION APPRO	VAL	

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

Facility ID: 00442

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 December 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 Meeth

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)

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 245373	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/23/2013
Name of Facility		Street Address, City, State, Zip Code	
PELICAN VALLEY HEALTH CENTER		211 EAST MILL AVENUE	

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	()	(5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item	ı	(Y5)	Date
ID Prefix	F0279	Correction Completed 12/01/2013	ID Prefix	F0282	(Correction Completed 12/01/2013		ID Prefix	F0309		Correction Completed 12/01/2013
	483.20(d), 483.20(k)(1			483.20(k)(3)(ii)					483.25		
ID Prefix	F0323	Correction Completed 12/01/2013	ID Prefix	F0371	(Correction Completed 12/03/2013		ID Prefix	F0497		Correction Completed 12/07/2013
	483.25(h)			483.35(i)				Reg. #	483.75(e)(8)		
ID Prefix	F0503	Correction Completed 12/01/2013	ID Prefix	F0509	(Correction Completed 12/01/2013		ID Prefix	F0519		Correction Completed 12/01/2013
Reg. # LSC	483.75(j)(1)(i-iv)		Reg. # LSC	483.75(k)(1)(i-ii)			,		483.75(n)		
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Correction Completed					
Reg. #			Reg. #			Correction Completed					Correction Completed
Reviewed I		•	Date:	Signature	of Surv					Date:	12/22/2012
State Agen Reviewed I CMS RO	cy MN By Review	M/GA ed By	03/28/2 Date:	Signature						Date:	12/23/2013
Followup t	to Survey Completed 10/25/2013	on:		Check for any Uncorrected					Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245373	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y	5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
Reg. #	F0279 483.20(d), 483.20(k)(1)	Correction Completed 12/01/2013	Reg. #	F0282 483.20(k)(3)(ii)		Correction Completed 12/01/2013			F0309 483.25		Correction Completed 12/01/2013
LSC		_	LSC					LSC			_
ID Prefix Reg. # LSC	F0323 483.25(h)	Correction Completed 12/01/2013		F0371 483.35(i)		Correction Completed 12/03/2013			F0497 483.75(e)(8)		Correction Completed 12/07/2013
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		_	ID Prefix Reg. # LSC	-				Reg. #			Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC								
Reviewed By	Reviewed	Ву	Date:	Signature of	f Surve	yor:				Date:	
State Agency	MM/0	GA	02/01/20	014	3	31256				12/2	23/2013
Reviewed By			Date:	Signature o						Date:	
Followup to	Survey Completed on: 10/25/2013				-				a Summary of to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

Ì	rovider / Supplier / CLIA / dentification Number 45373	(Y2) Multiple Constr A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 1/2/2014
Name of	Facility		Street Address, City, State, Zip Code	
PFI I	CAN VALLEY HEALTH CENTER		211 EAST MILL AVENUE	
	o		DELICAN DADIDS 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) I	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			11/25/2013		ID Prefix				ID Prefix			
Rea.#	NFPA 101				Reg. #				Reg. #			
_	K0038				LSC				LSC			_
				 					-			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Dog #							-					_
Reg. #					Reg. #				Reg. #			_
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			0				0					0
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
							-					_
Reg. #					Reg. # LSC				Reg. #			_
LSC									LSC			=
			• "									
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
							-					_
Reg. #					Reg. #				Reg. #			_
LSC				<u> </u>	LSC				LSC			_
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
							-					_
Reg. #					Reg. #				Reg. #			_
LSC					LSC _				LSC			
Reviewed By		viewed E		Da		Signature of Surve	yor:				Date:	12/2014
State Agency	<i>y</i>	MM/P	ა	02/	/01/2014	03	3006				01/0	02/2014
Reviewed By	, Re	viewed E	Ву	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed	d on:				Check for any	Uncorrected	Defici	encies. Was a	a Summary of		
	10/24/2	013								o 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 00442	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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) D	ate
ID Prefix	20560	Correction Completed 12/01/2013	ID Prefix	20565	Correction Completed 12/01/2013		ID Prefix	20830	Correction Completed 12/01/2013
	MN Rule 4658.0405 Subp. 2		Reg. # LSC	MN Rule 4658.0405 Subp. 3			•	MN Rule 4658.0520 Subp.	1
ID Prefix		Correction Completed 12/03/2013	ID Prefix		Correction Completed 12/03/2013		ID Prefix		Correction Completed
Reg. #	MN Rule 4658.0610 Subp.		Reg. #	MN Rule 4658.0675 Subp.			Reg. #		
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. # LSC			Reg. # LSC				Reg. #		- -
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. #			Reg. #				Reg. #		-
Reg. #			Reg. #				ID Prefix Reg. # LSC		
Reviewed By		-	Date:	Signature of Surve				Date:	2/2012
State Agency Reviewed By CMS RO	1,11,1		02/01/201 Date:	Signature of Surve	256 yor:			12/2. Date:	3/2013
Followup to Survey Completed on: 10/25/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						NO	

ID: CF6S

Facility ID: 00442

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

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245373 2.STATE VENDOR OR MEDICAID NO. (L2) 537342500 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	3. NAME AND ADDRESS OF FACILITY (L3) PELICAN VALLEY HEALTH CENT (L4) 211 EAST MILL AVENUE (L5) PELICAN RAPIDS, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	(L6) 56572 .02. (L7) 13 PTIP 22 CLIA	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
6. DATE OF SURVEY 10/25/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 40 (L18) 13.Total Certified Beds 40 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 40 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE)	A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
See Attached Remarks 17. SURVEYOR SIGNATURE Denise Erickson, HFE NEII	Date: 12/13/2013 (L19)	18. STATE SURVEY AGENCY AS	
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	
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 Financ 2. Ownership/Control 3. Both of the Above :	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION BEGINNING 12/01/1986 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIVA. Suspension	DATE ENDING DATE (L25)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety
(L27) B. Rescind Sus	(L44) pension Date: (L45)		00-Active
28. TERMINATION DATE: 29	INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	03001 (L31)		
31. RO RECEIPT OF CMS-1539 32 (L32)	DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPRO	DVAL

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

Facility ID: 00442

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

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.



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Pelican Valley Health Center November 13, 2013 Page 2

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

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

· DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/201: CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245373 B. WING NAME OF PROVIDER OR SUPPLIER 10/25/2013 STREET ADDRESS, CITY, STATE, ZIP CODE PELICAN VALLEY HEALTH CENTER 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 000 | INITIAL COMMENTS F 000 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 addered le 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 279 483.20(d), 483.20(k)(1) DEVELOP Pelican Valley Health Center ensures that F 279 12/1/13. COMPRÉHENSIVE CARE PLANS SS=D the results of the assessment are used to develop, review and revise the resident's A facility must use the results of the assessment plan of care. Resident # R1's to develop, review and revise the resident's comprehensive plan of care was reviewed comprehensive plan of care. and revised with regards to dialysis services/care. At this time no other The facility must develop a comprehensive care residents are receiving dialysis services. plan for each resident that includes measurable The Director of Nursing will have a objectives and timetables to meet a resident's meeting with nursing staff to review the medical, nursing, and mental and psychosocial facility policy regarding care plans and needs that are identified in the comprehensive adherence to the individual resident plans assessment. of care, specifically with regards to dialysis. The Director of Nursing or designee will The care plan must describe the services that conduct random audits to ensure correction are to be furnished to attain or maintain the

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

resident's highest practicable physical, mental,

and psychosocial well-being as required under

Executive

is achieved and maintained. The Quality

Assurance Committee will review audits

and make recommendations as needed.

(X6) DATE

11124113 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 disclosured as 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.

DEC 0 3 2013

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	O. 0938-0391 PATE SURVEY OMPLETED
		245373	B. WING			1.	0/05/00/0
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	.1_1	0/25/2013
PELICA	N VALLEY HEALTH CI			and the second of	I EAST MILL AVENUE LICAN RAPIDS, MN 56572		
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in the second se	tunder § 483.10(b)(4) This REQUIREMEN by: Based on interview facility failed to dever access for 1 of 1 residialysis. Findings include: R1 had diagnoses infailure, with placement of a dialysis treadmission Minimum 10/7/13, identified R1 equired assistance with the modern of the interdistruction of the interdistruction of a dialys of documentation four mergency care.	ervices that would otherwise 483.25 but are not provided sexercise of rights under the right to refuse treatment. IT is not met as evidenced and document review, the elop a comprehensive care and precautions of dialysis idents (R1) receiving cluding chronic kidney and of a dialysis PermaCath eatment on 10/18/13. The Data Set (MDS) dated I was cognitively intact and with all activities of daily DS identified R1 was oning from various surfaces son assistance with bathing. sciplinary progress notes 20/18/13, which identified is PermaCath. There was and regarding the location of actions for care, or er, 2013 treatment record ocumentation of monitoring and regarding the ocumentation of monitoring ocumentation	F 2	79			
VI CMS-2567(02-99) Previous Versions Obe	rolete = -				12.1	

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STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
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NAME C	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE 1	0/25/2013
PELIC	AN VALLEY HEALTH C	ENTER	1	211 EAST MILL AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PELICAN RAPIDS, MN 56572		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 27	The care plan, revishad chronic kidney exacerbation and fle listed were to have and coordinate care M.D. and family upochanges in condition However, the care paddress care and prodialysis access, emethe dialysis catheter. During an interview clicensed practical numbrad recently started aware R1 had a cath She stated she would dressing covering the During an interview or registered nurse (RN started dialysis theral confirmed R1's care approaches/intervent access care. The care location and type of dand did not include procare of the catheter. In not had a dialysis patinave to research what caused a missed dialy. The facility policy title revised December 200	disease with recent disease with recent disease with recent did retention. The approaches labs and vitals as ordered s with dialysis unit, keep lated and observe for and keep M.D. current. Italian lacked approaches to ecautions to use with the ergency procedures related to and dialysis therapy. On 10/24/13, at 10:16 a.m. rese (LPN)-A confirmed R1 dialysis, stated she was eter for dialysis treatments. It deeper to dialysis the dry. On 10/24/13, at 11:25 a.m. or	F 27			
F 282 SS=E	483.20(k)(3)(ii) SERVI PERSONS/PER CARI	CES BY QUALIFIED	F 282			

FORM APPROVED

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

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

	THE PROPERTY OF THE	T WILDIOAID OLIVICES	,		OMB NO	0. 0938-039
AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245373	B. WING_		10	/2E/2042
NAME	OF PROVIDER OR SUPPLIER		, T	STREET ADDRESS, CITY, STATE, ZIP CODE	110	/25/2013
PELIC	CAN VALLEY HEALTH C	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
(X4) I PREF TAG	IX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	COMPLETION DATE
F 28	The services provided by accordance with eacare.	led or arranged by the facility y qualified persons in ch resident's written plan of	F 28	Pelican Valley Health Center en services are provided by qualifie in accordance with each residen plan of care. Residents # R40, R and R39 care plans were reviewed revised to reflect appropriate improvised to reflect appropriate improvised.	ed persons it's written 34, R31, ed and	12/1/13
	by: Based on observati review the facility fa related to appropriat 4 of 4 residents (R40 with frequent falls. Findings include: R40's personal safet securely attached re-	ndering inoperable.		tion of personal alarms. All other residents currently usin alarms were also reviewed. Eduprovided immediately to all staff cares to residents in regards to apuse of alarms. The facility policiuse of alarms was reviewed and in the Director of Nursing or her dewill conduct random audits to encorrection is achieved and maintate The Quality Assurance Committee review audits and make recommendanced.	g personal cation was providing propriate y regarding revised. esignee sure ained.	
3	nad potential for injurced cognition and mobilit accident, multi infarcunpredictable activity falls. The care plan li which included: clip a	ed 10/19/13, identified R40 ry (falls) related to impaired y due to cerebrovascular t dementia with behaviors, and history of sted various interventions alarm on in bed, and clip to alert staff of needs.				21
	out loudly, with her be leg was hanging over floor. R40 wore a blac arm and her left hand while she was rocking bed, attempting to get	n 10/23/13 at 8:45 a.m., room, lying in bed, yelling ed in a low position, her left the side of the bed onto the ck fabric sling on her right was clutching her right arm ther torso back and forth in to of of bed. A metal clip was shoulder of her gown and	2			

		& MEDICAID SERVICES			0		0. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245373	B. WING			10	/25/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 .10	12012010
PELICA	N VALLEY HEALTH C	ENTER			211 EAST MILL AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PELICAN RAPIDS, MN 56572		
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F 282	the cord of the clip of pillow. R40 continued bed, with her leg has continued to rock be when the surveyor rassistant (NA)-B car	ge 4 was laying over the top of the ed to attempt to get out of nging out of bed and ack and forth until 8:49 a.m. notified staff. Nursing me to R40's room to assist e sounding during the entire	F 2	82		- dose	
	in a chair. NA-B state bed and does try to the confirmed that the clothing towards her would either hook the wheelchair or lay it of the pillow. NA-B. con	n the bed on the far side of firmed that R40's clip alarm en she was attempting to					
	10:14 a.m. to 10:24 a transfer into a recline a.m. NA-A attached t R40's left shoulder ar the left arm of the recwalked out of the lour	servation on 10/23/13 from a.m., NA-A assisted R40 to ir in the lounge at 10:14 he metal clip of the alarm to ind placed the alarm box on cliner and immediately inge. The personal safety fixed to a stationary surface.					
t s	R40 was to have a clichair or recliner, and other alarm box on the stated, "we don't have	a.m., NA- A confirmed that p alarm on while in the confirmed she had rested arm of the recliner. NA-A anything to hook it to." eentered the lounge and afety alarm from the left	P.				

CENT	EKO FUK WIEDICAK	L & MEDICAID SERVICES				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DA	O. 0938-039 ATE SURVEY MPLETED
		245373	B. WING_			
	PROVIDER OR SUPPLIER N VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	DDE 10	0/25/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
	arm of the recliner of wheelchair and sect large metal clip. The the small metal clip shoulder. NA-A ther R40's personal safe securely to an affixed while R40 sat in the During continuous of 11:12 a.m. to 11:26 arecliner in the lounge sitting next to the recattached to the back large metal clip. The of the string, from the seat of the wheel resident. At 11:26 a.m. on 10/2 continued to be obsewheelchair next to the second continued to the obsewheelchair next to the second continued to the second continued to the second continued to the obsewheelchair next to the second continued to the second continued to the second continued to the obsewheelchair next to the second continued continued to the second continued to the second continued continued to the second continued c	to the back of R40's ured the alarm box with a en NA-A proceeded to hook of the alarm to R40's right a exited the area. Prior to this, ty alarm was not attached ed object for ten minutes recliner unsupervised. bservation on 10/23/13 from a.m., R40 was seated in a e area, with her wheelchair cliner and the alarm box of the wheelchair with a small metal clip at the end e box was observed laying in Ichair, not attached to the	F 28			
to a second of the second of t	ime, NA-B confirmed attached to R40. NA-blip of the alarm to the shoulder, while the alard not been appropriate fourteen minutes with the shoulder of the back of R40's with the shoulder of the back of R40's with the shoulder of the should	terview with NA-B at that if the clip alarm was not B proceeded to hook the e back of R40's right arm box remained attached wheelchair. R40's clip alarm lately attached to her shirt while she sat in recliner a.m., registered nurse alip alarm on R40 while N-A confirmed R40 self and was confused. RN-A leed fractures after her falls				
M CMS-2567(02-99) Previous Versions Obs	olete Event ID:CF6S11	Facil	ity ID: 00442 If co	entinuation sheet	Page 6 of 50

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	HUKI	M APPROVED D. 0938- 0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
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NAME OF P	PROVIDER OR SUPPLIER		<u>' </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10	0/25/2013
PELICAN	VALLEY HEALTH CE				11 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
Fisher At	practice was to attact towards her shoulde attached to the whee above the pillow. RN securely attached to R34's personal safet securely attached reference at risk for falls repain, dementia, arthrimitations. R34's carboan further directed alarm" in place when ouring observation on the back of R34's securing at the back of R34's securing and could hair. The continuous observed at the back of R34's head on the recliner and could hair. The continuous observed at the back of R34's head on the recliner and could hair.	9/13. RN-A stated the usual on the clip to R40's clothing or area and alarm box to be elchair or it rested on the bed land. A stated "alarm is not anything." y alarm unit was not endering inoperable. ed 10/4/2013, identified R34 elated to impaired mobility, it and would forget e plan directed facility staff es, and toileting. The care R34 was to have a "clip in bed and in the chair. In 10/22/2013, at 1:17 p.m., eated in a brown overstuffed e facility TV lounge. The d and R34's feet were on clip on a cord was attached weater, however, the white ettering was loosely placed the top edge of the back of ot affixed to the fabric of move freely from the servation from 1:17 p.m., is seated in the TV room in the alarm box loosely e of the chair above her	F 2	82	DEFICIENCY)		
ngi	ht to see the TV, the	alarm box continued in					

OLIVIE .	NOT ON WEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
NAMEOE	DDOWDED OF	245373	B. WING			10)/25/2013
	PROVIDER OR SUPPLIER N VALLEY HEALTH CE	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	1 10	1120/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X6) COMPLETION DATE
	the same position, la affixed to the chair. At 2:38 p.m., R34 walarm box remained headrest, not affixed At 2:56 p.m. NA-C Ithen proceeded to walarm box did not check remained resting on not affixed to the chair At 4:01 p.m., LPN-B R34's clip alarm box the box was not affix further confirmed that clip the alarm box to the magnetic clip to othe magnetic did alarm to detach and trigical control of the mattree of the control of the magnetic clip to othe magnetic clip to othe magnetic did alarm to detach and trigical control of the magnetic clip to othe magnetic clip to	The alarm did not sound. as resting in the chair, the resting on top of the recliner it to the chair. Oriefly approached R34 and talk out of the lounge area. The alarm box which top of the recliner headrest, air. and the surveyor examined and LPN-B confirmed that ted to R34's chair. LPN-B at usual practice would be to a surface which would allow detach if R34 attempted to by. The geometric continuous observation of a.m., R34 was lying in the alarm box was loosely above the pillow, and was face to allow the magnetic ger the personal safety of to transfer independently. The proached R34 with a RN-A raised the head of the emedication and the alarm d of the bed. RN-A then under R34's pillow	F 2	282	DEFICIENCY)		
A	urrace. t 7:18 a.m., NA-H sta	x was not affixed to any ated R34 did frequently ed independently and the					
M CMS-2567((02-99) Previous Versions Obs	colete Event ID: CF6S11			JD:00440		

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		O. 0938-039 ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		9		MPLETED
		245373	B. WING		1	0/25/2042
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	0/25/2013
PELICA	N VALLEY HEALTH CE	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	Continued From page	70.8				1
	personal safety clip	alarm was utilized to alert	F 282			
	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.					
i v	at a dining table, how not present, not attac wheelchair. The ADO	s seated in the wheel chair ever, the safety alarm was hed to R34's clothing or N was present in the dining ms from the steam table.			g.	
p p ir d b	the was not aware R3 place. She confirmed tersonal safety alarm the chair or in bed. ining room and return ox and proceeded to	nterview, ADON indicated 14's safety alarm was not in R34 was to have a attached at all times when ADON immediately left the ned with R34's safety alarm attach the clip to R34's box to the back of the				
	¥					
R: se	31's personal safety a curely attached rend	alarm unit was not ering inoperable.		a a	est:	8

AND EARN OF CORRECTION (A) POWDERS (PERCECLA DELIVER) (A) POWDER OF GORGETION (A) DELIVER (COMPLETE) NAME OF PROVIDER OR SUPPLIER PELICAN VALLEY HEALTH CENTER SUMMAY SINTEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST SE PRECEDED BY FULL to be at risk for falls with numerous fall interventions which included signal light within reach and reinforce use, non-stip mat at bedside, motion alarm at night to alert staff of needs, staff to anticipate needs and clip palarm 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 a stationary surface. During observation on 10/23/13, at 10-54 a.m. R31 saf forward in the 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 a stationary surface. During observation on 10/23/13, at 10-54 a.m. R31 saf forward in the recliner and began moving the blanket away from the area. The personal clip fall alarm was not securely attached to a stationary surface. During an interview on 10/23/13, at 10-54 a.m. R31 saf forward in the recliner and began moving the blanket away from because the clip alarm box fell out of the chair, and hit the floor. During an interview on 10/23/13, at 12-7 p.m. NA-D 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 she has done this before and fallen. NA-D stated the clip alarm "goes where she goes" in wheel chair, in bed.	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		APPROVED 0. 0938-0391
PELICAN VALLEY HEALTH CENTER PELICAN VALLEY HEALTH CENTER SUMMARY STATEMENT OF DEFCIENCIES (EACH DEFCIENCIES TAGE) (EACH DE SUMMARY STATEMENT OF DEFCIENCIES (EACH DEFCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 this, 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 the legs stating "In needed to go see." During this movement the clip alarm box reli out of the chair, and hit the floor. During an interview on 10/23/13, at 1:49 p.m. LPA-A confirmed the clip alarm box was stitting in 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.	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY
PELICAN VALLEY HEALTH CENTER O(A9) D PRETRY TAG SUMMARY STATEMENT OF DESCRENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FILL TAG TAG CONTINUED FROM THE PROVIDER PROPERTY OF DESCRENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FILL TAG 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 cilip 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 R31s lap and arms with a blanket, attached a metal cilp with cord attached to the rshirt then proceeded to place alarm box on the seat of the recliner next to R31's tight, NA-G walked away from the area. The personal cilp 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 he recliner and began moving the blanket away from he recliner and began moving the blanket away from he recliner and to R31's left side between her thigh and the recliner arm and not attached to a stationary surface. 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.			245373	B. WING			40	/9/E /0/04 0
CALL DEFICIENCY MUST SET PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEPCIENCIES PREFER (EACH DEPCIENCY MUST BE PRECEDED BY FULL TAG F 282 Continued From page 9 The care plan revised 8/25/13, identified R31 to be at risk for falls with unmerous 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 e 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 thip, 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 setting 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 clip alarm box was stitting in the recliner arm and not attached to a stationary surface. She confirmed the personal old principles and the recliner arm and not attached to a stationary surface. She confirmed the personal old plant is used because R31 will bend over and reach too far, the clip alarm is used because where she goes" in wheel chair, in bed.	NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	10	120/2013
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	I I I I I I I I I I I I I I I I I I I	The care plan revised be at risk for falls will interventions which reach and reinforce motion alarm at night to anticipate needs a wheelchair. During an observation NA-G assisted R31 to both feet on the raised R31's lap and arms wheelchair lip with cord a proceeded to place a recliner next to R31's from the area. The penot securely attached buring observation of R31 sat forward in the moving the blanket are lip alarm box fell out loor. During an interview of PN-A confirmed the late recliner next to R31's and the recliner sationary surface. Shouring an interview of R31 will bend over and arm is used because and fallen. NA-D states	ed 8/25/13, identified R31 to the numerous fall included signal light within use, non-slip mat at bedside, at to alert staff of needs, staff and clip alarm in when in on on 10/23/13, at 10:44 a.m. o sit in a recliner and place ed foot rest. NA-G covered with a blanket, attached a larm box on the seat of the stringh. NA-G walked away ersonal clip fall alarm was atto a stationary surface. In 10/23/13, at 10:54 a.m. e recliner and began way from her legs stating "I uring this movement the tof the chair, and hit the continuous farm and not attached to a e confirmed the personal of 10/23/13, at 2:27 p.m. sip alarm is used because defence to far, the clip alarm goes of the clip alarm goes of the clip alarm goes	F 2	282			
M CMS-2567(02-99) Previous Versions Obsolete Event Dicesorate	M CMS 2567/0	12 00\ De-vi						

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. 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.	CENTE	ERS FOR MEDICAR	E & MEDICAID SERVICES				FORM	APPROVE
PELICAN VALLEY HEALTH CENTER PELICAN VALLEY HEALTH CENTER PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEN TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEN TAG 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 transfers 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.	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY
PELICAN VALLEY HEALTH CENTER 21 1EAST MILL AVENUE PELICAN RAPIDS, MN 56572 (AG) ID PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 fail due to learning 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 waking and clip alarm in bed and while up in wheelchair to alert staff or 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 varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety alarms to all varieties to the pillow personal safety ala	NAME OF	DDO) (DEC		B. WING			10	/0E/0040
PREFIX TAGE THE PROPERTY OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATIONY OR LSC IDENTIFYING INFORMATION) 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 learning 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.					211 EAST MILL AVE	NUE	1 10	120/2013
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	f f c iii a w C ly a pi Ti cl at to ap	The care plan, revise had potential for injuctognition, history of fractured right hip, visor assist with transferare plan included vancluded call light had walking and clip wheelchair to alert stand walking and stand walking and clip wheelchair to alert stand walking and clip wheelchair to alert stand walking and stand walking and clip wheelchair to alert stand walking and walking and walking and clip walking in bed with a surface.	endering it inoperable and ent's reach. ed 10/1/13, identified R39 by related to impaired falls with one resulting in itamin D deficiency, and need er and ambulation. R39's arious interventions which andy, assist with transfers alarm in bed and while up in aff of any potential needs. a.m. R39 was observed MART" personal safety the mattress next to the de. arm was attached to R39's equit was not securely a.m. NA-B confirmed the esting on the mattress, next dicated that is how staff y alarms to all residents.					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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

		THE DISTRIBUTION			MR MO	. 0938-0391
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		245373	B. WING_		10	/25/2013
PELICA	PROVIDER OR SUPPLIER N VALLEY HEALTH CE			STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	1 10	123/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 282 F 309 SS=D	On 10/23/13, at 8:2: care plan and confir up at the edge of he is at risk for further to alert staff that she	5 a.m. RN-A confirmed R39's med R39 does attempt to sit or bed. RN-A confirmed R39 falls and stated the alarm is a statempting to get up. ARE/SERVICES FOR	F 282			12/1/13
	Each resident must a provide the necessary or maintain the higher mental, and psychost accordance with the and plan of care. This REQUIREMENT by: Based on observation review, the facility fail implement care plant dialysis access care freceiving dialysis service.	receive and the facility must ry care and services to attain est practicable physical, ocial well-being, in comprehensive assessment. T is not met as evidenced on, interview, and document illed to develop and an interventions related to for 1 of 1 resident.		Pelican Valley Health Center ensures each resident receives the necessary of and services to attain or maintain the highest practicable physical, mental, a psychosocial well-being, in accordance with the comprehensive assessment as plan of care. Resident #R1's care plan revised relating to dialysis access. The facility policy for dialysis care planning was reviewed and revised. The Direct of Nursing will have a meeting with nestaff to review the policy. The Director of Nursing or her designed will conduct random audits to ensure correction is achieved and maintained. The Quality Assurance Committee wireview audits and make recommendations as presided.	and ce nd n was ee ng ursing ee	14113
in the second se	failure and had a dialy 10/18/13. The admiss (MDS) dated 10/7/13, cognitively intact and activities of daily living dentified R1 was unsiform various surfaces assistance with bathin	required assistance with all g. Further, the MDS eady with transitioning and required one person		tions as needed.		

CENTERS FOR MEDICARI	E & MEDICAID SERVICES			0	HUKI	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
	245373	B. WING			40	/05/0040
NAME OF PROVIDER OR SUPPLIER			'ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10	/25/2013
PELICAN VALLEY HEALTH C	ENTER		21	1 EAST MILL AVENUE ELICAN RAPIDS, MN 56572		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
exacerbation and fle listed were to have and coordinate care M.D. and family upon changes in condition However, the care produced and produced and produced and produced and produced and placement of a dialyth of the PermaCath, instruction of the PermaCath, instruction and placement of a dialyth of the PermaCath, instruction of the PermaCath, instruction of the dialysis of the produced the surveyor port on the upper right center of the gauze of the dialysis o	disease with recent uid retention. The approaches labs and vitals as ordered as with dialysis unit, keep dated and observe for and keep M.D. current. Dian lacked approaches to ecautions to use with the ergency procedures related to and dialysis therapy. Isciplinary progress notes 0/18/13, which identified sis PermaCath. There was und regarding the location of ructions for care, or Der, 2013 treatment record documentation of monitoring PermaCath site. In 10/22/13, at 9:32 a.m. R1 her gauze covered dialysis at side of her chest. The ad a half dollar size brown a middle that did not dressing. R1 confirmed that he middle that did not dressing. R1 confirmed that he middle that did not dressing. R1 confirmed that he middle that did not dressing assistance by facility In 10/24/13, at 10:11 a.m. F confirmed she assisted She stated she had not an R1's chest and it had that are prior to giving the	F3	09			

STATEMEN	IT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII 7	TIPLE CONSTRUCTION		0. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NG		TE SURVEY MPLETED
NAME OF	DDO VDD	245373	B. WING_		10	/25/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	120/2013
	N VALLEY HEALTH C			211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
(X4) ID PREFIX •TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(X5) COMPLETION DATE
E F d junsis	During an interview licensed practical nad recently started aware R1 had a cat She stated she wou dressing covering the During an interview registered nurse (RN started dialysis there confirmed R1's care approaches/intervent access care. The cat coation and type of and did not include pare of the catheter. In the data dialysis parawet to research where aused a missed dialouring an interview action and type of any action and type of action any action and a	on 10/24/13, at 10:16 a.m. urse (LPN)-A confirmed R1 dialysis, stated she was heter for dialysis treatments. Id expect staff to keep the ne dialysis site dry. on 10/24/13, at 11:25 a.m. N)-B confirmed R1 had apy in the recent past. She plan did not include tions for care of dialysis re plan did not address the dialysis access that R1 had, precautions to follow for the RN-B stated the facility had tent in a while, and would at to do if severe weather.	F 30	DEFICIENCY)		
CO	ntact the dialysis acce	ess and she would need to it and medical doctor to be doing here." The DON				

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

PRINTED: 11/13/201 FORM APPROVEI OMB NO. 0938-039

STA	TEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			0	<u>MB NO</u>	. 0938-03
AND	PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		TE SURVEY MPLETED
NIA	ME OF DRO	MIDER	245373	B. WING	€		10	/2E/2042
NA	ME OF PRO	VIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	10/	25/2013
PE	LICAN VA	ALLEY HEALTH CI	ENTER			211 EAST MILL AVENUE		
			-IAICIV		4	PELICAN RAPIDS, MN 56572		
	(4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		1
	REFIX	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE
F	309 Co	intinued From no	~					
	1	entinued From pag	ge 14	F3	309			
	if t	he dressing sauld	eed to call dialysis to find ou	t				
	EVI	ne dressing could	get wet and she would				j	
	chs	ame nurse for dim	stants to check with the					
	wh	en something is a	ections to care for residents				ı	
	unc	deretanding that	new. The DON stated				1	
	spe	Cific type cares s	emergency procedures and hould be part of the care				1	
	pla	n. The DON state	d she would clear up any		ı		ŀ	
	mis	S understandings	today and get the care plan		1			
	upd	ated.	today and get the care plan	İ	- 1			
F:	323 483	.25(h) FREE OF	ACCIDENT		امد			
S	S=J HAZ	ZARDS/SUPERV	ISION/DEVICES	.√ F3	23	<u>F323</u>	Ì	12/1/13
	1.				- 1	Pelican Valley Health Center ensures	,	TOTAL CONTRACTOR OF THE PARTY O
	The	facility must ens	ure that the resident			I hat the resident environment remain	s	
	env	ironment remains	as free of accident hazards			as free of accident hazards as is possib	le	
	as 18	s possible; and ea	1Ch resident receives			and each resident receives adequate		
	ade	quate supervision	and assistance devices to		-	supervision and assistance devices to prevent accidents. The comprehensive		
	prev	ent accidents.		1		assessments for Resident #R40 and R3	fall	
						were completed prior to exit and care	4	
						plans updated. The comprehensive fall	. !	
	1				- [assessments for Resident #R31 and R36	0 11	
	This	REQUIREMENT	is not met as evidenced			were also completed and care plans upo	lated	
	by:	The state of the s	is not met as evidenced			All current residents with high risk for	falla	
	Base	ed on observation	, interview and document		1	WIII be assessed and care plans updated	00	
	16416	w, the facility fail	ed to comprehensively		1	needed. The Director of Nursing review	wed	
	1 00000	ss residents for ris	SK Of falls and effectively			and revised the policy regarding residen	ife	
	mibie	ment the applica	tion of personal safety			risk for falls and use of personal alarms.	. 11	
	alaiti	is resulting in an	immediate ieonardy			All staff that provides direct cares to		
	Situat	ion for 2 of 4 resi	dents (R40, R34) reviewed		1	residents was educated immediately on		
	at Hor	VIOLIBIIS. BOTH R	40. R34 sustained actual			the policy. A monitoring system was		
	Haim	when they sustai	ned fractures following o			implemented to ensure compliance with		
	I Idil. II	i addition to the r	esidents in immediate			appropriate use of alarms. The Director of Nursing or her designee will conduct		
	imple	ment personal a-	iled to appropriately			random audits to ensure correction is		
	result	ed in the notant	fety alarms, which			achieved and maintained. The Quality	.	
	imme	diate ieonardy for	al for harm that was not 2 of 2 residents (R31,		1	Assurance Committee will review audits	. 11	1
	R39) v	with a history of fa	alls			and make recommendations as appropria	ite.	1
			ALIG I		1		(VW*)	,

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES				MAPPROVE 0. 0938-039		
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DA	(X3) DATE SURVEY COMPLETED		
		245373	B. WING _		10	/25/2042		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	/25/2013		
PELICA	N VALLEY HEALTH CE	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE	OULD BE	(X5) COMPLETION DATE		
F 323	Continued From pag	ge 15	F 32		= 311			
	appropriately implent to prevent falls. The director of nursing (I 10/23/2013, at 5:25 jeopardy for R40 and on 10/25/2013, at 10 non-compliance remissive rity level of G, w for R40 and R34 due following falls.	ardy began on October 23, temic failure of the facility to nent personal safety alarms administrator and the DON) were notified on p.m. of the immediate it R34. The IJ was removed :24 a.m., however, ained at a scope and which indicated actual harm to fractures sustained	V					
t i i i i i i i i i i i i i i i i i i i	impairment of gait an falls, forgets limitation falls, forgets limitation behaviors. Intervention neluded the use of a solution of the used while R40 dowever, during observerated alarm was notifixed object nor was alothing that would allound the alarm to ale acility failed to comprosk factors related to fossible causal factors insafe independent training the property, aphasia and in the property and property.	d transferring, history of as and has unpredictable ans identified by the facility personal safety clip alarm was in bed or in a chair. It is securely attached to an the clip attached to R40's ow the peg to detach to att staff. In addition, the ehensively assess R40's falls which would include a related to attempts at ansfers. In addition, the ehensively assess R40's falls which would include a related to attempts at ansfers. In addition, the ehensively assess R40's falls which would include a related to attempts at ansfers. In addition, the ehensively assess R40's falls which would include a related to attempts at ansfers. In addition, the ehensively assess R40's falls which would include a related to attempts at ansfers.						

AND PLAN OF CORRECTION (X3) DATE (X2) MULTIPLE CONSTRUCTION (X3) DATE	0. 0938-0391 TE SURVEY MPLETED
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STREET ADDRESS, CITY, STATE, ZIP CODE	/25/2013
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) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 Continued From page 16 to lite 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 setocarthritis 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 wee	
tolerating medications well with no adverse effects noted. Mood and cognition was identified A CMS-2567(02-99) Previous Versions Obsolete Event ID: CESS14	

CENT	ERS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245373	B. WING_		10/25/2012
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	10/25/2013
PELICA	AN VALLEY HEALTH CI	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI	D BE COMPLETION
	as stable. However R40 had knee disco at times, but also id would use handrails continue plan of car. The quarterly function 6/30/13, identified R independent with su transfers, and ambur R40's facility undate sheet directed staff the was in her wheelchast and revealed R40 hunwitnessed fall in the report, R40 had sheet indicated R40 hunwitnessed fall in the report indicated R40 had implemented at the bowel and bladder coresident was to utilized The report also revealed mentia and macula underlying conditions impaired vision, depresedential plan of action observe the resident's for the next 3 days and specific toileting plan collected. A facility incident report incident report incident resident's for the next 3 days and specific toileting plan collected.	the fall assessment indicated briffort which affected her gait entified R40 was steady and in the hallways. Will e. Onal safety assessment dated t40 continued to be pervision for bed mobility, lation. In different dated taken as a clip alarm when R40 air and in bed at night. Ont dated 8/14/13, at 9:00 and experienced an and in determined to sit floor missing the chair. The had no injuries, that staff colleting plan after a 3 day ollection, and that the ea wheel chair as needed. The aled R40 had risk factors of ar degeneration, as well as of impaired mobility, ession, change in mood, dimpaired cognition. The new as to assess and a normal toileting schedule and then to implement a based on the data	F 32		
M CMS-2567	(02-99) Previous Versions Obs	solete Event ID: CE6911			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		VI APPRUVEU D. 0938-0391	
AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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PELICA	VALLEY HEALTH CE	NTER			11 EAST MILL AVENUE			
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i i a g a a r h a a tr o o a a a a a a a a a a a a a a a a a	the Watchmate (a Complaints of paleg. Staff implement attached to R40's charesident to alert staff transfer or ambulate R40 had risk factors macular degeneration impaired vision, deput behaviors, and impapalan of action indicate placed on R40's when when the resident attachmate by herself. The annual fall risk andicated R40 was attached R40 was attached R41's and assessment indicated R41's and sustained a pelviolation. The annual functional andicated R40 was not obtained a seated to standard off toilet, and duri ansfers. R40 had fur function to lower extense side due to left persessment identified sesist of two persons to trivities of daily living	o the inside of the wrist from Vanderguard bracelet), and ain in her shoulder and left led a clip alarm to be lair and clipped to the for R40's attempts to self. The report also revealed of dementia, knee pain, in, impaired mobility, ression, change in mood, ired cognition. The post fall led a clip chair alarm was el chair to help alert staff empts to transfer or seessment dated 8/29/13, high risk for falls related to ondary diagnosis, impaired forgets limitations. The R40 had experienced two and 8/15/13, and that R40 contacture from the fall on assessment dated 8/29/13, it steady, and was only able in assistance when moving ding position, moving on ang surface to surface remity with impairment on the fall in the remity with impairment on the fall on t	F 3	23				
CI	ip alarm in the chair	and a motion alarm in bed.						
VI CIVIO-2007((02-99) Previous Versions Obs	oloto E un once					Annual Control of the	

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED O. 0938-0391
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			1	P	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 PREF TAG		PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X6) COMPLETION DATE
F 323	Continued From page	ge 19	FS	323			
	a.m. revealed R40 v next to her bed cluto The report indicated	port dated 10/19/13, at 5:30 was found sitting on the floor ching her right upper arm. R40 stated to staff that she	4 <u>.</u>				
	arm. The report indi- inch skin tear on the	I and landed on her right cated R40 had sustained a 1 right elbow and had swelling					
	humerus (upper arm revealed R40 had ris	bone). The report also					
ů.	cognition and judgen awareness, as well a knee pain, environm	nent, impaired safety s underlying condition of					
	post fall plan of actio	d mobility, and balance. The n was to keep R40's bed in R40 was in bed to prevent	**************************************		V 40		
**************************************	Interdisciplinary prog 7/29/13 to 10/21/13 r	ress notes reviewed from evealed:					
	independently in her	sived limited assistance with sfers and she ambulates room and hall. R40 will luring day due to knee pain.					
	any movement, R40 i	ng severe pain today with unable to stand or sit on pain which seemed to be knees.	€:				
í	to her left hip, and have and any weight bearin with all transfers. R40	inued to have severe pain ving difficulty with transfers g. R40 required two assist sent to clinic to be ex-ray. Results from x-ray			ĕ		
M CMS-2563							

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			0	FORM	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	Oi	(X3) DATE	0938-039° E SURVEY PLETED
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NAME OF	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	10/2	25/2013
PELICA	AN VALLEY HEALTH CI	TO A STATE OF THE		211 EAST MILL AVENUE PELICAN RAPIDS, MN 5	66572		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 323	revealed left superior On 8/29/13, R40 hat cares and more income health and strength, movements of lower	ge 20 or and inferior pelvic fracture. s been more dependent with ontinent due to decline in Has severe pain upon any r extremities. At present time llating due to a fractured	F 32		America America (America America Ameri		
	transferring to alert staff transferring to and fr standby to assure sa ambulate in her room independently but stawill assist her dependent to pelvic fracture. At up without any assist resident to keep her standard to her bed clutching tharm/shoulder, and was	form bathroom. Staff to fety. R40 will attempt to an, and in the hall aff are alerted by alarm and ding on her level of pain due times makes efforts to get ance, alarm is connected to safe.					
i i	During observation or R40 was alone in her out loudly, with her being was hanging over floor. R40 wore a blacter and her left hand while she was rocking bed, attempting to get attached to R40's left the cord of the clip wa	n 10/23/13, at 8:45 a.m., room, lying in bed, yelling ed in a low position, her left the side of the bed onto the ex fabric sling on her right was clutching her right arm her torso back and forth in of of bed. A metal clip was shoulder of her gown and s laying over the top of the to attempt to get out of ing out of bed and					

FORM APPROVED

PRINTED: 11/13/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245373 B. WING 10/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 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

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CENTI	ERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0. 0938-039
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		245373	B. WING_		10	0/25/2013
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PELICA	N VALLEY HEALTH CI	ENTER	1	211 EAST MILL AVENUE		
				PELICAN RAPIDS, MN 5657	2	*
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
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F 323	Continued From pa	ne 22				
	Committee of the commit	of the alarm to R40's right	F 32	23		
	shoulder. NA-A ther	exited the area. Prior to this,				
	R40's personal safe	ty alarm was not attached				
	securely to an affixed	ed object for ten minutes				
	while R40 sat in the	recliner unsupervised.	-			
	During continuous o	bservation on 10/23/13, from				İ
	11:12 a.m. to 11:26	a.m., R40 was seated in a		1		
	recliner in the lounge	e area, with her wheelchair				
	sitting next to the rea	cliner and the alarm box				
	attached to the back	of the wheelchair with a				35
	of the string from th	e small metal clip at the end e box was observed laying in				
	the seat of the whee	lchair, not attached to the				
	resident.	ionali, not attached to the				
	At 11:26 a m on 10/	22/42 45 - 12- 4				
	continued to be obse	23/13, the clip alarm erved on the seat of R40's				
	wheelchair next to th	e recliner, not clipped to				
- 1	R40's shirt. During in	terview with NA-R at that				
1	time, NA-B confirmed	d the clip alarm was not				
1	attached to R40, NA-	B proceeded to hook the				
ĺ	Shoulder while the al	e back of R40's right arm box remained attached		-		
- 1	to the back of R40's v	wheelchair. R40's clip alarm				
1	nad not been appropi	riately attached to her shirt				
	ior lourteen minutes v	while she sat in recliner				
	unsupervised.					
1,	On 10/23/13, at 11:30	a.m., registered nurse				
1	(RN)-A confirmed R4	0's current care plan	13	,		
19	directed staff to have	a clip alarm on R40 while				
11	n bed or in a chair. R	N-A confirmed R40 self				
	ransferred at times, a	and was confused. RN-A				
	on 8/15/13 and 10/10	ned fractures after her falls /13. RN-A stated the usual			F.3	
r	practice was to attach	the clip to R40's clothing				
į	owards her shoulder	area and alarm box to be			74	
1						

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				D: 11/13/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				M APPROVE D. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		245373	B. WING			VOT 100 10
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		/25/2013
PELICA	N VALLEY HEALTH CE	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
t t	attached to the whe above the pillow. RI securely attached to On 10/23/13, at 1:53 R40's care plan dire when she is in bed on R40 did attempt to swheelchair to the red On 10/23/13, at 2:08 was to have a clip all and in a chair. NA-B of bed and also did to confirmed the clip was clothing towards her box was attached to bed the box lays on don't think it is secured On 10/23/13, at 2:24 nurse (LPN)-A confirmal arm on while in been has fallen in the past transfer herself occase the clip was to be hoo he alarm box either the when in bed the box in her pillow.	elchair or it rested on the bed N-A stated, "Alarm is not anything." 3 p.m., NA-C confirmed cted staff to use a clip alarm or in a chair. NA-C stated elf transfer from her cliner routinely. 5 p.m., NA-D confirmed R40 arm on when she was in bed stated R40 did try to get out ransfer herself. NA-B as to be hooked to R40's shoulder area and the alarm the wheelchair and when in the bed. NA-D stated, "I ely attached." p.m., licensed practical med R40 was to have a clip d or in a chair because she she stated R40 did try to sionally. LPN-A confirmed oked to R40's clothing and nooked to the wheelchair or s placed on the bed under	F 32			

On 10/23/13, at 11:16 a.m., the assistant director of nursing (ADON) confirmed it would be

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STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED		
		245373	B. WING		10	10/25/2013		
PELICA	PROVIDER OR SUPPLIER N VALLEY HEALTH CE			STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE		
	expected the person attached to R40's cl would be affixed to was in any chair or l indicated attaching to surface would allow trigger the sound of R40's movements. Review of the facility Prevention, dated Offacility would provide secure environment ongoing system for refurthermore, the fact of falls in order to de implement the approvide approvided to the Alert-Mate Alarm known as a "clip alarm attach the alarm by unalarm to the bed, chain out of reach of the refurther indicated a Maused, to insert alarm bed, chair, wheelchait of the resident. R34 had been assess risk for falls, and had fracture. Interventions or the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing, with the opposition of the resonal safety clip all blothing.	nal safety alarms would be othing and the alarm box a secure surface while R40 her bed. The ADON further the alarm box to a secure the clip alarm to detach, and the alarm to alert staff of y policy titled Fall ctober 2007, included: The e a safe, comfortable and for residents, and provide an monitoring residents. illity would analyze incidents termine causal factors and priate interventions. Iter's guidelines undated, for model #SAM-1 alarm, also m," identified techniques to sing Velcro and to affix the air, wheelchair or night stand sident. The guidelines ate holder could also be into holder and attach to r or nightstand, out of reach ed by the facility as high a history of a fall with a sidentified by the facility to included the use of a arm attached to R34's posite end of the cord	F 3	23				
1	R34 had been assess risk for falls, and had fracture. Interventions prevent further falls in bersonal safety clip all blothing, with the opposite	ed by the facility as high a history of a fall with a didentified by the facility to acluded the use of a arm attached to R34's	•					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245373 B. WING 10/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 25 F 323 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

was in bed.

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

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			1	PRINTE	D: 11/13/2013	
CENTERS FOR MEDICARE		·			FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245373	B. WING			10	0/25/2013	
NAME OF PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	1/20/2013	
PELICAN VALLEY HEALTH CEI	NTER	5	2	11 EAST MILL AVENUE			
		- 41	F	PELICAN RAPIDS, MN 56572			
PREFIX (EACH DEFICIENCY N	JMMARY STATEMENT OF DEFICIENCIES I DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	DBE	(X5) COMPLETION DATE	
F 323 Continued From page	e 26	F 3	23				
brief interview for me performed as R34 wa MDS further revealed required supervision, ADL's, and required suring movements fromoving on and off the between bed and a chactivities of daily living general medical condiagnoses and identificassistance with cares. R34 was at high risk for problems, a recent fall anti-anxiety and antide R34's facility fall risk at 12/13/2012, revealed while attempting to get fall assessment dated was at high risk for fall to continue with a bown assess and manage paremote sensor alarm a when R34 was in bed at The facility incident reprevealed R34 was found floor by her bathroom colooking to go to the bathrevealed R34 received scratch to her mid back	as rarely understood. The d R34 made poor decisions, extensive assistance for all staff to stabilize her balance on seated to standing, a toilet and transferring hair. I dated 12/13/2012, for g, revealed a decline in her ition related to multiple ited R34 required more. The CAA further identified for falls related to balance if and the utilization of epressant medication. Assessment dated R34 had a fall 10/25/12, the up to the bathroom. The 1/17/13, identified R34 is and interventions were ell and bladder plan, ain, discontinue use of the indutilize a clip alarm and when in a chair. Boort, dated 3/8/2013, and at 8:15 p.m., on the door. R34 stated she was throom. The report a 5 centimeter (cm) is the intervention illeting after supper and to illeting after s						

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/13/2013 MAPPROVED				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED				
		245373	B. WING		40	/25/2013				
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE						
PELICA	N VALLEY HEALTH CE	ENTER		211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572						
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	JLD BE	(X6) COMPLETION DATE				
	analysis of the fall in had impaired mobili arthritis and was not She was impulsive a needed extensive as had a clip alarm to a transfers. The facility incident revealed R34 was for her room on her side her head. R34 had no cause analysis of the R34 had dementia the physical limitations. Imobility and poor physicated the clip alanew intervention was pad the outer edge of	dentified the following: R34 ty related to rheumatoid to oriented to her own abilities. and unaware of safety. She sist of one for toileting and alert staff to independent report, dated 3/30/13, and resting on the floor in with hands tucked under o apparent injuries. The root of fall identified the following: nat prevented insight into her R34 had arthritis with limited sysical strength. The report rm had been utilized, and a to place a foam "noodle" to f the bed to give the clip ance to catch movement."	F 3:	23		Sun and a sun and a sun and a sun and a sun a su				
	a.m., in the facility diresident witness who walked to another din resident with a tray, to chair, and fell on the factorial and severe right to touch. Ice was apply Morphine given with stubsequently admitted severe right hip pain a	and on the floor at 10:30 ining room with another stated R34 got up and ing table to help another urned to go back to the floor. The report revealed hip pain and stated it hurt lied to the right hip and				e .				

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

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			P		D: 11/13/2013 M APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) D/	O. 0938-0391 ATE SURVEY DMPLETED
		245373	B. WING		<u> </u>		
NAME O	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1	0/25/2013
PELICA	AN VALLEY HEALTH CE	ENTER		1	211 EAST MILL AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PELICAN RAPIDS, MN 56572		· · · · · · · · · · · · · · · · · · ·
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pag	ne 28	-			-	
		vareness deficit. R34	F3	323	3		
	appeared to forget t was too painful for h	hat she was too weak and it					
	The fall risk assessi	ment dated 4/24/13, revealed					
	was at continued hig	ne hospital on 4/22/13 and the risk for falls, was					
	cognitively impaired	and resistive to cares and					
	R34 did not ambulat	The assessment identified e, transferred with the assist			•		
	or one to two, and ha	ad chronic pain from					
	was to continue with	The plan for fall prevention previous measures.					
	The facility incident r	report dated 5/2/13, revealed e floor in her room at 2:10					
	a.m. There were no i	njuries noted. The root					
	cause analysis revea impaired mobility and	led the following: R34 had pain due to fracture of the					
	right hip on 4/20/13.	Her cognition was impaired					
	due to a diagnosis of had judgement/safety	senile dementia. R34 also awareness deficit and did		ĺ			
	not know her own lim	itations. The intervention					
	initiated was to change	le R34's bed to one lower to fall mat next to the bed					
-	made to absorb impa	ct in the event of another					
	fall, and keep the clip	alarm on in bed and chair.					
	The facility incident re	eport dated 9/13/13,					
	revealed R34 fell from another resident atten	n a recliner lift chair when opted to assist her out of					
	the recliner chair. R34	received 2 scratches on					
1	her mid back and left	buttock and on the left cm pink area. The root					
1	cause analysis of the t	fall revealed the following.			•		
	୯୪4 nad an underlying	diagnosis of senile toid arthritis and a history					
	of falls making her an	increased risk for falls.			•		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245373 B. WING 10/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 29 F 323 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

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			F	PRINTE FOR	D: 11/13/2013 M APPROVED	
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	PROVIDER OR SUPPLIER N VALLEY HEALTH CE	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	<u> </u>	0/25/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From page	ge 30	F 32	23				
	alarm attached to he of attempt to indepe	routinely checked during o hour rounds and had a clip er night clothes to alert staff ndently transfer. The r identified R34 would times.						
	been irritable. Orders	able to verbalize needs, was and aggression and had swere obtained for an lication and to evaluate for and restlessness.	4				·	
i i i i	sitting up and removing required extensive as bathroom. R34 was nand staff was required provide them due to down and staff was clipped to her niglowest position, and a floor next to bed "for lepisodes, climbing our remove the clip alarm."	s night R34 was found ing clip safety alarm. R34 sistance to ambulate in the sever using the call system d to anticipate needs and dementia. A safety alarm shtgown, the bed was in a safety mat was kept on her history of restless it of bed and falling. Will and hide it under her se her time, staff have been oon as alarm has						
s a c a	arety mat was placed larm was attached to ontinued to have a hi	s kept in lowest position, a						

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER N VALLEY HEALTH C	ENTER		211	EET ADDRESS, CITY, STATE, ZIP COE EAST MILL AVENUE LICAN RAPIDS, MN 56572	DE I.	10/25/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLE		
	9/13/13- R34 had a out of the recliner. back and left buttoo cm around. No other systems are stless, digging get out of bed, transangry at staff. R34 alarm to alert staff or During observation R34 was observed a recliner lift chair in the fact of the back of R34's alarm box with UMF above R34's head of the recliner and was the recliner and was the recliner and coulc chair. During continuous of 4:01 p.m. on 10/22/17 room in the recliner on the above her head. At 1:50 p.m., R34 rego see the TV, the alarm position, loose the chair. The alarm at 2:38 p.m., R34 was alarm. R34 was alarm box with the alarm.	scratches to her skin and cks with a pink raised area 4 er injuries apparent. when R34 had poor sleep she ig in drawers, attempting to sfer to a standing position, had a personal safety clip when she was restless. on 10/22/13, at 1:17 p.m., seated in a brown overstuffed the facility TV lounge. The ned and R34's feet were on al clip on a cord was attached a sweater, however, the white plettering was loosely placed in the top edge of the back of a not affixed to the fabric of all move freely from the servation from 1:17 p.m. to 13, R34 was seated in the TV chair with the alarm box to be top edge of the chair positioned herself to the right farm box continued in the ly resting, and not affixed to did not sound. The resting in the chair, the resting on top of the recliner in the resting on top of the recliner.	F3	23				
							1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245373	B. WING			10/	25/2013
	F PROVIDER OR SUPPLIER AN VALLEY HEALTH CE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 111 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	1 10/	20/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 323	At 2:56 p.m. NA-C then proceeded to w NA-C did not check	briefly approached R34 and valk out of the lounge area. the alarm box which top of the recliner headrest.	F3	323			,
1	R34's clip alarm box the box was not affix further confirmed the clip the alarm box to	and the surveyor examined and LPN-B confirmed that ked to R34's chair. LPN-B at usual practice would be to a surface which would allow detach if R34 attempted to tly.					:
	7:03 a.m. to 8:50 a.m. room in bed on her le safety alarm was clip nightgown, however, resting on the mattre not affixed to any sur tab to detach and trig	continuous observation from m., R34 was lying in her eft side. R34's personal oped to the back of her the alarm box was loosely as above the pillow, and was afface to allow the magnetic ger the personal safety ed to transfer independently:					
	bed for R34 to take the box slid down the heaplaced the alarm box	pproached R34 with a RN-A raised the head of the ne medication and the alarm ad of the bed. RN-A then under R34's pillow, bx was not affixed to any					
	attempt to get out of I personal safety clip a	tated R34 did frequently bed independently and the larm was utilized to alert s attempting to get out of bendently.					

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(VA) ID	SLIMMARYSTA	FEMALE OF PERIOR LOS			PELICAN RAPIDS, MN 56572		
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F 323	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.		F3	323	3		
	was not in place. She have a personal safe times when in the chaimmediately left the dwith R34's safety alar	t aware R34's safety alarm confirmed R34 was to ty alarm attached at all air or in bed. The ADON lining room and returned m box and proceeded to	,				
1	rrequently attempted to out of the wheel chair stated the usual place R34's personal safety place the box loosely R34. NA-D further stat the alarm box when in	a.m., NA-D stated R34 to get out of bed or get up independently. NA-D ment of the alarm box for alarm while in bed was to on the mattress behind ted the usual way to place the recliner chair was to on the recliner or clip it to					
(On 10/23/13, at 10:06	a.m., NA-B stated R34					

DEP	ARTMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 11/13/201
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NAME	OF PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10	/25/2013
PELIC	AN VALLEY HEALTH CI	ENTER	- 1		EAST MILL AVENUE		
(X4) II	SUMMARYSTA	TEMENT OF DEFICIENCIES		PE	LICAN RAPIDS, MN 56572		= -
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F 32	3 Continued From page	ne 3/					
	The state of the pay	d to get up from the recliner	F 32	23			
	chair by swinging le	gs over the edge of the chair				4	
	Out of the chair was	t time R34 attempted to get approximately 2 weeks prior.		1			
	NA-B stated R34 al	so frequently attempted to					
	get out of bed indep	endently, the last time was					
	of the personal safe	stated the usual placement ty alarm box when R34 was					
	in bed was to lay it o	on the mattress behind R34's					
nead. NA-B indicated		d the alarm box was not but loosely placed on the			#		
	mattress.	but loosely placed on the				50	
	and indicated R34 ha	0 a.m., NA-A stated R34 o lean forward in the chair ad an alarm on the wheel any attempts to transfer					
	On 10/23/13 at 10:36	a.m., RN-A confirmed R34			G#1		
	was frequently restles	ss at night and made					
	attempts to get out of	bed independently DN A				`	
	were the reason for th	's attempts to self transfer ne low bed, floor mat and					
	safety alarm.	, we are much and				Ĭ.	
	On 10/23/2013 at 11··	16 a.m., during review of			4		
	R34'S Tall reports and	fall assessments the			€ 2		
45	ADON confirmed the	current care plan for R34					-
	safety clip alarm attac	was to have a personal ched when in bed or a chair.					
	The ADON further cor	ofirmed R34 was at high					
	risk for falls and had facture in the past. The	allen and sustained a ne ADON also confirmed it					
, i	would be expected that	at the personal safety					
	alarms would be attac	hed to R34's clothing and	**				
	the alarm box would b surface while R34 was	e affixed to a secure in any chair or her bed.				(11)	
		or not bed.					1.97

1	DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 11/13	3/2013
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ST	FATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D	ATE SURVI	EY
			245373	B. WING					
٨	NAME OF	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	1	0/25/201	3
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	F 323	The ADON indicated magnetic tab to deta	ge 35 If this would allow the ach, and trigger the sound of aff of R34's movements.	F 3.	23				
		the personal safety a	p.m., the director of nursing allation and instructions for alarms. DON confirmed the ection to secure the alarm surface.						
		techniques to attach	rer's guideline instructions d monitor identified the alarm to a non movable chair strap and a mounting			e e	6		1
		manufacturer's representative p.m., a representative Products company state be firmly affixed to a company and be firmly affixed to a company to the products are the products and the products are the products and the products are the products are the products are the products are the products are the products are products br>products produ	whone response from the sentative on 11/5/13 at 4:15 of the Universal Medical ated the alarm box was to chair or bed to allow the roken between the monitor			*			
72	f p a	provide an ongoing sy	ober 2007, revealed the ongoing assessments, and stem for monitoring and falls in order to determine	04				-	
	a	.m., after verification	dy that began on 10/23/13, oved on 10/25/13, at 10:24 of staff education, training nent of all residents at risk devices.	\$		be .			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 11/13/20	01
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	E1
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		245373	B. WING _		10/25/2012	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	10/25/2013	-
PELICA	N VALLEY HEALTH CE	ENTER	1.			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PELICAN RAPIDS, MN 56572 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC	NC
F 323	Continued From page	ge 36	F 32	3		
1	and osteoporosis. The state of the care plan revise the at risk for falls with interventions which in reach and reinforce upont on all arm at night.	d 8/25/13, identified R31 to				
fr n p re fr n	NA-G assisted R31 to both feet on the raise R31's lap and arms whetal clip with cord a roceeded to place all ecliner next to R31's rom the area. The peot securely attached uring observation on	n on 10/23/13, at 10:44 a.m. o sit in a recliner and place d foot rest. NA-G covered ith a blanket, attached a ttached to her shirt then arm box on the seat of the thigh. NA-G walked away rsonal clip fall alarm was to a stationary surface.				
m ne cli	oving the blanket aw eeded to go see." Du	recliner and began yay from her legs stating "I ring this movement the of the chair, and hit the	1.55	* ***		
LF	IN-A confirmed the d	n 10/23/13, at 1:49 p.m. lip alarm box was sitting in 1's left side between her			Se	

thigh and the recliner arm and not attached to a

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245373 B. WING 10/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 323 Continued From page 37 F 323 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.

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 11/13/2013
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NAME OF	PROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	11	0/25/2013
PELICA	N VALLEY HEALTH CE	ENTER		211	EAST MILL AVENUE LICAN RAPIDS, MN 56572		4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
r r tt	dated 8/25/13, identicommunication due needed extensive as transfers, ambulation Review of the falls ri 8/25/13, identified Ri and was not always of due to impaired cognidentified R31 had no place to prevent falls plan of care. During an interview of RN-D confirmed the cand indicated the clip R31 fell to alert staff to leaning over, or attrictair since she was a The Standard Monitor referred to as a "clip an annufacturer's instruction attach the alarm to with use of a chair strator the bed. 39's personal safety ecurely attached and each.	onal/safety assessment ified R31 had altered to Alzheimer's disease, sist of one or two for n, toileting. sk assessment, dated 31 remained at risk for falls cooperative with ambulation nition. The assessment umerous interventions in and would continue same on 10/23/13, at 4:08 p.m. current care plan for R31 alarm was started after of the potential to fall due tempting to get out of the mbulatory in the past. T (MDT8400) alarm alarm undated ctions identified techniques a non movable surface, ap and a mounting bracket alarm unit was not was within the resident's	F 3:	23	DET IOIENCY)		
R	39's diagnoses includ	led dementia, history of a surgical repair of a			# # # # # # # # # # # # # # # # # # #		

fractured right femur on 3/12/13, after a fall out

DEPAR	RTMENT OF HEALTH	H AND HUMAN SERVICES			FORM	D: 11/13/201 M APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO	D. 0938-039 TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIF 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	CODE	/25/2013
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i i i i i i i i i i	of bed at home. The indicated R39 had sand required extens ADL's. The CAA dat dependent in all ADI and cognitive deficit R39 was at risk for for the care plan, revisinad potential for injuction, history of fractured right hip, voter assist with transfecare plan included voincluded call light has and walking and clip wheelchair to alert store a loud noise art floor in the middle of indicated she hit her injury noted. The root R39 had impaired moright femur fracture. For cognition, judgement and the code in place at that time in socks while in bed, are now limitations.	e MDS dated 3/27/13, severely impaired cognition sive assistance from staff for ted 4/3/13, indicated R39 was bus related to recent fracture to the CAA also indicated that	F 323	3		

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.

D	EPAF	RTMENT OF HEALTH	AND HUMAN SERVICES): 11/13/2013
<u> </u>	ENIE	ERS FOR MEDICARE	& MEDICAID SERVICES	<u> </u>				APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245373	B. WING					
NA	ME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	10/25/2013	
PE	PELICAN VALLEY HEALTH CENTER					211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572		
P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
F		were to continue alabed in lowest position next to bed. Also, Rawhen by nurses desikeep an eye on her. The fall risk assessm R39 remained at risk falls, secondary diag devices, weak gait/tralimitations. The plan fall interventions as considered in the considered on pillow on R39's left signal and the considered to a surface. On 10/23/13, at 8:22 alarm unit had been reliable to be so the considered to a surface.	rms to wheelchair and bed, in and a padded mat on floor 39 was to sit in wheelchair or it in a recliner so staff could ment dated 9/27/13, identified a for alls related to history of nosis, use of assistive ansferring and forgot at that time was to continue direction on the care plan. a.m. R39 was observed MART" personal safety the mattress next to the de. arm was attached to R39's equit was not securely	F 3	323			
i.	v C C u	opplied personal safet when alarms were utilion on 10/23/13, at 8:25 a are plan and confirms p at the edge of her b at risk for further fall	ized in bed. a.m. RN-A confirmed R39's ed R39 does attempt to sit ped. RN-A confirmed R39 is and stated the alarm is					
•	O th	o alert staff that she is on 10/23/13, at 2:24 p ney have assignment	m. NA-B reported that sheets that let them know larms, then NA-B stated	N.				

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		A MILDICAID SERVICES			omb nc	0. 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572	1 10	12012013
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i i i i i i i i i i i i i i i i i i i	apply the alarm or to the undated Smart Installation and Use make certain the meand out of the reside effectiveness of this entirely on the direct response by the care Failure to compy [sizesult in injury or det 483.35(i) FOOD PRESTORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/STORE/PREPARE/STOR	Caregiver Corporation Instructions indicated to conitor is securely attached ent's reach. The monitoring device relies to supervision and immediate egiver to this monitor's alert. Color with this warning may eath. OCURE, SERVE - SANITARY In sources approved or corp by Federal, State or local distribute and serve food cions. Is not met as evidenced on interview and document led to implement sanitary the spread of food born handling ready to eat foods of pans in the kitchen. This the potential to affect all 33 the facility.	F 371	3	repare, ary th Staff ditions, I follow ge of o ately to ality	12/3/13
	on 10/24/13, at 8:56	a.m. the cook (C)-A was				

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				D: 11/13/2013
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	reached into a carto and poured the raw water. She immedia with her bare hands and placed the brea a.m., with her soiled the two slices of toas plate. She continued of boiling water, rembread bag and put in hands for the entire of cands for the entire of sanitizing her hands. On 10/24/13, at 9:25 handled the bread arafter cracking raw eghands or applying glotypically used tongs for the entire of the plant is touched, then shat is touche	the dining room, preparing With her bare hands, C-A on, cracked open a raw egg egg into a pan of boiling tely picked into a plastic bag, removed two slices of bread d into the toaster. At 8:58 bare hands, C-A removed st and placed them on a late to crack raw eggs into a pan love bread slices out of the lot toaster with her bare observation until 9:02 a.m. and toast using her bare observation, without or wearing gloves. a.m. C-A confirmed she and toast with bare hands gs without washing her loves. C-A stated she for getting bread out of the of the toaster. C-A reported your hands after each item stated they would need to do it correctly and they staff for that. p.m. the kitchen tour our large pans placed on a pans were separated, each	F 3			

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F 497 SS=E	and pans in the past handling bread and was not acceptable. staff to use gloves witems. The policy titled Handirected staff to was between working witeready to eat food. The facility Employed ated 2005, indicated to handle food. The facility Washing Policy undated, indicated to handle food. The facility Washing Policy undated, indicated to handle food. The facility Washing Policy undated, indicated to handle food. The facility Washing Policy undated, indicated to feeling of wetness. 483.75(e)(8) NURSE REVIEW-12 HR/YR ITHE facility must compose a feeling of the in-service sufficient to ensure the facility was and must propose a feeling of the in-service sufficient to ensure the facility was and must propose a feel the facility was address are determined in nurse a feel may address the facility was address	ted on proper storing of pots i. The DM also confirmed raw eggs with bare hands She stated she would expect when directly handling food Id Washing dated 2005, In hands when switching In raw food and working with Be Sanitary Practices Policy Id staff were to use utensils and Storage of Dishware ated that dishware should Is fully dry and has no sign AIDE PERFORM INSERVICE In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance review It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 12 In plete a performance reviews It least once every 13 In plete a performance reviews It least once every 14 In plete a performance reviews It least once every 15 In plete a performance reviews It least once every 16 In plete a performance reviews It least once every 17 In plete a performance reviews It least once every 18 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once every 19 It least once	F 49	F497 Pelican Valley Health Center complet performance reviews for every nursin assistant at least every 12 months and	riews.	12/7/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245373 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 497 Continued From page 44 F 497 This REQUIREMENT is not met as evidenced 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

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ta	F 503 SS=C	received eight hours. This was four hours. NA-L was hired by the of training records received any of the received any of the reducation. On 10/24/13, at 5:11 administrator confirms stated the continuing assistants had not be date of hire for the enfurther stated the facilitation calendar year to track employees and this we 483.75(j)(1)(i-iv) LAB REFERRED, AGREE of the facility provides the services must meet requirements for laborates of this chapter. If the facility provides the services, it must meet equirements for laborates of this chapter. If the laboratory choose esting to another laboratory must be certification and subspecialities and subspecialities and subspecialities.	de facility on 1/30/12. Reviewe le facility on 1/30/12. Reviewe le facility on 1/30/12. Reviewe le facility on 1/30/12. Reviewe le facility on 1/30/12. Reviewe le facility on 1/30/12. Reviewe le facility le facility le facility le facility le facility le facility le facility le facility le facility le facility le facility had been using the facility had been using the facility had been using the facility had been using the facility had been using the facility had been using the facility had been using the facility had been using the facility le facilit	F 503	97	Center does not vices on site but e obtained from a e applicable ninistrator has th of Pelican en agreement The Administrator s annually to	12/1/13

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F 50	If the facility does non site, it must have these services from	ge 46 of provide laboratory services an agreement to obtain a laboratory that meets the ents of part 493 of this	F ŧ	503			
	Based on inferview, laboratory testing wit provide outside labor	T is not met as evidenced the facility was providing hout a written agreement to ratory services for residents ad the potential to affect all in the facility.					
	agreement to provide services. The facility services from an outs laboratory staff to the	was conducted on 10/24/13. le to provide a written outside laboratory received laboratory ide agency. The clinic sent facility to do draw lab work ek to the clinic to be tested.					
e e	On 10/24/13 at 4:05 p confirmed the facility agreement and stated to the clinic next door	.m. the administrator did not have a written the facility sends residents or the emergency room.			F509 Pelican Valley Health Center does not provide diagnostic services on site but ensures that services are obtained from		12/1/13
F 509 SS=C	If the facility provides the services must mee	NOSTIC SVCS - MEET MENTS its own diagnostic services, of the applicable conditions pitals contained in §482.26	F 509	9	another provider that meets the applicable requirements. The Administrator has contacted Sanford Health of Pelican Rapid to obtain a written agreement for diagnost services. The Administrator will review all contracts annually to ensure compliance is achieved and maintained.	ds tic	

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		S MILDIO/ ND OLIVIOLO			DMB NO). 0938-039	91
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F 509	of this subchapter. If the facility does no services, it must have these services from	ge 47 of provide its own diagnostic re an agreement to obtain a provider or supplier that is these services under	F 50	9			
	by: Based on interview, an written agreement services. This had the residents who resident Findings include: An extended survey of the services of the service	was conducted on 10/24/13					
	services and received agency called Essent unable to provide a w Medicare approved si	ovide its own diagnostic d services from an outside ial Health. The facility was ritten agreement with a upplier.		# ± 5		5	
F 519	On 10/24/13 at 4:05 p confirmed the facility agreement for radiolog the facility sends residue the emergency room 483.75(n) TRANSFERHOSPITAL	did not have a written gy diagnostic and stated lents to the clinic next door m.	F 519	Pelican Valley Health Center ensures residents needing emergency care are to an Emergency Room to receive appropriate treatment. The Administration has contacted four area hospitals to of	sent ator	12/1/13	
	racility (other than a ni ocated in a State on a nave in effect a writter	ction 1861(I) of the Act, the ursing facility which is in Indian reservation) must a transfer agreement with approved for participation	**	written transfer agreements with Esser Health Fargo, Essentia Health St. Mar Detroit Lakes, Lake Region Hospital Fergus Falls and Sanford Hospital Far The Administrator will review the tranagreements annually.	ntia ry's		

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES						D: 11/13/201
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t I b I what a F Duil oil according a principle oil according a princi	transferred from the ensured of timely ad transfer is medically by the attending phy other information ne of residents, and, who deems it appropriate such residents can be less expensive setting the hospital, will be expensive setting the hospital, will be expensive setting the hospital in effect in good faith to enterphospital sufficiently consider a feasible. This REQUIREMENT by: Based on interview, the properties of the provide a wind the provide a wind market timely to a hospitals, to a dimitted timely to a hospitals.	and Medicaid programs that that residents will be facility to the hospital, and imission to the hospital when appropriate, as determined sician; and medical and eded for care and treatment ten the transferring facility, for determining whether e adequately cared for in a gight that either the facility or exchanged between the ered to have a transfer of the facility has attempted into an agreement with a lose to the facility to make is not met as evidenced the facility failed to ensure a ment with one or more the had the potential to affect and in the facility was inten agreement with one assure residents would be ospital when medically	F 51	9				
0	n 10/25/13, at 9:15 a	.m., the administrator						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/13/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245373 B. WING 10/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 49 F 519 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CF6S11

Facility ID: 00442

If continuation sheet Page 50 of 50

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 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245373 10/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 EAST MILL AVENUE PELICAN VALLEY HEALTH CENTER PELICAN RAPIDS, MN 56572 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY PICOK 13-13 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 1 n 2013 CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** IN DEPT, OF PUBLIC SAFETY Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Director ZXCCUTIVE

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.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245373	B. WING			10/2	24/2013
	PROVIDER OR SUPPLIER VALLEY HEALTH C	ENTER		2'	TREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST MILL AVENUE ELICAN RAPIDS, MN 56572		12
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s Barbara.Lundberg@ Fax Number 651-2° THE PLAN OF COP DEFICIENCY MUS' FOLLOWING INFO 1. A description of w to correct the deficie	tate.mn.us and Destate.mn.us 15-0525 RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done	K	0000	•		
	The Pelican Valley I constructed at 4 diff building without a babuilding was built ar Type II (111) construthe with a clinic build the building was cornorth of the clinic bube Type II (000) conoffice/ family room a the north of the 1963 determined to be Tyconnecting link to the building to the north north of the 1996 ad be Type V (111) confrom the assisted liv barrier. The building	dection and monitoring to note of the deficiency Health Center was deferent times and is a 1-story desement. In 1951 the original and was determined to be of ction (it is the lower level of ching). In 1969 the majority of distructed to the west and dilding and was determined to struction. In 1996 a business addition was constructed to					

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		& MEDICAID SERVICES			OMB NO. 0988-0	1391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	iple construction 10 01 - Wain Building 01	(X3) DATE SLIPVEY OGMPLETED	
NAME OF	DROVIDER OF SUPE	245373	B. WING _		10/24/2013	3
PELICA	PROVIDER OR SUPPLIER N VALLEY HEALTH CE			STREET ADDRESS, OITY, STATE, ZIP CODE 211 BAST MILL AVENUE PELICANIRAPIOS, MN 56572		No.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREPIX TAG	EROVERT AS OF CONSECUTE (EACH CONTROL ACTION SHOULD ORGEN REPERBIGION TO THE APPROXIMATION OF THE APPROXIMATION OF THE APPROXIMATION OF THE APPROXIMATION OF THE APPROXIMATION OF THE APPROXIMATION OF THE APPROXIMATION OF T	IN DEBE COMPLE PRIATE CATE	TIGN
K 000	accordance with NF Installation of Sprink The facility has a ma corridor smoke deter building in accordant National Fire Alarm (PA 13 Standard for the der Systems 1999 edition. anual fire alarm system with ction in the 1969 and 1996 are with NFPA 72 "The	K 00			\
5	all rooms required by Code 2007 edition at fire department notifi The facility has a car	of the Minnesota State Fire and is monitored for automatic cation.		K038 Pelican Valley Health Center ensu	11/25/1	L3
	census of 37 at the ti Because the original 1969, 1996 and 2002 sprinkler protected ar requirements of NFP.	me of the survey. 1951 building, and the additions are completely ad all meet the construction A 101 "The Life Safety are complex was surveyed as	(영) 전 전 위	that it will protect and follow all Li Safety Code Standards. The locked exit doors will now ren unlocked after a fire alarm, loss of power or sprinkler activation. A	fe	
K 038 N SS=F E	NOT MET as evidence NFPA 101 LIFE SAFE Exit access is arrange	2 CFR Subpart 483.70(a) is ed by: ETY CODE STANDARD ed so that exits are readily in accordance with section	K 038	manual key switch has been install to relock the doors. The codes to open the locked exit doors will be kept posted by each at all times. The Environmental Director will be responsible for keet these codes posted.	door	***
st	Based on observation taff, it was determine ot in accordance with	ot met as evidenced by: as and an interview with d that 2 of 4 exit doors are NFPA 101 The Life Safety 3 and the Centers for				36

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MIXIN BUILDING 01 B. WING		(X3) DAT	(X3) DATE BURVEY COMPLETED	
		245373			40		
	PROVIDER OR SUPPLIER N VALLEY HEALTH C	ENTER	21	rreet abdress, oity, state, zip 14 east will avenue Elican Ratios, wh ever2	CODE	4388810	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		中代の何义 (仮名が出版的に対象を対象 X (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)		CHRECTION IN GHOULD BE B APROPRIETE	OGNITION BARE	
K 038	residents, any visito situation.	ge 3 Services (CMS) informational practice could effect all 40 irs and staff in an emergency	K 038				
	that: 1) The south and ea against egress with each door in according formational letter, I the code to open the	n interview with the Director of the facility tour on October :00 pm and 2:30 pm revealed st exit doors are locked a key pad release device at ance with the CMS nowever the sign indicating doors had been removed,		A 2	**************************************	20.00	
v e s	and 2) It could not be ver doors can only be re- vithin the unit after b darm activation, loss	ified that the locks on the exit activated manually from eing released by the fire of power or sprinkler required by the Minnesota	-:		93	i B	
	hese deficient pract pirector of Maintenan uring the facility and	ces were confirmed by the ce and the Administrator at the time of exit.	8 2	e a e	E .		
ş ð	g (60)	20		E1 25 25 25 25 25 25 25 25 25 25 25 25 25			
	3 A A A A A A A A A A A A A A A A A A A	- 147 - 12	.e	¥ *1			