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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EY5V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**

2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NEII — 01/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 02/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/17/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5495

On December 22, 2014 a health Post Certification Revisits (PCR) was completed and verified correction of deficiencies not corrected at the November 25, 2014 PCR. Based on the health revisit, it was determined that the facility had obtained substantial compliance, effective December 15, 2014. As a result of the visit, this Department discontinued the Category 1 remedy of State monitoring, effective December 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of November 26, 2014:

-Mandatory denial of payment for new Medicare and Medicaid admissions (MDPNA) effective December 18, 2014, be rescinded. (42 CFR 488.417 (b))

Furthermore, since MDPNA didn't go into affect, the two year loss of NATCEP is also rescinded.

Refer to the CMS 2567b for the result of this visit.

Effective December 15, 2014 the facility is certified for 109 skilled nuring facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245495
February 6, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

Dear Mr. Roche:

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 15, 2014 the above facility is certified for or recommended for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 102 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.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 6, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495023

Dear Mr. Roche:

On October 10, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 15, 2014. (42 CFR 488.422)

On January 2, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 18, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of January 2, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from NO DATA.

This was based on the deficiencies cited by this Department for a standard survey completed on September 18, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 25, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 22, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 25, 2014, as of December 15, 2014.

As a result of the revisit findings, the Department is rescinding the Category 1 remedy of state

monitoring effective December 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 8, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 18, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 18, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 18, 2014, is to be rescinded.

In our letter of October 8, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 18, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 15, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Sent via email on February 11, 2015

February 11, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

Re: Project # S5495023

Dear Mr. Roche:

On November 25, 2014, 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 September 18, 2014 with orders received by you on October 14, 2014.

State licensing orders issued pursuant to the last survey completed on September 18, 2014 and found corrected at the time of this November 25, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on September 18, 2014, found not corrected at the time of this November 25, 2014 revisit and subject to penalty assessment are as follows:

21990 - MN St. Statute 626.557 Subd. 4 -- Reporting - Maltreatment Of Vulnerable Adults - $100.00

The details of the violations noted at the time of this revisit completed on November 25, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **$100.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected.

This written notification shall be mailed or delivered to the Department at the address below:

Brenda Fischer, Unit Supervisor
St. Cloud Survey Team A
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Brenda.fischer@state.mn.us

Phone: (320) 223-7338
Fax: (320) 223-7348

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of

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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

5495s15paltr

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building B. Wing	12/22/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	12/15/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	12/15/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 1/6/2015	Signature of Surveyor: 33562	Date: 12/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/18/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

AH Form Approved

12/29/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00299	A. Building B. Wing	12/22/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21990 Reg. # MN St. Statute 626.557 Subd. 4 LSC	Correction Completed 12/15/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	1/6/2015	33562	12/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/18/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EY5V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**

2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NEII — 12/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 02/05/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/05/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/17/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5495

On October 30, 2014 and November 25, 2014, health and life safety code Post Certification Revisits (PCR) were completed, Based on the health revisit, it was determined that the facility had not obtained substantial compliance. The following health deficiencies were not corrected:

F0225 - S/S: D - 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 - S/S: D - 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

As a result of the revisit findings, this Department imposing the Category 1 remedy of State monitoring, effective December 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of November 26, 2014:

-Mandatory denial of payment for new Medicare and Medicaid admissions (MDPNA) effective December 18, 2014 remain in effect. (42 CFR 488.417 (b))

If MDPNA goes into effect, the facility would be subject to a two year loss of NATCEP, beginning December 18, 2014

Refer to the CMS 2567b and CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 10, 2014

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495023

Dear Mr. Roche:

On November 26, 2014, we informed you that we were recommending to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 18, 2014. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of November 26, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 18, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on September 18, 2014. However, at the time of the November 26, 2014 notice, compliance with the health deficiencies had not yet been verified . The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On November 25, 2014, the Minnesota Department of Health completed to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant a standard survey completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2014. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on. The deficiencies not corrected are as follows:

F0225 - S/S: D - 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 - S/S: D - 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

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

As a result of the revisit findings, this Department is imposing the Category 1 remedy of State monitoring, effective December 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of November 26, 2014:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 18, 2014 remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of October 6, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 18, 2014.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud Survey Team A
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Brenda.fischer@state.mn.us

Phone: (320) 223-7338
Fax: (320) 223-7348

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2385

December 11, 2014

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495023

Dear Mr. Roche:

On November 26, 2014, we informed you that we were recommending to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 18, 2014. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of November 26, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 18, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on September 18, 2014. However, at the time of the November 26, 2014 notice, compliance with the health deficiencies had not yet been verified . The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On November 25, 2014, the Minnesota Department of Health completed to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant a standard survey completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2014. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on. The deficiencies not corrected are as follows:

F0225 - S/S: D - 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 - S/S: D - 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

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

As a result of the revisit findings, this Department is imposing the Category 1 remedy of State monitoring, effective December 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of November 26, 2014:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 18, 2014 remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of October 6, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 18, 2014.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud Survey Team A
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Brenda.fischer@state.mn.us

Phone: (320) 223-7338
Fax: (320) 223-7348

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's Poc if the Poc is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's Poc will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the Poc must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your Poc for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable Poc and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 26, 2014

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495023

Dear Mr. Roche:

On October 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 30, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on September 18, 2014.

However, compliance with the health deficiencies issued pursuant to the September 18, 2014 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 18, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 18, 2014. They will also notify the State Medicaid Agency that they

must also deny payment for new Medicaid admissions effective December 18, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Evergreen Terrace is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 18, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification Revisit (PCR) was completed, on November 25, 2014 to follow up on deficiencies issued related to the recertification survey on September 18, 2014. Deficiencies were reissued as part of this post certification revisit. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	{F 225}		12/15/14

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

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure alleged allegations of abuse, neglect, inquiries of unknown origin were immediately reported to the state agency for 2 of 5 residents (R85, and R183) allegations reviewed. Findings include: The facility Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The Administrator...must be informed of all incidents and internal investigations immediately. Report all alleged violations...to the State of Minnesota as required...immediately. All staff are required to report suspected maltreatment of a vulnerable	{F 225}	Immediate Corrective Action: DON/Designee, (LPN)-A and Activities Director (AD-A) were counseled for failing to ensure timely notification according to facility abuse prevention plan. Corrective Action as it Applies to Others: The policy and procedure "Evergreen Terrace Abuse Prevention Plan" was reviewed and amended on 11/27/2014. Staff will be educated on the timely reporting to the administrator and OHFC by 12/15/14. Staff will be re-educated on the revised policy by 12/15/2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 2 adult to Administrator, Director of Nursing, if they are not in the building report to the Nursing Supervisor, at the time of suspicion." R85's annual Minimum Data Set (MDS) dated 10/21/14, indicated she had dementia was severely cognitively impaired and needed extensive assist of one with activity of daily living (ADL's). R85's care plan dated 11/06/14, indicated her short term memory was impaired and had diagnosis of Alzheimer disease and dementia with depression. The care plan further indicated staff to monitor for confusion or delirium and evaluate. The facilities incident form Evergreen Terrace dated 11/17/14, indicated at 5:30 p.m. "when resident woke up- staff got her changed and noticed a 6" length x 2.5 " width scratch/abrasion on her right shoulder." The report further indicated the director of nursing (DON) received a message on 11/17/14, at 9:25 p.m. The report did not indicate if the state agency was notified of the allegation. A interview statement was attached to the report which indicated "I was getting res ready for bed. When I was changing her top I noticed a red scratch that I hadn't seen before I let the trained medical assistant (TMA) know right away." During interview 11/24/14, at 2:26 p.m. licensed practical nurse (LPN)-A stated she was aware of the incident that occurred on 11/17/14 and she just looked at the area today and thought the abrasion was due to her bra clasp and that she had pushed the clasp back to prevent anymore injury. During interview 11/25/2014, at 8:05 a.m. the	{F 225}	Recurrence will be prevented by: Audits will be conducted daily (Monday-Friday) of all alleged violations involving mistreatment, neglect, abuse or injuries of unknown origin and/or misappropriation of resident property to ensure incidents were reported in accordance with facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. Dated of Completion: 12/15/2014 The Correction will be monitored by: Administrator or Designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 3 DON stated she was informed of the incident on 11/17/14 when it occurred. The DON further stated it was a large abrasion and the incident should have been immediately reported to the state agency and then investigate. Although R85 had sustained a large scratch/abrasion on her right shoulder the facility failed to report the incident immediately to the state agency. R183's admission Minimum Data Set (MDS) dated 10/27/14 indicated had severe cognitive impairment, however displayed no behaviors but did need supervision with locomotion and activities of daily living (ADL)'s. R183's care plan dated 10/20/14 indicates history of memory loss. The elopement risk and the care planning regarding elopement was completed after R183 eloped from the veterans day event on 11/24/14. The Evergreen Incident Report identified on 11/11/14, "Resident [R183] attended an outing with activities for Veterans day. When program was done resident walked across street where he used to live. Activity staff walked him back to program. No injuries noted." The report identified the DON and administrator was informed of the incident on 11/12/14, one day after the event. The form did not identify the state agency was notified, of the incident. Review of the Minnesota Department of Health (MDH) report, identified the facility submitted a report to the state agency (MDH) on 11/12/14, one day after the incident occurred. During interview on 11/24/14 at 4:02 p.m. The activities director (AD-A) stated the Veterans day	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 4 event was at the armory and she wasn't there but my staff were. The group watched the event, when it ended, the staff stood up and moved the wheelchair people around. When they got done moving the wheelchair people [R183] was gone. The staff present didn't know where he had gone. We were not aware that he used to own a house across the street. "By the time my staff found him, he had crossed the street, and was being brought back to the armory by the lady who owns the house now. He was wearing veterans clothing so she assumed he belonged at the event" The director of nursing (DON) who was present during the interview, added, "I was notified the next day in the AM [morning]," and so was the administrator. The AD-A acknowledged the DON and administrator were not notified of the incident until 11/12/14, one day after the elopement occurred. During interview on 11/24/14 at 3:58 p.m. The administrator stated, "I was notified about the veterans day elopement ,the next day at the stand up meeting". Although R185 had an elopement on 11/11/14 the administrator/designee and state agency were not immediately notified of the alleged neglect until 11/12/14 one day after the incident.	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	{F 226}		12/15/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the facility implemented their policy for allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator or the state agency and thoroughly investigated for 2 of 5 resident's (R85,and R183) allegations that were reviewed. Findings include: The facility Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The administrator is ultimately in charge of the Abuse Prohibition plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately. In the case of the Administrator being unavailable, the Designee will be notified in this timeframe. The state Agency must also be notified immediately...." R85's annual Minimum Data Set (MDS) dated 10/21/14, indicated she had dementia was severely cognitively impaired and needed extensive assist of one with activity of daily living (ADL's). R85's care plan dated 11/06/14, indicated her short term memory was impaired and had diagnosis of Alzheimer disease and dementia with depression. The care plan further indicated staff to monitor for confusion or delirium and evaluate. The facilities incident form Evergreen Terrace dated 11/17/14, indicated that at 5:30 p.m. "when resident woke up- staff got her changed and	{F 226}	Immediate Corrective Action: DON/Designee and Activities Director (AD-A) were counseled for failing to implement facility policy for abuse prevention. Corrective Action as it Applies to Others: The policy and procedure "Evergreen Terrace Abuse Prevention Plan" was reviewed and amended on 11/27/2014 to include naming the DON/SS Director as the appointed designees and the "administrative authority of the Designee in the absence of the administrator". Staff will be educated on the timely reporting to the administrator and OHFC by 12/15/14. Staff will be re-educated on the revised policy by 12/15/2014. Recurrence will be prevented by: Audits will be conducted daily (Monday-Friday) of all alleged violations involving mistreatment, neglect, abuse or injuries of unknown origin and/or misappropriation of resident property to ensure incidents were reported in accordance with facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. Date of Completion: 12/15/2014 The Correction will be monitored by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 6 noticed a 6" length x 2.5 " width scratch/abrasion on her right shoulder. The report further indicated the director of nursing (DON) received a message on 11/17/14, at 9:25 p.m. There report did not indicate if the administrator was notified or the state agency. A interview statement was attached to the report which indicated "I was getting res ready for bed. When I was changing her top I noticed a red scratch that I hadn't seen before I let the trained medical assistant (TMA) know right away." There was no indication if the administrator/designee and state agency were immediately notified as directed by the facility policy. During interview 11/25/2014, at 8:05 a.m. the DON/designee stated she was informed of the incident when it occurred on 11/17/14. The DON further stated it was a large abrasion and the incident should have been reported immediately to the state agency according to their policy and it was not. Although R85 had sustained a large scratch/abrasion on her right shoulder the facility failed to immediately report to the state agency regarding the alleged abuse for R85. R183's admission Minimum Data Set (MDS) dated 10/27/14 indicated had severe cognitive impairment, however displayed no behaviors but did need supervision with locomotion and activities of daily living (ADL)'s. The Evergreen incident report identified on 11/11/14, "Resident [R183] attended an outing with activities for Veterans day. When program was done resident walked across street where he	{F 226}	Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 226}	Continued From page 7 used to live. Activity staff walked him back to program. No injuries noted." The report identified the DON and administrator were informed of the incident on 11/12/14, one day after the event. The form did not identify the state agency was notified, Review of the Minnesota Department of Health (MDH) report, identified the facility submitted a report to the state agency (MDH) on 11/12/14, one day after the incident occurred, and was not immediately to the state agency as directed by the facility policy. During interview on 11/24/14 at 4:02 p.m. with the director of nursing (DON) and activity director (AD)-D, the DON stated she was notified the next day in the AM [morning]," and so was the administrator. The AD-A acknowledged the DON and administrator were not notified of the incident until 11/12/14, one day after the elopement occurred. Although R185 had an elopement on 11/11/14 the administrator/designee and state agency were not immediately notified of the alleged neglect until 11/12/14 one day after the incident.	{F 226}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: A licensing order revisit survey was completed, on November 25, 2014 to follow up on licensing orders related to the licensing survey on September 18, 2014. Licensing orders were reissued and penalty assessment may be imposed.	{2 000}	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

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{2 000}	Continued From page 1	{2 000}	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{21990}	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the	{21990}		12/12/14

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{21990}	Continued From page 2 caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 9/18/14, will remain in effect. Penalty assessment recommended. Based on interview, and document review the facility failed to ensure alleged allegations of abuse, neglect, inquiries of unknown origin were immediately reported to the common entry point for 2 of 5 residents (R85, and R183) allegations reviewed. Findings include: The facility Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The Administrator...must be informed of all incidents and internal investigations immediately. Report all alleged violations...to the State of Minnesota as required...immediately. All staff are required to report suspected maltreatment of a vulnerable adult to Administrator, Director of Nursing, if they are not in the building report to the Nursing Supervisor, at the time of suspicion." R85's annual Minimum Data Set (MDS) dated	{21990}	Please see above plan of correction.	

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{21990}	Continued From page 3 10/21/14, indicated she had dementia was severely cognitively impaired and needed extensive assist of one with activity of daily living (ADL's). R85's care plan dated 11/06/14, indicated her short term memory was impaired and had diagnosis of Alzheimer disease and dementia with depression. The care plan further indicated staff to monitor for confusion or delirium and evaluate. The facilities incident form Evergreen Terrace dated 11/17/14, indicated at 5:30 p.m. "when resident woke up- staff got her changed and noticed a 6" length x 2.5 " width scratch/abrasion on her right shoulder." The report further indicated the director of nursing (DON) received a message on 11/17/14, at 9:25 p.m. The report did not indicate if the state agency was notified of the allegation. A interview statement was attached to the report which indicated "I was getting res ready for bed. When I was changing her top I noticed a red scratch that I hadn't seen before I let the trained medical assistant (TMA) know right away." During interview 11/24/14, at 2:26 p.m. licensed practical nurse (LPN)-A stated she was aware of the incident that occurred on 11/17/14 and she just looked at the area today and thought the abrasion was due to her bra clasp and that she had pushed the clasp back to prevent anymore injury. During interview 11/25/2014, at 8:05 a.m. the DON stated she was informed of the incident on 11/17/14 when it occurred. The DON further stated it was a large abrasion and the incident should have been immediately reported to the state agency and then investigate.	{21990}		

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{21990}	Continued From page 4 Although R85 had sustained a large scratch/abrasion on her right shoulder the facility failed to report the incident immediately to the common entry point. R183's admission Minimum Data Set (MDS) dated 10/27/14 indicated had severe cognitive impairment, however displayed no behaviors but did need supervision with locomotion and activities of daily living (ADL)'s. R183's care plan dated 10/20/14 indicates history of memory loss. The elopement risk and the care planning regarding elopement was completed after R183 eloped from the veterans day event on 11/24/14. The Evergreen Incident Report identified on 11/11/14, "Resident [R183] attended an outing with activities for Veterans day. When program was done resident walked across street where he used to live. Activity staff walked him back to program. No injuries noted." The report identified the DON and administrator was informed of the incident on 11/12/14, one day after the event. The form did not identify the common entry point was not notified, of the incident. Review of the Minnesota Department of Health (MDH) report, identified the facility submitted a report to the state agency (MDH) on 11/12/14, one day after the incident occurred. During interview on 11/24/14 at 4:02 p.m. The activities director (AD-A) stated the Veterans day event was at the armory and she wasn't there but my staff were. The group watched the event, when it ended, the staff stood up and moved the wheelchair people around. When they got done moving the wheelchair people [R183] was gone.	{21990}		

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{21990}	Continued From page 5 The staff present didn't know where he had gone. We were not aware that he used to own a house across the street. "By the time my staff found him, he had crossed the street, and was being brought back to the armory by the lady who owns the house now. He was wearing veterans clothing so she assumed he belonged at the event" The director of nursing (DON) who was present during the interview, added, "I was notified the next day in the AM [morning]," and so was the administrator. The AD-A acknowledged the DON and administrator were not notified of the incident until 11/12/14, one day after the elopement occurred. During interview on 11/24/14 at 3:58 p.m. The administrator stated, "I was notified about the veterans day elopement ,the next day at the stand up meeting". Although R185 had an elopement on 11/11/14 the administrator/designee and common entry point were not immediately notified of the alleged neglect until 11/12/14 one day after the incident.	{21990}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00299	A. Building B. Wing	11/25/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20435** Reg. # **MN Rule 4658.0210 Subp. 2 A.I** LSC	Correction Completed **10/27/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **10/27/2014**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	Correction Completed **10/27/2014**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **10/27/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **10/27/2014**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **10/27/2014**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **10/27/2014**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	Correction Completed **10/27/2014**	ID Prefix **21045** Reg. # **Mn Rule 4658.0620 Subp. 4** LSC	Correction Completed **10/27/2014**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **10/27/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	Correction Completed **10/27/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **10/27/2014**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **10/27/2014**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **10/27/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **10/27/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/mm	12/10/2014	33925	11/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00299	A. Building B. Wing	11/25/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21855** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **10/27/2014**				

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/mm	12/10/2014	33925	11/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/18/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS A Post Certification Revisit (PCR) was completed, on November 25, 2014 to follow up on deficiencies issued related to the recertification survey on September 18, 2014. Deficiencies were reissued as part of this post certification revisit. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	{F 225}		

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

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

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EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure alleged allegations of abuse, neglect, inquiries of unknown origin were immediately reported to the state agency for 2 of 5 residents (R85, and R183) allegations reviewed. Findings include: The facility Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The Administrator...must be informed of all incidents and internal investigations immediately. Report all alleged violations...to the State of Minnesota as required...immediately. All staff are required to report suspected maltreatment of a vulnerable	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 2	{F 225}		

adult to Administrator, Director of Nursing, if they are not in the building report to the Nursing Supervisor, at the time of suspicion."

R85's annual Minimum Data Set (MDS) dated 10/21/14, indicated she had dementia was severely cognitively impaired and needed extensive assist of one with activity of daily living (ADL's). R85's care plan dated 11/06/14, indicated her short term memory was impaired and had diagnosis of Alzheimer disease and dementia with depression. The care plan further indicated staff to monitor for confusion or delirium and evaluate.

The facilities incident form Evergreen Terrace dated 11/17/14, indicated at 5:30 p.m. "when resident woke up- staff got her changed and noticed a 6" length x 2.5 " width scratch/abrasion on her right shoulder." The report further indicated the director of nursing (DON) received a message on 11/17/14, at 9:25 p.m. The report did not indicate if the state agency was notified of the allegation. A interview statement was attached to the report which indicated "I was getting res ready for bed. When I was changing her top I noticed a red scratch that I hadn't seen before I let the trained medical assistant (TMA) know right away."

During interview 11/24/14, at 2:26 p.m. licensed practical nurse (LPN)-A stated she was aware of the incident that occurred on 11/17/14 and she just looked at the area today and thought the abrasion was due to her bra clasp and that she had pushed the clasp back to prevent anymore injury.

During interview 11/25/2014, at 8:05 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 3	{F 225}		

DON stated she was informed of the incident on 11/17/14 when it occurred. The DON further stated it was a large abrasion and the incident should have been immediately reported to the state agency and then investigate.

Although R85 had sustained a large scratch/abrasion on her right shoulder the facility failed to report the incident immediately to the state agency.

R183's admission Minimum Data Set (MDS) dated 10/27/14 indicated had severe cognitive impairment, however displayed no behaviors but did need supervision with locomotion and activities of daily living (ADL)'s. R183's care plan dated 10/20/14 indicates history of memory loss. The elopement risk and the care planning regarding elopement was completed after R183 eloped from the veterans day event on 11/24/14.

The Evergreen Incident Report identified on 11/11/14, "Resident [R183] attended an outing with activities for Veterans day. When program was done resident walked across street where he used to live. Activity staff walked him back to program. No injuries noted." The report identified the DON and administrator was informed of the incident on 11/12/14, one day after the event. The form did not identify the state agency was notified, of the incident.

Review of the Minnesota Department of Health (MDH) report, identified the facility submitted a report to the state agency (MDH) on 11/12/14, one day after the incident occurred.

During interview on 11/24/14 at 4:02 p.m. The activities director (AD-A) stated the Veterans day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 4 event was at the armory and she wasn't there but my staff were. The group watched the event, when it ended, the staff stood up and moved the wheelchair people around. When they got done moving the wheelchair people [R183] was gone. The staff present didn't know where he had gone. We were not aware that he used to own a house across the street. "By the time my staff found him, he had crossed the street, and was being brought back to the armory by the lady who owns the house now. He was wearing veterans clothing so she assumed he belonged at the event" The director of nursing (DON) who was present during the interview, added, "I was notified the next day in the AM [morning]," and so was the administrator. The AD-A acknowledged the DON and administrator were not notified of the incident until 11/12/14, one day after the elopement occurred. During interview on 11/24/14 at 3:58 p.m. The administrator stated, "I was notified about the veterans day elopement ,the next day at the stand up meeting". Although R185 had an elopement on 11/11/14 the administrator/designee and state agency were not immediately notified of the alleged neglect until 11/12/14 one day after the incident.	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the facility implemented their policy for allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator or the state agency and thoroughly investigated for 2 of 5 resident's (R85,and R183) allegations that were reviewed. Findings include: The facility Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The administrator is ultimately in charge of the Abuse Prohibition plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately. In the case of the Administrator being unavailable, the Designee will be notified in this timeframe. The state Agency must also be notified immediately...." R85's annual Minimum Data Set (MDS) dated 10/21/14, indicated she had dementia was severely cognitively impaired and needed extensive assist of one with activity of daily living (ADL's). R85's care plan dated 11/06/14, indicated her short term memory was impaired and had diagnosis of Alzheimer disease and dementia with depression. The care plan further indicated staff to monitor for confusion or delirium and evaluate. The facilities incident form Evergreen Terrace dated 11/17/14, indicated that at 5:30 p.m. "when resident woke up- staff got her changed and	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 6	{F 226}		

noticed a 6" length x 2.5 " width scratch/abrasion on her right shoulder. The report further indicated the director of nursing (DON) received a message on 11/17/14, at 9:25 p.m. There report did not indicate if the administrator was notified or the state agency. A interview statement was attached to the report which indicated "I was getting res ready for bed. When I was changing her top I noticed a red scratch that I hadn't seen before I let the trained medical assistant (TMA) know right away." There was no indication if the administrator/designee and state agency were immediately notified as directed by the facility policy.

During interview 11/25/2014, at 8:05 a.m. the DON/designee stated she was informed of the incident when it occurred on 11/17/14. The DON further stated it was a large abrasion and the incident should have been reported immediately to the state agency according to their policy and it was not.

Although R85 had sustained a large scratch/abrasion on her right shoulder the facility failed to immediately report to the state agency regarding the alleged abuse for R85.

R183's admission Minimum Data Set (MDS) dated 10/27/14 indicated had severe cognitive impairment, however displayed no behaviors but did need supervision with locomotion and activities of daily living (ADL)'s.

The Evergreen incident report identified on 11/11/14, "Resident [R183] attended an outing with activities for Veterans day. When program was done resident walked across street where he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 7 used to live. Activity staff walked him back to program. No injuries noted." The report identified the DON and administrator were informed of the incident on 11/12/14, one day after the event. The form did not identify the state agency was notified, Review of the Minnesota Department of Health (MDH) report, identified the facility submitted a report to the state agency (MDH) on 11/12/14, one day after the incident occurred, and was not immediately to the state agency as directed by the facility policy. During interview on 11/24/14 at 4:02 p.m. with the director of nursing (DON) and activity director (AD)-D, the DON stated she was notified the next day in the AM [morning]," and so was the administrator. The AD-A acknowledged the DON and administrator were not notified of the incident until 11/12/14, one day after the elopement occurred. Although R185 had an elopement on 11/11/14 the administrator/designee and state agency were not immediately notified of the alleged neglect until 11/12/14 one day after the incident.	{F 226}		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building B. Wing	11/25/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **10/27/2014**
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/27/2014**
ID Prefix **F0310** Reg. # **483.25(a)(1)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/27/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **10/27/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/27/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/mm	12/10/2014	33925	11/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building B. Wing	11/25/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/27/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/27/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/27/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/mm	12/10/2014	33925	11/25/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/18/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building / B. Wing **01 - MAIN BUILDING 01**	10/30/2014

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/27/2014**	ID Prefix	Correction Completed **10/27/2014**	ID Prefix	Correction Completed **10/27/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0052		LSC K0061	
ID Prefix	Correction Completed **10/29/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	12/10/14	03005	10/30/14
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/16/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EY5V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**

2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 10/31/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 11/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/17/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Cert Mail # 7013 2250 0001 6357 0686

October 8, 2014

Mr. Joseph Gubbels, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495023

Dear Mr. Gubbels:

On September 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Supervisor
St. Cloud Survey Team A
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: brenda.fischer@state.mn.us

Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 28, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Evergreen Terrace

HEALTHCARE COMMUNITY

by Welcov Healthcare

Brenda Fischer
Unit Supervisor
Division of Compliance and Monitoring
Licensing and Certification Program
3333 West Division Street, Suite 212
St. Cloud, MN 56301-4557

October 17, 2014

Dear Mrs. Fischer:

As we are working on out Plan of Correction, it was discovered that Resident-139, and Resident-53 were not disclosed as no longer in the facility. This affects F Tag 282 and F Tag 311.

Could this request be attached as an addendum to our Plan of Corrections sent yesterday?

If you have any questions or concerns, please notify me at any time.

Thank you for you time,

Lisa Parrott, RN DON
218-326-3431
lisa.parrott@welcov.com

10/31/14 accepted SA

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ MN Dept of Health St.Cloud B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F164 **Immediate corrective action:** Personal privacy was immediately provided for resident (R68). RN-C received coaching and re-education on 8/22/14 for failing to provide privacy when administering an injection to resident #145.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	**Action as it applies to others:** All residents will be interviewed to ensure their right to personal privacy is maintained by staff. Residents with concerns regarding their right to privacy will have grievance concerns completed with necessary follow up and resolution. The policy and procedure, Resident Privacy, was reviewed on 9/23/2014 and remains current. Staff will be re-educated on the Resident Privacy policy by 10/27/2014.	

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

Electronically Signed — DON — 10-16-14

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement measures to ensure personal privacy was provided for 2 of 6 dependent residents (R68, R145) observed who were dependent upon staff to provide privacy. Findings include: R68's quarterly Minimum Data Set (MDS), dated 7/18/14, indicated R68 had a diagnosis of quadriplegia. The MDS identified R68 had no cognitive impairment, required use of an indwelling supra-pubic catheter and colostomy, and received total assistance from staff for all daily needs. During observation on 9/15/14, at 4:30 p.m., R68 was lying in bed, his door was wide open, visible from the hallway where residents,visitors and staff could see the resident exposed. R68's abdomen was exposed along with their colostomy device (equipment that collects stool, typically a bag) which contained stool. R68's had an incontinence brief on, with blue chux (disposable pad used to absorb fluids typically used for incontinence). R68 was unable to cover himself due to limited use of his upper body extremities. His abdomen and lower body remained exposed,	F 164	**Date of completion:** 10/27/2014. **Recurrence will be prevented by:** Random weekly resident interviews and visual observations will be conducted on each unit to ensure staff implement measures to ensure personal privacy for residents. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

10/31/14 received Dir Education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 2 and could be viewed from the hallway by other residents, visitors and staff. When interviewed on 9/15/14, at 4:30 p.m., R68 stated he did not like the door open, and being exposed to other residents, and visitors from the hallway, but he was unable to close the door without staff assistance. R145's admission Minimum Data Set (MDS), dated 8/21/14, indicated R145 had diabetes mellitus, was cognitively intact, dependant on oxygen, and required total assistance from staff for all their daily needs. During an observation of medication administration, on 9/18/14 at 8:46 a.m., registered nurse (RN)-C entered R145's room and lift their shirt to provide a medication injection. RN-C left the residents door open while she administered his insulin. R145 could be viewed from the hallway where visitors were walking by during the admnistration of the insulin. RN-C did not closed the door or curtain in the resident room to provide visual privacy. When interviewed on 9/18/14, at 8:50 a.m., RN-C stated they would typically shut the door before providing medical treatment like an injection. A facility policy on privacy was requested, but none was provided.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 3 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure alleged allegations of	F 225	F225 **Immediate corrective action:** Resident R151 no longer resides in the facility. **Action as it applies to others:** The most recent elopement assessment for all other residents will be reviewed. Residents noted to have any change to their current assessment will be reassessed and those found to be at risk will have appropriate interventions in place to prevent elopement. The policy and procedure for Abuse Prevention was reviewed on 9/23/2014 and remains current. The policy and procedure for Elopement was reviewed on 9/23/2014 and remains current. Staff will be re-educated on the abuse prevention and elopement policies by 10/27/2014.	

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F 225	Continued From page 4 abuse, neglect, injuries of unknown origin and misappropriation of resident property incidents were immediately reported to the administrator, state agency and were thoroughly investigated for 1 of 4 residents (R151) allegations reviewed. Findings include: R151's admission Minimum Data Set (MDS), dated 8/20/14, indicated R151 had severe cognitive impairment, however displayed no behaviors or wandering. R151's care plan, dated 8/13/14, indicated R151 had an altered mental status and dementia with barriers to him going home due to memory loss and inability to find home and becomes angry when he asks about going home which staff are to redirect him when agitated. The care plan further stated he was aware of his surroundings and people around him but not always to time and place. The facility's Elopement Risk Assessment dated 8/20/14, indicated R151 had no history of elopement, or history of wandering. The assessment further indicated "Resident has made no attempts to leave the building. He is staying in the same room with his wife. He will not be placed at Elopement Risk". During interview 9/17/14, at 12:30 p.m. R151 stated he does not understand why he is at the facility and wanted to go home. Review of R151's progress notes indicated on 9/5/14, at 12:59 p.m. "Res [resident] was note by staff to be outside walking, he was in employee parking lot when I caught up with him, Res very cooperative and pleasant, stating he was stretching his legs before winter comes, pointing	F 225	**Date of completion:** 10/27/2014. **Recurrence will be prevented by:** Random weekly chart reviews and resident interviews will be conducted on each unit to ensure alleged allegations of abuse, neglect, injuries of unknown origin, statements regarding elopement and elopement attempts and misappropriation of resident	

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F 225	Continued From page 5 to the main entrance door stating "I'm just going to walk over their and go in that door...walked with Res who entered building without diff and down to room to see wife". There was no indication the administrator, state agency were immediately notified nor was the elopement thoroughly investigated. During interview 9/18/14, at 9:21 a.m. with the director of nursing (DON) stated they did not report the incident on 9/5/14 since she didn't feel he was attempting to elope. The DON verified R151 had left the building went into the parking lot unattended, and the progress note was not clear if the staff knew where he was or if they had just found him out there. The facilities Elopement policy revised July 2013, indicated nursing must report and investigate all reports of missing residents. The policy further indicated, "Any elopement where the resident is not seen leaving, or has unusual circumstances is considered a reportable incident under the Vulnerable Adult Law in Minnesota". The Facilities Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect is defined as failure of a caregiver to supply a resident with the care or services, including but not limited to food, clothing, shelter, health care or supervision which is reasonable and necessary to obtain or maintain the residents physical and mental health or safety, considering the physical or mental dysfunction of the resident which is not the result of an accident or therapeutic conduct.	F 225	property were immediately reported in accordance with facility policy. A facility designated staff person will maintain, on an ongoing basis, a log of reported allegations of abuse. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 225	Continued From page 6 Although R151 had severe cognitive impaired, had left the facility and made comments that he wanted to go home. The facility did not reported the incident immediately to the administrator, state agency nor completed an investigation of the incident.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the facility implemented their policy for allegations of abuse, neglect, injuries of unknown origin and misappropriation of resident property incidents were immediately reported to the administrator, state agency and thoroughly investigated for 1 of 4 residents (R151) whose allegations was reviewed. Findings include: The Facilities Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The Administrator...must be informed of all incidents and internal investigations immediately. Report all alleged violations...to the State of Minnesota as required...immediately..." The policy also identified, "...that the internal investigation begins immediately..."	F 226	F226 **Immediate corrective action:** Resident R151 no longer resides in the facility. **Action as it applies to others:** The most recent elopement assessment for all other residents will be reviewed. Residents noted to have any change to their current assessment will be reassessed and those found to be at risk for elopement will have appropriate interventions in place to prevent elopement. The policy and procedure for Abuse Prevention was reviewed on 9/23/2014 and remains current. The policy and procedure for Elopement was reviewed on 9/23/2014 and remains current.	

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F 226	Continued From page 7 The facilities Elopement policy revised July 2013, indicated nursing must report and investigate all reports of missing residents. The policy further indicated "any elopement where the resident is not seen leaving, or has unusual circumstances is considered a reportable incident under the Vulnerable Adult Law in Minnesota". R151's admission Minimum Data Set (MDS) dated 8/20/14, indicated he was severely cognitively impaired with no behaviors and did not wander. R151's care plan dated dated 8/13/14, indicated he had altered mental status and dementia and barriers to him going home due to memory loss and inability to find home. The care plan further indicated he becomes angry when he asks about going home and staff are to redirect him when agitated. The care plan further stated he is aware of his surroundings and people around him but not always to time and place. The facilities Elopement Risk Assessment dated 8/20/14, indicated R151 had no history of elopement, has no history of wandering. The assessment further indicated "Resident has made no attempts to leave the building. He is staying in the same room with his wife. He will not be placed at Elopement Risk". During interview 9/17/14, at 12:30 p.m. R151 stated he does not understand why he is at the facility and wanted to go home. Review of R151's progress notes indicated on 9/5/14, at 12:59 p.m. "Res was note by staff to be outside walking, he was in employee parking lot when I caught up with him. Res very cooperative and pleasant, stating he was stretching his legs	F 226	Staff will be re-educated on the Abuse Prevention and the Elopement policies by 10/27/2014. **Date of completion:** 10/27/2014 **Recurrence will be prevented by:** Random weekly chart reviews and resident interviews will be conducted on each unit to ensure alleged allegations of abuse, neglect, injuries of unknown origin and misappropriation of resident property were immediately reported and investigated in accordance with facility policy. A facility designated staff person will maintain, on an ongoing basis, a log of reported allegations of abuse.	

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

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F 226	Continued From page 8 before winter comes, pointing to the main entrance door stating "I'm just going to walk over their and go in that door". Walked with Res who entered building without diff and down to room to see wife". There was no indication the administrator, and state agency were immediately notified nor was the elopement thoroughly investigated as identified by the facility policy. During interview 9/18/14, at 9:21 a.m. with the director of nursing (DON) who stated they did not report the incident on 9/5/14 since she didn't feel he was attempting to elope. The DON did verify resident did leave the facility and go to the parking lot unattended and indicated the note was not clear if the staff new where he was or if they had just found him out there. Although R151 was severely cognitively impaired and had attempted to leave the facility and has made comments that he wanted to go home the facility did not report or investigate the incident according to there policy.	F 226	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely grooming to promote dignity for 1 of 3 residents	F 241	F241 **Immediate corrective action:** Resident R77 received immediate assistance with fingernail care.	

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F 241	Continued From page 9 (R77), whom was reviewed for activities of daily living and grooming. Findings include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 required extensive assistance from staff for his personal hygiene, and had moderate cognitive impairment. R77's care plan, dated 9/8/14, indicated R77 required assistance with dressing, grooming, bathing and weekly nail care. During observation on 9/16/14, at 9:22 a.m., R77 was seated in his wheelchair in his room. with long, un-trimmed fingernails on both hands. There was a dark substance underneath several of the nails. Subsequent observations of R77 on 9/17/14 at 7:08 a.m., and 9/18/14 at 8:19 a.m., indicated R77 continued to have un-trimmed, fingernails with a black substance underneath. When interviewed on 9/18/14, at 8:19 a.m., R77 stated he would like his fingernails to be trimmed and kept shorter and that long, dirty fingernails was embarrassing for him to be seen by others with. During interview on 9/17/14, at 9:04 a.m., nursing assistant (NA)-D who cared for R77 stated his fingernails should be trimmed on the resident's bath day. R77's Treatment Administration Record, dated 9/1/14 to 9/30/14, did not indicate R77 should have his nails trimmed by the staff.	F 241	**Action as it applies to others:** All residents will receive fingernail care according to their personal preference. All nursing assistant care cards will be reviewed to assure resident grooming needs, to include nail care preferences, are included. The policy and procedure for Resident Dignity was reviewed on 9/23/2014 and remains current. Nursing staff will be re-educated on the policy Resident Dignity by 10/27/2014. **Date of completion:** 10/27/2014. **Recurrence will be prevented by:**	

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F 241	Continued From page 10 During interview on 9/18/14, at 9:29 a.m., registered nurse (RN)-A stated R77 fingernails should have been trimmed by a nurse as he was diabetic. Further, RN-A stated R77's long, dirty fingernails would be a dignity concern. When interviewed on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated nursing staff are expected to trim and clean fingernails routinely and R77's fingernails should have been trimmed according to his preference. An undated facility Dignity policy indicated a purpose of ensuring all residents are treated with dignity and respect. Further, the policy indicated examples of appropriate actions to promote dignity including, "Providing grooming according to each resident's individual wishes."	F 241	Random weekly visual audits and resident interviews will be conducted on each unit to ensure residents are receiving assistance with grooming according to their personal preferences in a manner which maintains or enhances each resident's dignity. **The correction will be monitored by:** Director of Nursing and/or designee.	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident were given the choice of meal preferences for 13 of 16 residents (R102, 92, 85,18,150,107, 67, 64, 105, 51, 117, 86 and 157) in the secured dementia unit who were identified as being capable of	F 242	F242 **Immediate corrective action:** Grievance reports were completed on behalf of residents R102, 92, 85, 18, 150, 107, 67, 64, 105, 51, 117, 86, 157 for not receiving a choice of meal entrée at the observed meals from 9/15/2014 – 9/17/2014, with the resolution reviewed by the ID Team of offering all residents a choice at mealtime.	

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F 242	Continued From page 11 making a choice of meal entrees. Findings include: During observation of the evenings meal on 9/15/2014 at 5:30 p.m., residents in the 100's wing, secured dementia unit, were seated at tables, awaiting the evening meal service. A cart loaded with resident meal trays, was delivered on the unit. Licensed practical nurse (LPN)-B pulled individual trays off the cart, each one for a resident, and in turn, removed the plate covers, and placed the food entree in front of the seated residents. Staff completed this for all residents in the secured dementia unit. Staff did not ask residents any questions related to the food entree, nor offer any choice to the residents regarding food choice. During observation of the breakfast meal on 9/17/14 at 8:00 a.m., the dietary staff (DS)-A wheeled a metal rack of trays into the secured dementia unit where residents were seated in the dining room. The rack had trays for each of the residents in the unit, and the plates were covered with a plastic insulated dome. Nursing assistant (NA)-I and licensed practical nurse (LPN)-P removed the cover from each plate which consisted of a cheese omelet, fried potatoes and toast, and served all the resident in the secured dementia unit their plates. NA-I and LPN-P did not ask the residents prior to being served about a food choice or preference but served the food that was already provided on each of the plates. Also, there was no indication in the secured dementia unit, that a list of meal alternatives or options were available for the residents to choose.	F 242	**Action as it applies to others:** All residents will receive preferences for meal choice with each meal. The policy and procedure for Resident Choice was reviewed on 9/23/2014 and remains current. Staff will be re-educated regarding the policy and procedure Resident Choice by 10/27/2014. **Date of completion:** 10/27/2014. **Recurrence will be prevented by:** Random weekly audits will be completed, at meal time, to ensure staff offer residents choices regarding meal preferences. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring.	

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F 242	Continued From page 12 On 9/15/2014 at 5:37 p.m. in the main dining room of the facility, nursing assistants (NA)-D, F and G were observed collecting menu slips from residents. Staff were asking residents what they wanted to eat, either lasagne with garlic toast and vegetable, or country fried steak, with potatoes and gravy. The entree choices were noted to be written on a white board on the south side of the dining room. Staff took the slips into the kitchen, and upon retuning, delivered the chosen meal to the resident. R102's undated facility diagnosis sheet identified diagnosis of altered mental status. R102's quarterly Minimum Data Set (MDS), dated 7/23/2014, identified intact cognition. The MDS also indicated R102 was capable of making herself understood to others, and understood others. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R102] to locate radio/TV/video/music programming of choice upon request." R92's undated facility diagnosis sheet identified diagnoses of dementia and Alzheimer's disease. The quarterly MDS, dated 8/26/2014, indicated cognitive impairment. The MDS also indicated R92 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct communication. The care plan print date of 9/18/14 identified a preference about attending facility activities which needs reminders, invites and escort to participate. The interventions	F 242	**The correction will be monitored by:** Dietary Manager/Designee	

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F 242	Continued From page 13	F 242		

included, "Staff assist to transport to these activities of choice as scheduled, encourage music programs, animal visits,, 3m's discussion group and social hours."

R85's undated facility diagnosis sheet identified diagnoses of Alzheimer's disease and presenile dementia. The quarterly MDS, dated 7/22/2014, indicated cognitive impairment. The MDS also indicated R85 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct communication. The care plan print date of 9/18/14 identified, I want to attend some facility activities," with the intervention of, "Staff assist [R85] with setting up videos/computer programming for him/her to view independently and return later on for additional assistance as needed." The care plan also directed staff to, "Pick up shopping needs as needed or requested."

R18's undated Self Limiting Problems and Diagnoses sheet identified diagnosis of dementia. The admission MDS, dated 6/5/2014, indicated cognitive impairment. The MDS also indicated R18 usually made himself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified wanting to attend some facility activities but also have independent activities. Staff were to assist with "I need assistance of invites, reminders and encouragement to get to the facility activities."

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F 242	Continued From page 14 R150's undated facility diagnosis sheet identified diagnosis of depression and cerebellar ataxis. The admission MDS, dated 8/12/2014, indicated cognitive impairment. The MDS also indicated R150: usually made himself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified, "I am able to communicate my needs", with a goal of, " I will effectively communicate needs daily." The care plan also identified "I am able to make my own decisions", with a goal of, "I want to remain in control of my care decisions", and "staff to fully inform me of my clinical status." R107's undated facility diagnosis sheet identified diagnosis of dementia and cerebrovascular disease. The admission MDS, dated 7/22/2014, indicated moderate cognitive impairment. The MDS also indicated R107, made himself understood to others, and was able to understand others. The care plan print date of 9/18/14 identified, I want to attend some facility activities," with the intervention of, "I need assistance of reminders, escorts and invites to get to the facility activities." R67's undated facility diagnosis sheet identified diagnosis of dementia and depression. The quarterly MDS, dated 8/5/2014, indicated cognitive impairment. The MDS also indicated R67 usually made herself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention	F 242		

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F 242	Continued From page 15 of, "Staff assist [R67] to locate radio/TV/video/music programming of choice upon request." R64's undated facility diagnosis sheet identified diagnosis of depressive disorder. The annual MDS, dated 8/13/2014, indicated cognitive impairment. The MDS also indicated R64: made herself understood to others, and usually understood others. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R64] to locate radio/TV/video/music programming of choice upon request." R105's undated facility diagnosis sheet identified diagnosis of confusion of unspecific site. The quarterly MDS, dated 6/25/2014, indicated moderate cognitive impairment. The MDS also indicated R105 usually made himself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R105] to locate radio/TV/video/music programming of choice upon request." R51's undated facility diagnosis sheet identified diagnosis of senile dementia. The annual MDS, dated 8/6/2014, indicated cognitive impairment. The MDS also indicated R51: usually made himself understood to others, sometimes understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care	F 242		

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F 242	Continued From page 16 plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R51] to locate radio/TV/video/music programming of choice upon request." R117's undated facility diagnosis sheet identified diagnosis of dementia with behavior disturbances. The quarterly MDS, dated 6/4/2014, indicated intact cognition. The MDS also indicated R117 made her self understood to others, and usually understood others. The care plan print date of 9/18/14 identified a preferences of attending facility activities, with the intervention of, "Staff invite/remind/assist to transport to activities of choice..." R86's admission MDS, dated 8/1/2014, indicated cognitive impairment. The MDS also indicated R86 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct communication only. R157 undated facility diagnosis sheet identified diagnosis of altered mental status. The MDS was unavailable to the R157 being new to the facility. During an interview on 9/17/2014 at 10:45 a.m., the dietary manager (DM) stated menu slips are printed for each meal for every resident. The DM explained the slips list each resident's preferences, "like cranberry versus apple juice;" and each resident's dietary needs, "like nectar thick liquids, a diabetic diet, and adaptive plate and spoon." The DM said the resident menu slip were printed with the day's main entree, but that	F 242		

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F 242	Continued From page 17 "the residents can choose to have an alternate entree." The DM said the main daily entree and the alternate entree were usually written on the board in the dining room. The DM said residents in main dining room would fill out their own slips, and were "...asked by the aides what they want to eat," and had a choice of different food items. Continuing the interview, the DM said on the secured dementia, " ...they follow a different system" in regard to the entree meal choices for residents. The DM said the daily menu slips for residents on the secured dementia unit reflected the residents' choices and preferences, based on "...what staff have learned about what each resident likes and dislikes." The DM said that resident's preferences on the secured unit, "it was difficult to get that input from the residents," and further stated, "...often we had no family input as to preferences." The DM said, "When we dish it up and put it on the tray; they [the residents in the locked unit] are not asked that day what they want to eat." The DM further added that if the resident did not like what was on the tray, the aides "...are good about coming back to the kitchen and can get a different entree for the resident." The DM said she did not know how many times staff actually returned to the kitchen to pick alternate meals for residents on the locked unit. During interview on 9/17/2014 at 11:03 a.m., cook (C)-A stated she didn't know the residents on the secured dementia unit "had a choice." C-A said those residents' entrees were dished up "as to what was is on their ticket." C-A said the aides can come back to the kitchen and pick up a different entree, from the secured unit, "About once a week or less."	F 242		

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F 242	Continued From page 18 During interview on 9/18/14 at 10:15 a.m. licensed practical nurse (LPN)-B stated residents in the secured dementia unit were not given a choice of entrees, and were always given the main entree unless they told us differently, even though there was no listing of these meal choice found in the secured dementia unit. LPN-B continued to state, there were 16 residents in the secured dementia unit and 13 of these residents (R102, R92, R85, R18, R86, R150, R157, R107, R67, R64, R105, R51, R117) were capable of making a choice between two different main entrees, but were not given a choice as other residents were in the main facility dining room. "We serve the food the kitchen provides to them." LPN-B said. During interview on 9/18/2014 at 2:24 p.m., the director of nursing (DON) said she had discussed "dining options" on the locked unit, and stated, no matter where the resident is in the nursing home, "each should have the choices afforded all other residents." The DON also said, we should allow "...each resident to make their dining choices, if they can." Even though the residents (R102, 92, 85,18,150,107, 67, 64, 105, 51, 117, 86 and 157) were identified as being capable of making a choice of entrees, they were not provided that opportunity by the facility due to being in the secured dementia unit.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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F 246	Continued From page 19 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adaptive equipment to promote safe independent eating and drinking for 1 of 1 residents (R150) who utilized a padded board on his lap for his meal plate and had difficulty drinking fluids with a standard cup/glass. Findings include: R150's admission Minimum Data Set (MDS) ,dated 8/12/14, indicated R150 had a diagnosis of cerebral vascular accident (CVA [stroke]) and kyphosis (an exaggerated forward rounding of the back). Further, the MDS indicated R150 had severe cognitive impairment, and required supervision with eating. R150's care plan, last updated 8/20/14, indicated R150 was independent with eating. During an observation on 9/15/14, at 5:10 p.m., R150 was seated at a table in the main dining room of the secured dementia unit. R150 had a padded board seated on his lap which was not attached to R150's wheelchair or the dining room table allowing it to move freely on his lap with any movement. R150's evening meal was placed on	F 246	F246 **Immediate corrective action:** Resident R150 no longer resides in the facility. **Action as it applies to others:** All residents will be evaluated on their need for the use of adaptive equipment to promote safe independent eating and drinking. Equipment will be provided for those residents found to benefit from the use of adaptive equipment by 10/27/2014. The policy Special Equipment needs was reviewed and remains current. Staff will be re-educated on the policy by 10/27/2014. **Date of completion:** 10/27/2014.	

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F 246	Continued From page 20 the padded board by unidentified staff and R150 began to eat independently. The padded board kept moving while R150 proceed to eat and drink his fluids. R150 had coffee, which was sloshing several times in the cup while sitting on the padded board on his lap. R150 struggled to drink his liquids and was unable to get the last 1/4 of the coffee in the bottom of his cup due to his severe kyphosis. R150 was not offered a straw to drink his liquids or a tray to stabilize the plate of food sitting on the padded board on his lap. A subsequent observation was made of R150 in the dining room on 9/17/14 at 8:13 a.m.. R150 had the padded board on his lap, which moved freely. Nursing assistant (NA)-M placed R150 breakfast plate on the padded board and place coffee, milk and juice on the table in front of R150. He started to eat his meal, and tried reaching for the fluids on the table in front of him. R150 made several times to reach the fluids but was unable to and began to eat his breakfast. After a few minutes, he unlocked his wheelchair and rolled himself forward to reach the fluids on the table. He poured milk into his coffee, spilling some on the table and his plate which was on the padded unstable board, then proceed to drink the coffee. He was unable to get the last few inches of the coffee in the cup due to his severe kyphosis, and not being able to lift his head back to drink all the coffee. He then held the cup, against his chest and used a teaspoon to spoon out the last few inches of coffee at the bottom of his cup until he finished the coffee. During this time, he was spilling the coffee on his clothing protector. He then reached for the juice and began to drink the juice but again was unable to get the last few inches of the juice in the glass due to his severe kyphosis, and not being able to	F 246	**Recurrence will be prevented by:** 3 Random weekly visual audits will be completed during the dining service and in each dining room to ensure residents requiring the use of adaptive equipment to promote safe independent eating and drinking are provided the necessary equipment to enhance their dining experience. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Dietary Director/Designee	

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F 246	Continued From page 21 lift his head back to drink all the juice. At 8:27 a.m. (a minimum of 14 minutes after being served his breakfast) licensed practical nurse (LPN)-B offered R150 a straw which he accepted and proceeded to drink 100% of the fluids with the use of a straw. An additional observation was made of R150 on 9/17/14 at 12:04 p.m.. R150 was seated in his recliner chair in his room with his legs elevated, and back of the recliner chair slightly leaned backwards so as to recline R150. R150 was eating using the same same padded board from the dining room in the same manner as above. R150 did not have a clothing protector on, and his shirt had spills on it. Staff had not provided him with a straw to drink all his fluids. Licensed practical nurse (LPN)-B entered R150's room as R150 finished his meal and offered him a straw. During interview on 9/17/14, at 12:24 p.m., R150 stated he was unable to reach the table for his cups of liquid and would like to be able to reach his coffee when he wanted it. When interviewed on 9/17/14, at 1:32 p.m., LPN-B stated R150 was unable to get close to the table in the dining room because of his severe kyphosis, and chooses to use the board on his lap for meals. LPN-B stated R150 will sometimes use a straw for meals, and they had not tried any other adaptive equipment to help R150 eat his meals and drink his fluids besides the unsteady padded board on his lap. LPN-B stated she does feel the padded board used on R150's lap could be a safety concern. During interview on 9/17/14, at 2:26 p.m., the	F 246		

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F 246	Continued From page 22 director of nursing (DON) stated she was unsure if anything had been tried to improve R150's ability to eat independently with use of adaptive equipment. A facility Special Equipment Needs policy, dated 3/2013, indicated all residents residing in the facility are assessed and provided with the special equipment necessary to reach their highest practicable level of functioning. Further, the policy indicated staff are responsible to monitor for potential needs of residents and report them on an ongoing basis.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide adequate notice of a new roommate for 1 of 1 residents (R15) who received a new roommate. Findings include: R15's care plan, dated 5/4/14, indicated R15 was alert and orientated, with an intervention of providing reminders and cues to help R15 maintain their establish routine to promote good psychosocial health. During interview on 9/16/14, at 9:00 a.m., R15	F 247	F247 **Immediate corrective action:** Resident R15 was interviewed on 9/17/2014 and expressed no concern with receiving a new roommate. **Action as it applies to others:** The policy: Room Change was reviewed on 9/24/2014 and remains current. Staff will be re-educated on the policy by 10/27/2014. **Date of completion:** 10/27/2014.	

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F 247	Continued From page 23 stated she received a new room-mate yesterday (9/15/14). She was not given notice beforehand, and would have liked to have known she was getting a new roommate with more notice than what was provided. During interview on 9/17/2014, at 9:14 a.m., licensed social worker (LSW)-A stated R15 did receive a new roommate on 9/15/14. LSW-A stated R15 was told she would be getting a new room-mate on the same day (9/15/14) a few hours before the roommate arrived. LSW-A stated she should have been given more notice of the incoming roommate but, "It an be difficult to adjust with only a few hours notice." A review of R15's progress notes, dated 9/5/14 to 9/16/14, did not identify that R15 was notified or questioned regarding her new roommate. A facility Room Change policy, dated 4/13/12, indicated all residents and family members are notified of room changes prior to them occurring. Further, the policy stated roommate(s) would be notified of the room change prior to receiving a roommate, but did not specify a length of time to be given prior to.	F 247	**Recurrence will be prevented by:** Chart audits and resident interviews will be completed with each room change or roommate change to ensure timely notice was given to the involved resident(s) and the notice is documented accordingly. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Social Services Director/Designee	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		

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F 282	Continued From page 24 Based on observation, interview, and document review, the facility failed to implement the care plan for the care areas of ambulation, rehabilitation, and pressure ulcer interventions for 11 of 59 residents, (R20, R27, R48, R22, R24, R53, R139, R14, R18, R36, R77) reviewed for these care areas. Findings include: AMBULATION R20's quarterly minimum data set (MDS) dated 7/17/14, indicated he had peripheral vascular disease, Alzheimer ' s and dementia. The MDS further indicated severe cognitive impairment and he walked in his room once or twice in his room or corridor with assist of two. R20's care plan dated 2/12/14, indicated he cannot ambulate independently due to recent toe amputation and decline in cognition. The care plan also indicated his balance while standing is unsteady and he participates in a functional maintenance program (FMP) for ambulation and supervision when able. Staff assist with FMP after supervision to ambulate 75-100 feet (ft.) up and down the hallway x2. The facilities nursing assistant care sheet undated indicated R20 to ambulate 75-100 ft. with front wheeled walker (FWW), gait belt two times daily. Review of the progress notes, physician notes and facility assessment from June 20, 2014 to September 18, 2014 did not identify R20 was being ambulated 75-100 ft. with a front wheeled walker (FWW), and gait belt two times daily, as directed by the Walking/Ambulation Program	F 282	F282 **Immediate corrective action:** Residents R20 was reassessed by therapy and new recommendations were received. The care plan and nursing assistant care sheets have been updated. Resident R27 was reassessed by therapy and ambulation guidelines have been re-established. The care plan and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task. Resident's R24, 22, 139, 14 and R48 were reassessed by therapy and ambulation guidelines have been re-established. The care plans and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task.	

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F 282	Continued From page 25 Guidelines Restorative Nursing/Functional Maintenance Recommendations which PT recommended for R20. During interview 9/18/14, at 9:44 a.m. NA-D stated R20 has stopped ambulating over a month ago and that he has becoming more combative with cares. R27's annual minimum data set (MDS) dated 6/12/14, indicated he ambulates with set up only and transfers with supervision and assist of one and was moderately cognitively intact. R27's care plan dated 6/2/14, indicated he was on a FMP which includes ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff. R27's nursing assistant care sheet undated indicated he was to ambulate 90 to 100 ft twice daily. R27's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 10/15/13, indicated he was to ambulate 90 to 100 ft. twice daily and to increase as tolerated. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify R27 "ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff," which was started on 10/15/13. There was no indication this has been completed as recommend on the 10/15/13 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R48's quarterly MDS dated 6/17/14, indicated he had a diagnoses of arthritis and cerebral vascular accident (CVA), was cognitively intact. He	F 282	Resident R48 received a walker to assist with ambulation. Resident R53 was reassessed by therapy and ambulation guidelines have been re-established. The care plan and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task. Resident R18 was reassessed by Occupational therapy and rehabilitation guidelines have been re-established. The care plan and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task. Resident R36's care plan was updated to include direction for staff to take when R36 refuses repositioning.	

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F 282	Continued From page 26 transferred and ambulated in his room with limited to extensive assist of one and did not ambulate in the corridor. R48's care plan dated 3/14/14, indicated he was on a FMP to ambulate 100 ft. twice daily with walker. R48's nursing assistant care sheet undated indicated he was to ambulate 100 ft. twice daily with a walker. R48's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 09/18/14, indicated he ambulated with a FWW 100 ft. with assist of two. During interview 9/17/14, at 8:20 am R48 stated he does not ambulate and the staff do not offer to ambulate him. He further stated if staff would offer to ambulate with him he would not refuse, there was no walker noted in his room. Review of the progress notes, and functional maintenance program from June 2014 to September 8, 2014 did not identify R48 had been ambulated 100 ft. twice a day with a walker, as identified by the 5/23/13 FMP. R22's annual MDS dated 7/1/14, indicated she had arthritis and osteoporosis. The MDS further indicated she was cognitively intact, transferred and ambulated independently in her room. She was able to ambulate in the corridor once or twice with no set up or physical assistance from staff. R22's care plan dated 1/20/14, indicated she can ambulate up to 100 ft. daily with a gait belt. but chooses not to, and uses a front wheeled walker	F 282	LPN-B received counseling for failing to offer or reposition R36. NA-A received counseling for failing to offer timely repositioning. Resident R77 received new protective boots. NA-F and NA-G received counseling for failing to follow the plan of care for R77. **Action as it applies to others:** All residents will be screened by therapy and as indicated, based on the therapy screens, nursing rehabilitation and ambulation programs will be established, care planned accordingly and carried out as recommended by 10/27/2014.	

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F 282	Continued From page 27 (FWW). R22's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 6/10/14 indicated she uses a FWW and ambulates 100ft with stand by assistance (SBA). Nursing assistant care sheet undated indicated to ambulate up to 100 ft. with gait belt and assist of one and FWW. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 100 ft. "With FWW and SBA daily" which was started on 06/10/14. There was no indication this has been completed as recommend on the 6/10/14, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R24's quarterly MDS dated 7/8/14, indicated he had dementia, was cognitively intact, independent with transfers and needed supervision and assist of one to ambulate in his room and corridor. R24's care plan dated 8/27/13, indicated he can ambulate independently in his room and he prefers to use his walker while going on outings and uses a FWW and transfer belt. The care plan indicated he was to ambulate twice daily for 400 ft. R24's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 9/17/14, indicated he is to ambulate 400 ft. The Nursing assistant care sheet undated indicated to ambulate 400 ft. twice a day.	F 282	The most recent skin risk assessment will be reviewed for each resident. Any resident noted to be at risk for impaired tissue integrity will have appropriately care planned interventions. The nursing assistant care sheets will be updated and the interventions will be carried out as care planned. Residents with current impaired tissue integrity will be assessed by a wound certified registered nurse to ensure appropriate care planned interventions are implemented. The policy and procedure, Care Planning Process, was reviewed on 9/23/2014 and remains current. Staff will be re-educated on the policy by 10/27/2014. **Date of completion:** 10/27/2014.	

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F 282	Continued From page 28 Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 400 ft. with one seated rest with FWW and SBA which was started on 8/27/13. There was no indication this has been completed as recommend on the 8/27/13, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R53's admission MDS dated 6/26/14, indicated she was cognitively intact, needed extensive assistance of two with transfers and did not ambulate in her room or corridor. R53's care plan dated 6/20/14, indicated she is on a FMP to ambulate 200 ft. with a FWW, gait belt and assist of one staff and resident is to walk on her left tiptoe due to heel wound on left heel and to take heel protector off when walking. R53's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/27/14, indicated she ambulates 200 ft. with a FWW , gait belt and contact guard assist (CGA). The nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW twice a day. During interview 9/17/14, at 8:20 a.m. R53 stated that she only walks to the bathroom and back, she stated she would need assistance from staff to walk in the hall and they do not offer to walk her. R53 also stated the staff are not offering to ambulate R139, as well.	F 282	**Recurrence will be prevented by:** Random weekly visual audits will be completed on each unit to ensure staff are following the resident's plan of care for pressure ulcer prevention, rehabilitation and ambulation services. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee. See addendum letter for R139 + R53 10/31/14.	

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F 282	Continued From page 29 Review of the facility Evergreen Terrace Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW, gait belt and contact guard assist (CGA) twice per day a.m. and p.m." which was started on 8/27/14. There was no indication this has been completed twice a day as recommend on the 8/27/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:18 a.m. with physical therapy (PT)-A stated she had just started (R53) on FMP and she has had no decline. R139's admission MDS dated 6/27/14, indicated he was moderately cognitively impaired, transferred with supervision/set up and ambulated in his room independently without assistance. R139's care plan dated 9/17/14, indicated he was on a FMP and ambulated 200 ft. with FWW and contact guard assist (CGA). R139's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/29/14, indicated he was to ambulate 200 ft. with FWW and CGA. The nursing assistant care sheet undated also indicated to ambulate 200 ft. with FWW and CGA. Review of the facility Evergreen Terrace Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW and contact guard	F 282		

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F 282	Continued From page 30 assist (CGA) twice per day" which was started on 8/29/14. There was no indication this has been completed twice a day as recommend on the 8/29/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R14's quarterly MDS dated 5/28/14, indicated she had dementia and a cerebral vascular accident (CVA), had severe cognitive impairment, and needed extensive assist of one to transfer and ambulate. R14's care plan dated 9/12/14, indicated she is on a restorative nursing program the care plan did not address her functional status with mobility. R14's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 5/28/14, indicated R14 ambulated 30 to 80 ft. with a FWW and assist of two by PT. Nursing assistant care sheet undated indicated to ambulate twice daily 30 to 80 ft. with FWW and minimal assist. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulation 30 to 80 feet with FWW twice per day" which was started on 5/28/14. There was no indication this has been completed two times a day as recommend on the 5/28/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/17/14 at 8:00 a.m. with nursing assistant (NA)-E and NA-D both stated they were unable to ambulate their residents due to not having enough time on her shift to complete this	F 282		

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F 282	Continued From page 31 task. During interview 9/17/14, at 11:30 a.m. the director of nursing stated they have had an issue with their FMP and restorative nursing program. The staff members who were in charge of the program had left their position the last week of August 2014 and they currently have no one in charge of the program. She was aware the program was not being completed as directed by the care plan for these residents. Although R20, R27, R48, R22, R24, R53, R139, R14 all had a FMP of ambulation on their care plan, the facility had not implemented these programs as care planned. REHABILITATION R18's quarterly Minimum Data Set (MDS) identified R18 had diagnosis of dementia, with severe cognitive impairment, no behavior disturbances and needed extensive assistance for activities of daily living (ADL's) including ambulation. Review of the Evergreen Terrace Range of Motion Guidelines sheet, dated 7/5/14 from occupational therapy (OT) identified a restorative nursing recommendation which included "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]." R18's care plan last updated on 7/21/14 identified a problem with falls preventions due to increased weakness. The staff were directed to use a "Nu-step 15 minutes a day 6 days per week."	F 282		

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F 282	Continued From page 32 During observation on 9/17/ 14 at 7:20 a.m., 11:00 a.m. and on 9/18/14 at 12:00 p.m. R18 was not observed to use the "Nu-step 15 minutes a day 6 days per week." Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 and August 2014 did not identify the use of the "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]," were being implemented as recommended by occupational therapy on 7/5/14. During interview on 9/17/14 at 2:13 p.m. Certified Occupational Therapy Assistant (COTA)-A stated the facility has a functional maintenance program which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated if we don't have any staff to do the programs the program does not get completed for any of the residents. During interview on 9/18/14 at 2:30 p.m. licensed practical nurse (LPN)-P stated the resident does not receive any exercise with the Nu-Step, due to not having any staff to implement the residents functional maintenance program. PRESSURE ULCER INTERVENTIONS R36's diagnoses, identified on the care plan (CP) dated 8/1/2014, included dementia, chronic kidney disease with hemodialysis, and fracture of scapula and multiple ribs. The admission Minimum Data Set (MDS), dated 7/23/2014, indicated R36 was cognitively impaired, and required extensive, physical assistance for	F 282		

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activities of daily living (ADLs), including two-person assist with bed mobility, transfers and ambulation. R36's CP identified pressure ulcers, and included various interventions to maintain intact skin, among which required [R36] "... to be turned and repositioned every 2 hours." The CP lacked any direction or action staff were to take when R36 refused repositioning or off-loading.

During observation on 9/17/2014 from 10:30 a.m. to 1:19 p.m. (2 hours and 49 minutes) R36 was seated in his wheel chair, without off-loading or repositioning. R36 was in the dining area prior to the noon meal at 10:30 a.m., then was relocated to his usual table at 11:22 a.m. before the meal. R36 was served, then ate his meal, during which time he continued to remain seated in the wheel chair. At 12:57 p.m., licensed practical nurse (LPN)-B approached R36, still seated in his wheel chair, and pushed him from the dining area to his room. Inside the room, LPN-B took R36's vital signs, continuing to be seated. LPN-B told R36 he was to attend a care conference meeting in a few minutes, then exited the room. LPN-B neither offered, nor repositioned or off-loaded R36 while in his room. R36 then propelled himself into the adjacent day room.

At 1:19 p.m., nursing assistant (NA)-A approached R36, and said it was time to get up and stretch. NA-A offered to assist R36 to stand, and encouraged him to ambulate and stretch. NA-D also asked R36 to use the toilet in his room. R36 refused all of NA-A's offers to move, reposition, off load, or toilet.

During an interview on 9/17/2014 at 1:22 p.m., NA-A stated R36 had been last repositioned "around 10:30 this morning. I know he had

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F 282	Continued From page 34 therapy and they off loaded him there for sure." NA-A said it had been "almost three hours" since R36 had been repositioned out of his wheel chair. NA-A stated that of late, R36 had been refusing more and more "to stand up, or repo, or do other things suggested, like brushing teeth." NA-A also said when R36 is here during the day, it was "very difficult" to get him to comply. During an interview on 9/18/2014 at 9:00 a.m., registered nurse (RN)-D stated "We usually do our repos [repositioning] at least every two hours." RN-D said that although [R36's] pressure area had resolved, he remained at risk for future pressure ulcers, and further, that [R36] "...should have been repositioned at 2 hours." RN-D said "We need to be more aggressive in follow through." During an interview on 9/18/2014 at 11:48 a.m., the director of nursing (DON) stated the plan of care "should be followed" for any resident who needed timely repositioning. R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had moderate cognitive impairment, had a stage III pressure ulcer (full thickness tissue loss), and required extensive assistance to complete transfers, bed mobility, and activities of daily living. R77's skin integrity care plan, dated 4/1/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. Further, the care plan indicated an intervention of floating R77's heels (to reduce pressure on them), and to wear	F 282		

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F 282	Continued From page 35 protective boots (Rooke Boots) while in bed. An observation of R77, made on 9/17/14, at 7:05 a.m., revealed R77 lying in bed with his eyes closed. R77 had his blankets pulled up over his face, and had his heels laying directly on the bed. R77 did not have any protective boots on to reduce the pressure on his heels or ankles. When interviewed on 9/17/14, at 2:20 p.m., nursing assistant (NA)-F stated R77 used to wear white protective boots when he was lying in bed, however she was unsure if he should still have them now or not. NA-F stated R77 wore protective boots in bed when he was in a different room, however had not seen them used for R77 since he moved rooms a couple months prior. During interview on 9/17/14, at 2:38 p.m., NA-G stated R77 has not used the protective boots in bed since moving rooms a couple months prior. When interviewed on 9/18/14, at 9:41 a.m., registered nurse (RN)-A stated R77 was supposed to be wearing protective Rooke boots while in bed to reduce the pressure to his heels and ankle. During interview on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated the care plan for R77 should have been followed. A facility Care Planning Process policy, dated 4/13, indicated implementation of the care plan occurs when disciplines read, understand, and act on the plan to deliver the residents daily care.	F 282		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	F 310		

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F 310	Continued From page 36 Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 9 residents (R20 and R48) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R20 and R48. Findings include: R20's quarterly Minimum Data Set (MDS) dated 7/17/14, indicated he had peripheral vascular disease, Alzheimer's, dementia, severe cognitive impairment, ambulated once or twice in his room or corridor with assist of two, received scheduled pain medication and had no presence of pain. R20's quarterly MDS dated 4/30/14, indicated he had severe cognitive impairment, did not walk in his room or corridor, received scheduled pain medication and had no presence of pain. The Care Area Assessment (CAA) dated 1/24/14, indicated R20 triggered for activities of daily living (ADLs) due to needing supervision with dressing, hygiene, bathing, not being steady and needs a wheelchair or walker. During interview 9/17/14, at 8:00 a.m. with	F 310	F310 **Immediate corrective action:** Resident R20 was reassessed by therapy and new recommendations were received. The care plan and nursing assistant care sheets have been updated. Resident R48 was reassessed by therapy and ambulation guidelines have been re-established. The care plan and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task. Resident R48 received a walker to assist with ambulation. **Action as it applies to others:** All residents will be screened by therapy and as indicated, based on the therapy screens, ambulation programs will be established, care planned accordingly and carried out as recommended by 10/27/2014.	

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F 310	Continued From page 37 nursing assistant (NA)-E and NA-D both stated they have not been able to ambulate R20 and other residents due to their work load assignments for the past several months. During observation 9/18/14, at 9:30 a.m. R20 was sitting in his room in a wheelchair, a walker was not observed in his room to assist with ambulation. During interview 9/18/14, at 9:44 a.m. nursing assistant (NA)-D who cared for R20 stated R20 has stopped ambulating over a month ago and that he has becoming more combative with cares. She also stated, "We have no time to ambulate our residents," which had been occurring for the past several months. Review of a Hospital Discharge Summary dated 1/5/14, indicated R20 was admitted for acute sepsis likely secondary to osteomyelitis, an amputation of the right second toe was completed on 1/3/14 without difficulty. R20's care plan dated 2/12/14, indicated he cannot ambulate independently due to recent toe amputation and decline in cognition. The care plan indicated R20's balance while standing was unsteady and that R20 was to participate in a functional maintenance program (FMP) to ambulate with supervision 75-100 feet (ft.) up and down the hallway times two, when able. Review of R20's Pain Assessment 3.0 which was updated on 6/20/14, indicated when asked he had no pain presence, rarely has pain and staff assessment for pain using numeric scale from 00-10 (00 being no pain to 10 being the worst pain experienced) R20 identified their pain as a "1" mild discomfort. The assessment identified R20 received Tylenol 500 milligrams (mg) (analgesic) three times a day. The Pain Assessment 3.0 dated 7/3/14, indicated R20 had no pain presence, rarely has pain and his	F 310	The policy Restorative Nursing Program was reviewed and remains current. Staff will be re-educated on the policy by 10/27/2014. **Date of completion:** 10/27/2014. **Recurrence will be prevented by:** 3 Random weekly visual audits and documentation review audits will be completed on each unit to ensure ambulation programs are implemented and carried out to prevent a decline in ambulation and that any resident is appropriately reassessed upon a decline in ambulation.	

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F 310	Continued From page 38 numeric rating was 00. The assessment identified R20 denied pain, and the Tylenol 500 mg three times a day on 6/20/14, and seems effective for pain relief. The Pain Assessment 3.0 dated 8/21/14, and 9/21/14, remained unchanged from the 7/3/14, assessment indicating resident denied pain and Tylenol extra strength seems effective for pain relief. Review of R20's progress notes from 7/1/14 thru 9/22/14, did not indicate R20 was having any pain or discomfort from his toe amputation in January 2014. The facility's nursing assistant care sheet undated, directed staff to ambulate R20 75-100 ft. with a front wheeled walker (FWW) and gait belt two times daily. A Walking/Ambulation Program Guidelines Restorative Nursing/Functional Maintenance Recommendations authorized by physical therapy (PT) dated 4/9/14, indicated R20 walked with a FWW and a gait belt 75-100 ft. with two self-performance and two support. Review of the progress notes, physician notes and facility assessment from June 20, 2014 to September 18, 2014 did not identify R20 was being ambulated 75-100 ft. with a front wheeled walker (FWW), and gait belt two times daily, as directed by the Walking/Ambulation Program Guidelines Restorative Nursing/Functional Maintenance Recommendations which PT recommended for R20. During interview 9/18/14, at 9:01 a.m. physical therapist (PT)-A stated she hadn't been informed that R20 was not ambulating, and confirmed that he had not been seen by physical therapy since 4/9/14, when he'd started on his walking/ambulation program. PT-A then stated she would reassess his ability to ambulate.	F 310	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 310	Continued From page 39 During interview 9/18/14, at 9:20 a.m. the director of nursing (DON) stated in November 2013, the facility started documenting the FMP's in a new computer system and stated she was unable to find any documentation that staff were providing R20 with his FMP that started on 4/9/14. The DON further stated the staff development nurse who left in March 2014, was supposed to be documenting quarterly on his progress with his FMP but she had not completed this. During interview on 9/17/14 at 2:13 p.m. certified occupational therapy assistant (COTA)-A stated the facility has a functional maintenance program which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated, "If we don't have any staff to do the programs, the programs have not been implemented for any of the residents." Review of the Physical Therapy Plan of Care dated 9/17/14, identified reason for referral was, "[functional decline] Patient is a 86 year old male who presents with a decline in transfers and ambulation due to patient not participating in current FMP for ambulation and decreased bilateral ankle ROM [range of motion]. This since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation." The referral indicated under initial assessment that his prior level was that he walked 100 ft. with his front wheeled walker. The current level of his assessment indicated he needs "moderate assist x 2 persons [Routinely requires 50 % physical assistance of 2 persons to transfer]." The referral under gait distance indicated his prior level was "100 feet" and his	F 310		

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current level is "0 feet." The evaluation also indicated "Therapy is necessary for improving bilateral ankle ROM, transfers, and ambulation along with updating current FMP to make it appropriate for the patient due to his dementia with behavior disturbances. Without therapy patient is at risk for further functional decline." The referral indicated R20 received acetaminophen for pain but did not indicate R20 was currently having any pain.
During interview 9/18/14, at 9:01 a.m. PT-A stated that R20 started on a FMP on 4/19/14, and that he was able to ambulate 75-100 ft. with his front wheeled walker. The PT-A stated she had attempted to ambulate R20 yesterday (9/17/14), and R20 would not ambulate with her. She had spoken to the staff and they informed her he [R20] was no longer ambulating. PT-A stated staff are supposed to inform her if a resident is declining or is no longer is able to complete their FMP, but stated she had never been informed that R20 was not ambulating anymore. PT-A stated she was going to try and get approval to pick him back up again for therapy.
During a phone interview 9/22/14, at 11:40 a.m. PT-A stated that if a resident was observed during her evaluation to have pain she would document that on the evaluation.
Although R20 had a FMP to assist with ambulation, the facility failed to ambulate R20, which resulted in a decline in ambulation which was not reassessed, and resulted in actual harm for R20.

R48's quarterly MDS dated 6/17/14, indicated he had a diagnosis of arthritis, cerebral vascular accident (CVA), was cognitively intact and transferred with limited assist of one. He ambulated in his room with extensive assist of

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F 310	Continued From page 41 one and did not ambulate in the corridor. R48's care plan dated 3/14/14, indicated on 5/23/13 he was placed on a FMP to ambulate 100 ft. twice daily with walker. The nursing assistant care sheet undated, indicated R48 was to ambulate 100 ft. twice daily with a walker. R48's FMP documentation dated May 2013 indicated under comments section of the FMP identified "[R48] to ambulation 100 ft. twice a day with walker and assist of one staff. he will demonstrate benefits from his program by his ability to stand & transfer with assist of one staff." During interview 9/17/14, at 8:00 a.m. with NA-E and NA-D both stated they have not been able to ambulate R48 or their other residents due to their work load assignments for the past several months. During interview and observation on 9/17/14, at 8:20 a.m. R48 stated he does not ambulate and the staff do not offer to ambulate him. He further stated if staff would offer to ambulate with him he would not refuse. There was no walker observed in his room. During interview on 9/17/14 at 2:13 p.m. COTA-A stated the facility has a FMP which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated, "If we don't have any staff to do the programs, the programs have not been implemented for any of the residents." Review of the progress notes, and FMPs from	F 310		

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F 310	Continued From page 42 June 2014 to September 8, 2014, did not identify R48 had been ambulated 100 ft. twice a day with a walker, as identified by the 5/23/13 FMP. During interview 9/18/14, at 9:01 a.m. PT-A stated she would be reassessing R48's ability to ambulate. Review of the Physical Therapy Plan of Care Evaluation dated 9/18/14 (during survey), indicated he was re-evaluated for ambulation to check for a decline. The evaluation indicated he was able to ambulate 100 ft and now was only able to ambulate 20 ft, but wanted to continue his FMP. During phone interview 9/25/14, at 10:30 a.m. PT-A stated that when she had evaluated R48 for a decline he was only able to ambulate 20 feet, and the program initially started May 2013. PT-A stated she had recommend the facility to ambulate R48 up to 100 feet with front wheeled walker and assistance of two staff. A request was made to the facility for the May 2013 FMP and none was provided. During interview 9/17/14, at 11:30 a.m. the DON stated they have an issue with their FMP and restorative nursing and indicated the staff member who was in charge of the program had walked off of the job the last week of August and they currently have no one in charge of the program. Although R48 had a FMP to assist with ambulation, the facility failed to ambulate R48, which resulted in a decline in ambulation which was not reassessed, and resulted in actual harm for R48. A Restorative Nursing Program policy revised	F 310		

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F 310	Continued From page 43 March 2013, indicated the policy to, "promote each residents ability to adapt to or attain his or her maximum functional potential. To promote each resident's highest practicable level of physical, mental and psychosocial functioning." The policy further indicated all restorative nursing programs must be reviewed by a registered nurse and need to address how they are working and if changes are made, why the changes were made. This needs to be done quarterly. They must be individualized and address how they are maintaining or improving ambulation, range of motion (ROM), continence etc. and be specific about how this is happening for each resident. The policy also indicated the notes need to assess progress or lack of progress, changes made, why programs needed to continue (or discontinue in some cases), and why program is maintaining or restoring a function that affects the residents activity of daily living skills (ADL'S).	F 310		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 7 of 9 residents (R27, R22, R24, R53, R139, R14 and R18) reviewed for rehabilitation services.	F 311	F311 **Immediate corrective action:** Residents R27, 22, 24, 53, 14 and 18 were reassessed by therapy and ambulation guidelines have been re-established. The care plans and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task.	

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F 311	Continued From page 44 Findings include: R27's annual Minimum Data Set (MDS) dated 6/12/14, indicated he had diabetes mellitus and depression. The MDS further indicated he ambulates with set up only and transfers with supervision and assist of one and is moderately cognitively intact. R27's care plan dated 6/2/14, indicated he was on a FMP which includes ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff. R27's nursing assistant care sheet undated indicated he was to ambulate 90 to 100 ft twice daily. R27's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 10/15/13, indicated he is to ambulate 90 to 100 ft. twice daily and to increase as tolerated. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated the reason for referral for re-evaluation for appropriateness of FMP for ambulation in order to check for any possible decline. The referral indicated for Initial Assessment his prior level was stand by assist for transfer and that he ambulated 100 ft. needing contact guard, and his current level indicated he now can ambulate 175 ft. with contact guard assist. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff." this was started on 10/15/13. There was no indication this has been completed	F 311	The care plan and nursing assistant care sheets have been updated. Daily documentation guidelines have been implemented to indicate completion of the task. **Action as it applies to others:** All residents will be screened by therapy and as indicated, based on the therapy screens, nursing rehabilitation and ambulation programs will be established, care planned accordingly and carried out as The policy Restorative Nursing Program was reviewed and remains current. Staff will be re-educated on the policy by 10/27/2014. **Date of completion:** 10/27/2014. **Recurrence will be prevented by:** 3 Random weekly visual audits and documentation review audits will be completed on each unit to ensure ambulation	

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	245495	A. BUILDING _____ B. WING _____	09/18/2014

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F 311	Continued From page 45 as recommend on the 10/15/13 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:05 a.m. physical therapist (PT)-A stated she evaluated R27 and he now ambulates 175 ft. R22's annual MDS dated 7/1/14, indicated she had arthritis and osteoporosis. The MDS further indicated she transferred independently and ambulated independently in her room and ambulated in the corridor once or twice with no set up or physical assist from staff and is cognitively intact. R22's care plan dated 1/20/14, indicated she can ambulate although she chooses not to, and uses a FWW. The care plan further indicated she can ambulate up to 100 ft. daily with a gait belt. R22's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 6/10/14 indicated she uses a FWW and ambulates 100ft with stand by assistance (SBA). Nursing assistant care sheet undated indicated to ambulate up to 100 ft. with gait belt and assist of one and FWW. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated she was able to ambulate 70 ft. and now can ambulate 70 ft. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to	F 311	programs are implemented and carried out to prevent a decline in ambulation and that any resident is appropriately reassessed upon a decline in ambulation. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 311	Continued From page 46 September 18th, 2014, did not identify he was ambulating 100 ft. with FWW and SBA daily" which was started on 06/10/14. There was no indication this has been completed as recommend on the 6/10/14, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:10 a.m. with PT-A stated R22 has remained the same with her ambulation and has not had a decline. R24's quarterly MDS dated 7/8/14, indicated he had dementia and was independent with transfers and needed supervision and assist of one to ambulate in his room and corridor and was cognitively intact. R24's care plan dated 8/27/13, indicated he can ambulate independently in his room and he prefers to use his walker while going on outings and he uses a FWW and transfer belt. The care plan indicated he is to ambulate twice daily for 400 ft. R24's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 9/17/14, indicated he is to ambulate 400 ft. with a seated rest and FWW and stand by assist (SBA). Nursing assistant care sheet undated indicated to ambulate 400 ft. twice a day. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated he is currently able to ambulate 420 ft. with one seated rest and supervision stand by assist (SBA).	F 311		

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F 311	Continued From page 47 Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 400 ft. with one seated rest with FWW and SBA" which was started on 8/27/13. There was no indication this has been completed as recommend on the 8/27/13, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:12 a.m. with PT-A stated R24 has not had a decline in his ambulation. R53's admission MDS dated 6/26/14, indicated she had a thyroid disorder and needed extensive assist of two with transfers and did not ambulate in her room or corridor. The MDS further indicated she is cognitively intact. R53's care plan dated 6/20/14, indicated she is on a FMP to ambulate 200 ft. with a FWW, gait belt and assist of one staff and resident is to walk on her left tiptoe due to heel wound on left heel and to take heel protector off when walking. R53's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/27/14, indicated she ambulates 200 ft. with a FWW , gait belt and contact guard assist (CGA). Nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW twice a day. R53's Physical Therapy Plan of Care Evaluation dated dated 9/17/14, indicated she was able to ambulate 200 ft. and now can ambulate 250 ft.	F 311		

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F 311	Continued From page 48 Review of the facility Evergreen Terrace Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW, gait belt and contact guard assist (CGA) twice per day a.m. and p.m." which was started on 8/27/14. There was no indication this has been completed twice a day as recommend on the 8/27/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/17/14, at 8:20 a.m. R53 stated that she only walks to the bathroom and back, she stated she would need assistance from staff to walk in the hall and they do not offer to walk her. R53 also stated the staff are not offering to ambulate her husband R139. During interview 9/18/14, at 9:18 a.m. with PT-A stated she had just started her on FMP and she has had no decline. R139's admission MDS dated 6/27/14, indicated he transferred with supervision and set up and ambulated in his room independently with no help and is moderately cognitively impaired. R139's care plan dated 9/17/14, indicated he is on a FMP and ambulates 200 ft. with FWW and CGA. R139's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/29/14, indicated he was to ambulate 200 ft. with FWW and CGA. Review of the facility Evergreen Terrace	F 311		

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F 311	Continued From page 49 Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW and contact guard assist (CGA) twice per day" which was started on 8/29/14. There was no indication this has been completed twice a day as recommend on the 8/29/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. Nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW and CGA. During interview 9/18/14, at 9:18 a.m. PT-A stated he had just started him on a FMP and he has had no decline and she did not re-evaluate him. R14's quarterly MDS dated 5/28/14, indicated she had dementia and a cerebral vascular accident (CVA) the MDS further indicated she needed extensive assist of one to transfer and ambulate and severely cognitively impaired. R14's care plan dated 9/12/14, indicated she is on a restorative nursing program the care plan did not address her functional status with mobility. R14's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 5/28/14, indicated R14 ambulated 30 to 80 ft. with a FWW and assist of two. Nursing assistant care sheet undated indicated to ambulate twice daily 30 to 80 ft. with FWW and minimal assist. R14's Physical Therapy Plan of Care Evaluation	F 311		

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F 311	Continued From page 50 dated 9/17/14, indicated she was able to ambulate 30 ft and now can ambulate 40 ft. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulation 30 to 80 feet with FWW twice per day" which was started on 5/28/14. There was no indication this has been completed two times a day as recommend on the 5/28/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:20 a.m. with PT-A stated R14 has had no decline in her mobility. During interview 9/17/14, at 8:00 a.m. with nursing assistant (NA)-E stated she is unable to ambulate her residents due to not having enough time on her shift. NA-D also stated she is unable to ambulate her residents. During interview 9/17/14, at 11:30 a.m. the director of nursing (DON) stated they had an issue with there functional maintenance (FMP) and restorative nursing she indicated the staff member who was uncharged of the program had walked off of the job the last week of august and they currently have no one in charge of the program and realized there has been no documentation that the programs are being completed. R18's quarterly Minimum Data Set (MDS) identified R18 had diagnosis of dementia, with severe cognitive impairment, no behavior	F 311		

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F 311	Continued From page 51	F 311		

disturbances and needed extensive assistance for activities of daily living (ADL's) including ambulation.

During in interview on 9/17/14 at 7:45 a.m. nursing assistant (NA)-I stated they assist R18 to ambulate in the hallway in the afternoon, then when the next shift comes, they also help him ambulate. He does well with ambulating and has no behaviors.

During interview on 09/17/2014 at 12:40 p.m. trained medication assistant (TMA)-P stated they ambulate R18 in the afternoon.

During observation on 9/17/14 at 2:00 p.m. R18 was in the dining room and was assisted to ambulate with his front wheeled walker, gait belt, and the assistance of trained medication aide (TMA)-P. His gait was unsteady, and had a limp on his right side but was able to ambulate from the dining room approximately 300 feet in the hallway.

Review of the PT [physical therapy] Therapist Progress & Discharge Summary dated 7/8/14 identified R18 had made gains in strength, transfers, and ambulation physically, however is limited to by dementia for safety awareness. The plan was for R18 to have a restorative nursing program and functional maintenance program for ambulation.

The facility Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet from PT dated 7/5/14 identified R18 was to ambulate with front wheeled walker and gait belt, 300 feet daily three times a day. The goal was identified, "Will maintain ability

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F 311	Continued From page 52 to walk 300 feet with FWW device..." The occupational therapy (OT)- therapist Progress & Discharge Summary sheet completed on 7/8/14 identified R18 had gained in strength, activity tolerance and balance have impacted the residents ability to perform self care, and functional mobility with a reduction in physical assist to stand by assistance and requires frequent cues for safety. The discharge plan and instructions were to start with functional maintenance program designed to maintain gains achieved as a result of OT. The Evergreen Terrace Range of Motion Guidelines sheet, dated 7/5/14 from OT identified a restorative nursing recommendation which included "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]." The care plan last updated on 7/21/14 identified a problem with falls preventions due to increased weakness. The staff were directed to "ambulate to all destinations, nu-step 15 minutes a day 6 days per week, and ambulate 300 ft [feet] with FWW [front wheeled walker], SB [stand by] of 1 and gait belt." The facility Pocket Care Plan (not dated), which the nursing assistants use to identify what needs to be completed for the residents directed the NA's to "ambulate 300 ft FWW SB of 1 and gait belt." There was no indication of frequency of ambulation nor was there any mention of the Nu-Step in the care plan even though therapy had made these recommendations on 7/8/14. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 identified "ambulation 300 ft with FWW and SBA	F 311		

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F 311	Continued From page 53 and gait belt Q [every] shift." this was started on 7/21/14 for 6-2 and 2-10 shifts. There was no indication this has been completed three times a day as recommend on the 7/5/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. Also, the ambulation had not been implemented until 7/21/14, and not 7/5/14, as identified on the Walking/Ambulation Program Guidelines Functional Maintenance Recommendation sheet. The August 2014 Documentation Survey Report sheet identified ambulation was completed twice a day and not three times a day as recommended by therapy. Also, there was no indication the "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]," had been completed as recommended for the functional maintenance program by OT on 7/5/14. During interview on 9/17/14 at 2:13 p.m. Occupational Therapy Assistant (OTA)-A stated the facility has a functional maintenance program which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated if we don't have any staff to do the programs so the programs have not been implemented for any of the residents, for the past several weeks, maybe months. During interview on 09/17/2014 at 2:25 p.m. NA-I stated they ambulate R18 in the afternoon, and the other shift as well. She stated they have not had any restorative aide at this time to complete the functional maintenance program of some of the residents.	F 311		

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F 311	Continued From page 54 During interview on 9/18/14 at 2:30 p.m. licensed practical nurse (LPN)-B stated the resident does not receive any exercise with the Nu-Step and verified R18 ambulates with staff in the hallway in the afternoon, but will be adding some ambulation to and from all meals, along with ambulating in the hallway. Although R27,R48,R22, R24, R53, R139, R14 and R18 were placed on a FMP the facility failed to complete there programs as ordered by therapy.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine grooming (nail care) for 1 of 3 residents (R77) whom was dependent on staff for care, whom was reviewed for activities of daily living and grooming. Findings Include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had an active diagnosis of diabetes mellitus, required extensive assistance	F 312	F312 **Immediate corrective action:** Resident R77 received immediate assistance with fingernail care. **Action as it applies to others:** All residents will receive fingernail care according to their personal preference. All nursing assistant care cards will be reviewed to assure resident grooming needs, to include nail care preferences, are included.	

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F 312	Continued From page 55 from staff for his personal hygiene, and had moderate cognitive impairment. R77's care plan, dated 9/8/14, indicated R77 required assistance with dressing, grooming, and bathing. Further, the care plan indicated R77 required weekly nail care. During observation on 9/16/14, at 9:22 a.m., R77 was seated in his wheelchair in his room. R77 had long, un-trimmed fingernails on both hands, with a dark substance underneath several of the nails. Subsequent observations of R77 on 9/17/14 at 7:08 a.m., and 9/18/14 at 8:19 a.m., were made and R77 continued to have un-trimmed, dirty fingernails. When interviewed on 9/18/14, at 8:19 a.m., R77 stated he would like his fingernails to be trimmed and kept shorter. R77's family member, whom was present during interview, stated at times s/he would take an emery board (nail file) to R77's nails because they were long and not kept trimmed. During interview on 9/17/14, at 9:04 a.m., nursing assistant (NA)-D stated fingernails should be trimmed on the resident's bath day. Further, NA-D stated R77's fingernails should have been clean and trimmed. During interview on 9/18/14, at 9:29 a.m., registered nurse (RN)-A stated R77 required help from staff to complete grooming and personal cares. RN-A stated R77 had no identified preference to have long fingernails, and his fingernails should have been trimmed by a nurse.	F 312	The policy and procedure for Nursing Care Standards was reviewed on 9/23/2014 and remains current. Nursing staff will be re-educated on the policy 10/27/2014. **Date of completion:** 10/27/2014. **Recurrence will be prevented by:** 3 Random weekly visual audits and resident interviews will be conducted on each unit to ensure residents are receiving assistance with grooming according to their personal preferences in a manner which maintains or enhances each resident's dignity. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 312	Continued From page 56 When interviewed on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated nursing staff are expected to trim and clean fingernails routinely. Further, the DON stated R77's fingernails should have been trimmed according to his preference. A facility Nursing Care Standards policy, dated 8/09, indicated standards to follow to ensure each resident is provided the highest practicable level of care. Further, the policy indicated, "Fingernails and toenails shall be clean and trimmed."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in accordance with an established care plan and physician orders, to promote healing and prevent infection for 2 of 3 residents (R77, R36) with current pressure ulcer(s). This resulted in actual harm for R77 evidenced by worsening pressure ulcer characteristics.	F 314	F314 **Immediate corrective action:** Resident #77 dressing was changed per MD order on 9/18/14. All nurses assigned to care for resident #77 on 9/16 and 9/17 were counseled and re-educated on following the MD order of viewing and changing the dressing daily. -See F28 for additional information R77 10/31/14 Date of completion	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 57 Findings include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had moderate cognitive impairment, had a diagnosis of diabetes mellitus (a metabolic disease resulting in high blood sugars over a long period of time), and required extensive assistance to complete transfers, bed mobility and activities of daily living. R77 had a stage III pressure ulcer (full thickness tissue loss, slough may be present but does note obscure the depth of tissue loss) with dimensions of 1.5 cm (centimeter) X (by) 1.5 cm X 0.2 cm, with granulation tissue (pink or red tissue with shiny, moist, granular appearance). R77's care plan, revised on 8/5/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The care plan indicated a goal of care to be free of skin breakdown, and further identified interventions of, "Treatment as ordered," "Float heels while in bed," and "I have Rooke boots to wear in bed." R77's Order Summary Report, dated 9/4/14, indicated R77 should have his right outer ankle wound (pressure ulcer) cleansed with normal saline, dressed with calcium alginate (a dressing used for wounds with significant drainage), and covered with Optifoam (a dressing used to absorb wound drainage). The Order Summary Report, signed by the medical doctor on 9/4/14, indicated R77 should have this dressing changed daily. During observation on 9/17/14, at 7:05 a.m. R77 was lying in bed with his eyes closed and had blankets pulled up over his face, with his heels lying directly on the bed. R77 did not have any	F 314	Resident #36 was reassessed by completing a new Tissue Tolerance Test to confirm the necessary times repositioning or off-loading should be performed. His refusal to comply was added to the care plan and resident was explained and given information on the Risks/Benefits of repositioning/off-loading per assessment. The results of the new TTT will be shared with the Dialysis Unit. **Action as it applies to others:** The policy and procedure for repositioning and pressure ulcer care were reviewed and remain current.	

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	245495	A. BUILDING _____ B. WING _____	09/18/2014

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F 314	Continued From page 58 protective boots (Rooke boots) on to reduce the pressure on his heels or ankles as identified in the care plan. When interviewed on 9/17/14, at 2:20 p.m. nursing assistant (NA)-F stated R77 used to wear white boots when he was lying in bed, however, she was unsure if he should still have them now or not. NA-F stated the resident had worn protective boots in bed when he was in a different room, however, had not seen them used since R77 changed rooms a few months prior. During interview on 9/17/14, at 2:38 p.m., NA-G stated R77 has not used the protective boots in bed since moving to a different room a few months ago. When interviewed on 9/18/14, at 9:41 a.m., registered nurse (RN)-A stated R77 was supposed to be wearing protective Rooke boots while in bed to reduce the pressure to his heels and ankles. During observation of pressure ulcer care on 9/18/14 at 10:05 a.m. RN-C stated the current treatment for R77's right ankle pressure ulcer was to cleanse it with normal saline, dress with calcium alginate, and cover the ulcer with Optifoam everyday. RN-C removed R77's cotton sock from his foot revealing a foam dressing to his right ankle. There was writing on the foam dressing which read, "9-19" (the following day). Further, the dressing had an illegible name written underneath the date. RN-D came into the resident's room at 10:15 a.m. to observe the ulcer with RN-C. RN-D stated it appeared as if the dressing had been placed on the ankle days prior, and the date on the dressing had been	F 314	All residents with pressure ulcers or at high risk of skin breakdown will be reviewed to assure their most recent assessments are current and care plans reflect their MD ordered treatments and repositioning/off-loading schedules. The nursing assistant care sheets will also be reviewed to assure they are accurate. All staff will be In serviced on repositioning needs and nurses will be In serviced on pressure ulcer treatment and following MD orders accurately. **Date of completion: 10/27/14**	

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F 314	Continued From page 59 changed. However, stated it appeared the actual dressing on R77's ankle had not been changed. RN-D stated the writing on the dressing appeared to be 9/15 versus 9/19. RN-A came into the room to observe the pressure ulcer at 10:19 a.m. with RN-C, and RN-D. RN-A stated she had seen the wound earlier that same week, and it that it appeared the dressing had not been changed since 9/15 according to writing on the dressing. RN-A stated the ulcer should be viewed, and the dressing changed everyday. RN-C removed the foam dressing from R77, and the pressure ulcer wound was observed by RN-A and the surveyor. RN-A measured the pressure ulcer at 1.0 cm X 1.0 cm X 0.1 cm, however stated the ulcer now had purulent drainage (primarily pus), foul odor, and the wound bed no longer had 100% granulation tissue, but now contained some slough (non-viable tissue that requires debridement [removal]). RN-A further stated the wound appeared to have increased redness around the wound edges from when she had previously viewed earlier in the week. RN-C completed the pressure ulcer treatment, and applied a new Optifoam dressing and dated it 9/18/14. When interviewed immediately following the wound care observation, at approximately 10:45 a.m., RN-C stated the pressure ulcer dressing had not been consistently changed on a daily basis, as the physician ordered. RN-C further stated the ulcer seems to be larger than she previously had seen. Review of R77 record identified the following: A fax communication to the physician on 8/13/14, identified R77 developed a "fluid filled blister on	F 314	**Recurrence will be prevented by:** Visual audits of repositioning/off-loading per care plan and pressure ulcer treatment procedures followed will be completed 3x weekly at various times on each unit for 90 days. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease or discontinue these audits. **The correction will be monitored by:** **DON or Designee**	

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F 314	Continued From page 60 [R right] outer ankle. Area measures 1.4 X 2.5 cm." R77's Weekly Wound Documentation Form, dated 8/27/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the ulcer to be 1.9 cm X 1.2 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, moderate serosanguinous drainage, no odor or pain associated with the ulcer. In addition, the form indicated the pressure ulcer was stable in condition with a plan to continue the current treatment of cleansing with normal saline, applying calcium alginate and covering with a foam dressing. R77's Weekly Wound Documentation Form, dated 9/2/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the ulcer to be 1.0 cm X 0.8 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, scant serosanguinous drainage, no odor or pain associated with the ulcer. Further, the form indicated the pressure ulcer was improved in overall condition with a plan to continue the current treatment. R77's most recently completed Weekly Wound Documentation Form, dated 9/9/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the wound to be 1.0 cm X 1.0 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, scant serosanguinous drainage (containing both blood and serous fluid), no odor, and no pain associated with the pressure ulcer. Further, the form indicated the pressure ulcer was stable in condition, and the plan was to continue the current treatment.	F 314		

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F 314	Continued From page 61 R77's Braden Scale for Predicting Pressure Sore Risk, dated 8/21/14, indicated R77 had no sensory perception impairments, was occasionally exposed to moisture, walked occasionally, had very limited mobility, excellent nutrition, and was potentially exposed to friction and shear. Further, the document indicated R77 had an open area (pressure ulcer) on his ankle, and a history of skin breakdown. R77's Care Area Assessment (CAA) progress note, dated 9/18/14, indicated R77 had a stage III pressure ulcer on his right outer ankle, and remained at risk for further skin breakdown related to R77's impaired mobility, being incontinent of urine, and cognitive impairments. Further, the note indicated, "staff are monitoring healing of stage 3 ulcer on right ankle daily with dressing changes and documenting weekly." During interview on 9/18/14, at 10:59 a.m. the director of nursing (DON) stated the physician orders and care plan interventions need to be followed. The DON stated R77's dressing changes should be completed per the physician orders, documented accordingly, and the care plan interventions should have been followed. R77 had a current stage III pressure ulcer, was assessed at risk for further pressure ulcer development, and had physician orders for daily dressing changes of the pressure ulcer. The facility did not implement daily dressing changes as ordered by the physician for R77's stage III pressure ulcer. The facility also did not implement pressure relieving boots while in bed to prevent additional ulcer development or worsening of the current ulcer. As a result, R77's stage III pressure	F 314		

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F 314	Continued From page 62 ulcer on his right ankle went from 100% granulation tissue in the wound bed on 9/9/14, to having slough tissue present, developed a foul odor when none had been present before, and developed purulent drainage indicative of infection on 9/18/14. A facility Prevention of Pressure Ulcers policy, dated 2/2014, indicated pressure ulcers were a serious skin condition for the resident, and the facility should have a system or procedure to assure assessments are timely, appropriate, and for changes in condition to be recognized, evaluated, and reported. Further, the policy indicated the date and time skin care was given should be recorded in the medical record. R36's diagnoses, as identified on the care plan (CP), dated 8/1/2014, included dementia, chronic kidney disease with hemodialysis, and fracture of scapula and multiple ribs. The admission MDS, dated 7/23/2014, indicated R36 was cognitively impaired, and required extensive, physical assistance for ADLs, including two-person assist with bed mobility, transfers and ambulation. A Braden Pressure Sore risk assessment, dated 8/18/2014, indicated R36 was at low risk for development of pressure sores, and further, that R36 repositioned himself. The CAA for pressure ulcers, dated 5/29/2014, indicated R36 was at risk to develop pressure ulcers related to chronic kidney disease, and needing extensive assistance with bed mobility and weakness. A nursing progress note dated 7/31/2014, indicated R36 had an open area on left buttocks, which measured 3 centimeters (cm) by 2 cm by less than 0.2 cm in depth. During observation on 9/17/2014, R36 was	F 314		

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F 314	Continued From page 63 seated in his wheel chair from 10:30 a.m. to 1:19 p.m., a total of 2 hours and 49 minutes, without any off-loading (removing pressure to allow tissue perfusion) or repositioning. At 10:30 a.m., R36 was seated in his wheel chair at a table in the dining area prior to the noon meal, visiting with other residents. At 11:37 a.m., R36 was assisted by staff, and relocated to his usual table in the dining area, and subsequently ate the noon meal. At 12:57 p.m., licensed practical nurse (LPN)-F removed R36, still seated in his wheel chair, from the dining area, and pushed him to his room. Inside the room, LPN-F took R36's vital signs, and continued to remain seated. LPN-F told R36 he was to attend a care conference meeting in a few minutes, and a staff member would help him to the meeting room. At 1:05 p.m., LPN-F then exited R36's room. LPN-F neither offered nor repositioned or off-loaded R36 while in his room. At 1:09 p.m., R36, still seated in his wheel chair, propelled himself from his room into the adjacent day room, positioning his wheel chair at a table. At 1:19 p.m., NA-A entered the day room, approached R36, and told him it was time to get up and stretch. NA-A offered R36 to assist him to stand, and encouraged him to ambulate and stretch. NA-D also asked R36 to use the toilet in his room but R36 refused all of NA-A offers to move, reposition, or off load. During an interview on 9/17/2014, at 1:22 p.m. NA-A stated R36 had been last repositioned "...at 10:30 this morning," it had been "almost three hours" since R36 had been repositioned out of his wheel chair. NA-A acknowledged that R36 had been seated in his wheelchair, without repositioning or off-loading, for nearly 2 hours and 50 minutes. NA-A stated that of late, R36 had	F 314		

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F 314	Continued From page 64	F 314		

been refusing more and more "to stand up, or repo, or do other things suggested, like brushing teeth." NA-A also said when R36 was was there during the day, it was "very difficult" to get him to comply.

A review of a weekly wound documentation progress noted on 8/13/2014, indicated presence of a stage 2 pressure ulcer on R36's left buttock, measuring 0.8 cm x 0.5 cm x < [less than] 0.2 cm. The ulcer was 100% granulation tissue, with scant, serous drainage, surrounding area pink, with no signs or symptoms of infection. The note also indicated R36 exhibited mild pain during treatment. A review of the weekly wound notes from 8/13/2014, to 9/10/2014, indicated the pressure ulcer was healing, and subsequently, had resolved.

During observation on 9/18/2014, at 10:27 a.m. LPN-A had assisted R36 with toileting. R36's buttocks was slightly pink and had no open areas. LPN-A applied a barrier cream to R36's previously open area, during which time R36 denied any sensation of pain.

During an interview on 9/18/2014, at 9:00 a.m. RN-D stated, "We usually do our repos [repositioning] at least every two hours." RN-D said that although [R36's] pressure area had resolved, he remained at risk for future pressure sores, and further, that [R36] "...should have been repositioned at 2 hours." RN-D said, "We need to be more aggressive in follow through." In a subsequent interview at 11:10 a.m., RN-D said she did not know if R36 was routinely repositioned or off loaded when off site receiving dialysis, and noted those runs can last "more than three hours." RN-D also said that recently, R36

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F 314	Continued From page 65 was refusing to follow staff direction, especially on the days he does not leave the building. RN-D said R36's refusal to reposition, or get up out of the wheel chair "should be part of his assessment and care plan." RN-D said she was unaware of any repositioning schedule while R36 attended dialysis. Although R36's assessments indicated he was at risk to develop pressure ulcers, the assessment did not identify R36's refusal of cares, including repositioning or off loading. The assessment did not identify if R36 was repositioned while at dialysis, even though he was gone for several hours three days a week. R36's CP identified pressure ulcers, and included various interventions to maintain intact skin, among which required [R36] "... to be turned and repositioned every 2 hours." The CP lacked further direction, or action, staff were to take either, when R36 was off-site, such as when attending dialysis, or when R36 refused repositioning or off-loading, regardless of location. During an interview on 9/18/2014, at 11:48 a.m. the DON stated the plan of care "should be followed" for any resident who needs timely repositioning. The DON agreed a resident's refusals of care also needed to be assessed, and that risks and benefits of refusal "needed to be identified."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		

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F 315	Continued From page 66 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident received timely assistance with toileting for 1 of 3 residents (R77) who had a toileting program; In addition, the facility failed to have medical justification of use for an indwelling urinary catheter for 1 of 1 residents (R150) who had a urinary catheter. Findings include: R77's quarterly Minimum Data Set (MDS) indicated R77 had moderate cognitive impairment, required extensive assistance with toileting, and was frequently incontinence of urine. R77's care plan, dated 10/5/13, indicated R77 was frequently incontinent of urine, used a toilet or urinal for elimination with staff assistance and had a goal of wanting to participate in his toileting program to become more continent. Further, the care plan indicated to offer R77 the toilet every 2 hours. During observation of personal cares on 9/17/14, at 7:08 a.m., nursing assistant (NA)-G and NA-F assisted R77 to stand with the use of a	F 315	F315 **Immediate corrective action:** NA-F and NA-G were counseled and re-educated on the need to offer resident #77 urinal or take to toilet q 2 hours per care plan and the appropriate cleanser to be used for incontinence hygiene. Resident #150 MD was contacted to obtain the appropriate diagnosis and amount of retention and date last tested for retention in order to justify the need for an indwelling catheter. An order to remove catheter and test for retention and amount of retention will be obtained if the necessary documentation is not provided by discharging hospital.	

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F 315	Continued From page 67 mechanical lift at his bedside. NA-F removed R77's incontinence product at the bedside and placed it in the trash. The incontinence product was saturated with urine, and had a moderate amount of stool present. NA-G sprayed R77's coccyx and buttocks with Medline Wound Cleanser, dried R77 with a disposable washcloth, and applied a new incontinence product before seating R77 on the bed. NA-G and NA-F completed the remainder of R77's cares,and left the room, without offering or assisting R77 to use the toilet or urinal. Review of R77's Bladder Assessment, dated 8/21/14, indicated R77 was incontinent of urine, and had several risk factors for continued incontinence including impaired mobility, and being dependent on staff for transfers. The assessment indicated R77 had functional incontinence resulted from mobility impairments and, "Lack of ability to get to toilet or toilet substitute...". Further, the assessment indicated staff were to assist with toileting and hygiene, but did not identify a toileting frequency for R77. During interview on 9/17/14, at 2:20 p.m., NA-F stated this was their normal routine procedure (observation that morning on 9/17/14 at 7:08 a.m.) for delivering care to R77. NA-F stated the resident should have been offered the use of the toilet versus being changed at the bedside. Also, they should not have used wound cleanser on his coccyx and buttocks to provide perineal care. When interviewed on 9/17/14, at 2:38 p.m., NA-G stated R77 was not offered the toilet during the morning observation (9/17/14 at 7:08 a.m.) as R77 had already been incontinent of urine and bowel. Further, NA-G stated R77 should have	F 315	**Action as it applies to others:** The policy and procedure for indwelling catheter use was reviewed and remains current. The policy and procedure for providing incontinence care and toileting was reviewed and remains current. All residents with indwelling catheters will be reviewed to assure the necessary diagnosis and amount of retention if applicable is documented. All residents with incontinence care needs will be reviewed to assure their plans are accurate and current.	

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F 315	Continued From page 68 been offered the toilet during care, and should not have had wound cleanser used on his coccyx and buttocks for perineal care, "That was my fault." During interview on 9/18/14, at 12:40 p.m., registered nurse (RN)-A stated R77 had been incontinent of urine for several months and should have been offered the toilet with cares. R77 was at a higher risk of further bladder function loss because he was not given the opportunity to use the toilet. During interview on 9/18/14, at 12:43 p.m., the director of nursing (DON) stated R77 should have been helped to the toilet by staff during morning cares as directed by the assessment and care plan. The DON further stated not assisting R77 to the toilet increases R77's risk of further bladder incontinence and loss of function. A facility Bowel and Bladder Retraining policy, dated 4/13, indicated the facility will ensure each resident is, whom was incontinent, is given the opportunity to achieve continence when appropriate. R150's admission minimum data set (MDS) dated 8/12/14, included a diagnosis of cerebral vascular accident (CVA), had severe cognitive impairment, an indwelling Foley catheter, extensive assistance for toileting, transferring and hygiene. The urinary care area assessment (CAA) had not been completed. An observation on 9/17/14 at 8:30 a.m. in his wheelchair with an indwelling catheter hanging below his wheelchair.	F 315	All nursing staff will be Inserviced on the following the plans of care for each resident with toileting needs and incontinence care. **Date of completion: 10/27/14** **Recurrence will be prevented by:** All new or readmissions who have an indwelling catheter upon admit/readmit will be reviewed by the ID Team to assure the appropriate reason for the catheter is documented. Medical records will keep a list of all residents with indwelling catheters and their reasons for use. This will be an ongoing system.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 69 Review of the emergency department provider note dated 8/5/14 lists a indwelling urinary catheter and in the same document under problem list, indicates "urinary retention." Review of the progress notes, and the physician referral form from 8/5/14 to 9/2/14, did not identify a bladder assessment had been completed, nor was there any diagnosis that justified the reason R150 continued to need the indwelling catheter. The care plan updated, 8/20/14 indicates urinary catheter and than listed under problem list is "my diagnosis:urinary retention" there was no diagnosis that identified why R150 had urinary retension. During an interview on 9/18/14 at 10:29 a.m. with licensed practical nurse (LPN)-B said the catheter is because he has urinary retention. She was unsure if he just had the catheter when in the hospital, was unsure of how many cc of retension R150 experienced, or how frequently did R150 experience retension and if it still was a problem. An interview on 9/18/14 11 a.m. the DON said the history and physical from the hospital does not indicate why he has urinary retention. Policies regarding urinary catheter and/or urinary retention were requested from the facility but not received.	F 315	Visual audits of incontinence care and toileting times will be completed 3x weekly at various times on all units x 90 days to assure each resident's toileting/incontinence plan is being followed. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease or discontinue the audits. **The correction will be monitored by:** **DON or Designee**	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328		

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F 328	Continued From page 70 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure environmental factors did not contribute to acute respiratory distress for 7 of 12 residents (R154, R43, R144, R96, R93, R143 and R19) identified with respiratory impairment on the 300 wing. Findings include: During observation on 9/16/2014 from approximately 9:30 a.m. to 11:15 a.m., workers, using jack hammers and other tools, were removing ceramic tile from a floor, near resident rooms on the 300's wing of the nursing home. The construction area, located just beyond double doors in the southwest corner of the main dining room, was 6 and 1/2 feet wide, by 41 feet in length. The south end of the construction area intersected the nursing station, where the unit split into two hallway wings, which formed the 300's unit. Removal of the floor tiles resulted in intermittent noise in the facility, and created visible lingering dust. The dust wafted from the construction area, into the adjacent dining room, and down the hallways of the 300's wing and nursing station,	F 328	F328 **Immediate corrective action:** The construction was stopped and a plan put into place as soon as the issue was identified. Resident # 154, 43, 144, 96, 93, 143, and 19 were assessed for respiratory status per facility policy. **Action as it applies to others:** All residents residing on the 300 Unit were assessed for respiratory status per facility policy. A plan to create a barrier to contain dust was established with the construction workers. The policy and procedure for resident assessment pre and post construction were reviewed and remain current.	

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F 328	Continued From page 71 including into the rooms of residents with tracheostomies and ventilators. Neither the gateway at the end of the construction area nearest the dining room, nor the opposite end of the construction area, by the nursing station, were fitted with any kind of dust barrier to contain dust and debris during the removal of the floor tile. At about 10:15 a.m., the double doors to the dining area were observed to be closed while the floor tiles were being removed. In the construction area, there was a dust-abetment machine, with an intake tube, and an exhaust tube leading to a window and outside. Tracking marks and foot prints, from walkers, wheel chairs and shoes, were observed both in the dining area, and near the 300's wing nursing station, as residents, staff and visitors walked through the construction area. Dust was also observed throughout the 300's unit, on various surfaces and equipment: a mailbox, chair rails on the wall, light fixtures, shadow boxes, a number of mechanical lifts, and the nursing station desk. In an interview on 9/16/2014 at 11:00 a.m., maintenance worker (MW)-A agreed there was dust created during the removal of the tile floor this morning. MW-A stated there was work on the floor "today and some in the past two weeks." MW-A said the doors to the dining area were closed, and "the filtration system was on." There were not dust barriers observed to protect the residents who lived on 300 unit. Presently the 300's unit had seven residents with tracheostomies, four of whom also utilized ventilators. In addition, several other residents had various respiratory diagnoses. The 300's unit was also a short-term rehabilitation unit.	F 328	A policy was put into place to assure the Administrator and Maintenance Director would meet with any construction workers during any facility projects to assure a plan was in place to create a safe environment for any residents in close proximity and if unable to do so, a plan to move residents to another area of the facility during these times as well as barriers to contain dust. Staff will be re-educated on the Construction policy and the Pre and Post Construction Policy by 10/27/2014. **Date of completion:** 10/27/2014.	

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F 328	Continued From page 72 On 9/16/14 at 12:30 p.m. 20 residents were interviewed on the 300 wing about the construction dust, and if they had any respiratory difficulties as a result of the dust. The residents interviewed stated they did not have any respiratory problem, but they did notice lots of dust on the unit. Review of the resident records identified the following: R154's diagnoses, from the Minimum Data Set (MDS) dated 8/25/2014, included respiratory failure, with dependence on a ventilator, aphonia (inability to produce voice}, and quadriplegia. The MDS further indicated R154 was totally dependent upon staff for activities of daily living (ADLs). The care area assessment (CAA) for ADLs, dated 8/31/2014, indicated R154 required use of a mechanical lift, with three staff, for all transfers due to inability to stand, and for safety related to tracheostomy and ventilator. R154's room was approximately 50 feet from the construction area, at the end of the southwest wing. A progress note dated 9/14/2014, indicated that at 8:00 p.m., R154 complained of pain in the ribcage and chest area, and had shortness of breath, which at that time was not relieved by suctioning or repositioning. R154's lungs had "rhonchi" throughout. The note further indicated that staff attempted various interventions, completed assessments, and that initial offers to send R154 to the emergency room which were declined by the resident. At 10:15 p.m., R154 again requested to be suctioned; following additional interventions, and requested to be sent to the hospital for evaluation.	F 328	**Recurrence will be prevented by:** All future construction projects will be conducted with daily meetings prior to each day's start of construction and will include the Administrator and Maintenance Director. These meetings will be held to discuss the plan for the day, to assure barriers for dust are established, and determinations made as to whether any resident(s) would need to be relocated to another part of the building at any time. This will be an ongoing process and will be discussed at QA each construction project month. **The correction will be monitored by:** Administrator or Designee	

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F 328	Continued From page 73 A review of the emergency room (ER) nursing notes, dated 9/14/2014, indicated R154 presented with increasing shortness of breath (SOB), coarse lungs sounds, and that he requested pain medication. The ER treatment included blood work, vital sign monitoring, a chest x-ray, suctioning, and various medications including two different nebulizer treatments. R154 returned to the nursing home on 9/15/2014 at 3:40 a.m. In a telephone interview on 9/16/2014 at 4:48 p.m., R154's medical doctor (MD)-A said in a review the 9/14/14 ER visit, stated R154 had equalizer treatments, and was given a diagnoses of adelectasis (a collapse of lung tissue). Further, the MD-A stated R154 had a chest x-ray, and had been improving. When asked if the construction dust could have been the reason for R154's visit the the ER, the MD-A stated "I can't say the inhalation of dust was the reason why [R154] was admitted to the ER for evaluation." MD-A also said the breathing in of the dust "could make [R154] short of breath, and have contributed" to his recent ER admission. R154 was at a high risk for respiratory complications because of his ventilator status, and other medical issues and was "very vulnerable." The MD-A further stated, he hoped the nursing home would do "all it could" to minimize as much dust as possible with ventilated residents, and indicated agreement that it would be best to put up barriers during construction to reduce the dust and debris in the area. R144's diagnoses, from the admission MDS dated 7/16/2014, included chronic respiratory failure, and congestive heart failure. A review of	F 328		

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F 328	Continued From page 74	F 328		

nursing progress notes from 9/6/2014 to 9/16/2014, indicated R144 requested nebulizer treatments twice each day on 9/6 and 9/7/2014, for complaints of shortness of breath. R144 resided on the 300's wing.

R93's diagnoses, from the annual MDS dated 4/18/2014, included chronic airway obstruction, and tracheostomy status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no respiratory concerns were identified. R93 resided on the 300's wing.

R43's diagnosis, from the admission MDS, dated 8/14/2014, included respiratory failure, and dependence on respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory distress or occurrences were identified. R43 resided on the 300's wing.

R96's diagnoses, from he admission MDS dated 9/2/2014, included respiratory failure and chronic airway obstruction. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns. R96 resided on the 300's wing.

R19 diagnoses, from the annual MDS dated 5/13/2014, included acute respiratory failure, and dependence on respirator status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no respiratory concerns were identified. R19 resided on the 300's wing.

R143's diagnoses, from the MDS dated, included chronic airway obstruction, dependence on

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F 328	Continued From page 75 respirator status, and tracheostomy status. A review of progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory concerns were identified. R143 resided on the 300's wing. During an interview on 9/16/2014 at 10:00 a.m., registered nurse (RN)-B stated she had "concerns" on the 300's unit, over the past weekend. RN-B said some residents "were complaining of shortness of breath" and "we did a lot of nebs [nebulizer treatments] over the weekend. RN-B stated there was dust on the unit over the weekend, and that "It was a lot better after I asked them to open the windows and get fans on to blow dust outside." RN-B stated that work was "going on Saturday, [the dust] bothered the vent [ventilated] residents," and the ventilated residents "required more suctioning, especially [R154]." During interview on 9/16/2014 at 10:33 a.m., registered nurse (RN)-D (the nurse manager for the unit) stated she was aware there had been remodeling completed over the past weekend, as well as construction going on right now. RN-D said there have been "No barriers put up," since they started to remove the tile floor. When asked if she had any concerns for the residents on the unit who had tracheostomies and ventilators, in light of the construction, RN-D stated "I have a little concern, with the dust." RN-D said she had not talked to anyone about the construction dust, and did nothing further to address those concerns regarding the residents on the 300's wing.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 76 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide an appropriate psychiatric referral, and complete routine monitoring for 1 of 5 residents (R6) whom was given prescribed psychotropic medications. Findings include: R6's admission Minimum Data Set (MDS), dated 5/21/14, indicated R6 admitted to the facility in	F 329	F329 **Immediate corrective action:** Resident #6 was seen by Psychiatry on 9/29/14 for review of medication regime and recommended doses. Target Behaviors to be monitored were added to her Care Plan. **Action as it applies to others:** All residents receiving psychopharmacological medications will be reviewed by the Consultant pharmacist by 10/27/14 to assure recommendations for required GDR's or documentation to support dose as well as Target Behaviors needed and referrals to psychiatry if indicated. **Date of completion: 10/27/2014**	

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F 329	Continued From page 77 May 2014. R6's quarterly Minimum Data Set (MDS), dated 8/19/14, indicated R6 was cognitively intact, had diagnoses of depression, manic depression, and schizophrenia. Further, the MDS indicated R6 displayed no hallucinations, delusions, or other documented behaviors during the review period. R6's care plan, dated 6/23/14, indicated R6 had bipolar schizophrenia and received medication daily for treatment. The care plan did not indicate specific target behaviors, nor intervention(s) of having psychiatry input for R6. R6's Psychopharmacological Drug Assessment, dated 5/14/14, indicated R6 took the following psychotropic medications: Escitalopram Oxalate (an anti-depressant medication) 40 mg daily for depressive disorder and; Lorazepam (an anti-anxiety medications) 1 mg daily at HS (hour of sleep) for paranoid schizophrenia and; Lorazepam 0.5 mg daily at 10 a.m. and; Lorazepam 1 mg twice a day as needed and; Haldol (an anti-psychotic medication) 5 mg daily in the morning and; Haldol 10 mg daily at HS for a diagnosis of paranoid schizophrenia. The assessment indicated R6 was a new admission to the facility, and had a long history of paranoid schizophrenia, however the assessment did not identity if a psychiatry referral was needed or gradual dose reduction (GDR) should be completed for R6. A subsequent Psychopharmacological Drug Assessment, dated 7/2/14, indicated R6 continued to take Escitalopram Oxalate,	F 329	**Recurrence will be prevented by:** All residents on psychopharmacological medications will be grouped together in the report from the Consulting Pharmacist and results reviewed by the DON to assure recommendation for GDR or documentation needed to support current dosing, Target Behaviors needed, and a suggested psychiatry referral are included in the Report if indicated. This will be an ongoing practice and the results will be shared with the QA Committee monthly.	

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F 329	Continued From page 78 Lorazepam, and Haldol at the same doses and time(s) as when assessed on 5/14/14. The form further indicated an additional antipsychotic medications, Latuda (an anti-psychotic medication), was added to R6's medication regimen, but did not indicate a reason why it had been added. In addition, the assessment indicated R6 was a new admission and did not address if or when a GDR would be attempted, or a psychiatry referral would be made for R6, as it identified R6 as a new admission to the facility still. During interview on 9/18/14, at 9:16 a.m., the assistant director of nursing (ADON) stated she was responsible for R6's care until recently. The ADON stated nothing had been done to address R6's psychopharmacological medication reduction or monitoring. Further, the ADON felt R6 was stable (regarding her cognition and psyche) and she was not in a hurry to address R6's medication regimen as a result despite her significant psychopharmacological medication use. The ADON stated she was unsure the last time any referral to psychiatry was made for R6, "I'm thinking we have to work on this stuff." When interviewed on 9/18/14, at 9:27 a.m., registered nurse (RN)-A stated R6 should have been referred to a psychiatrist given her extensive history of schizophrenia. Further, RN-A stated R6 should have a plan in place to address GDR's for R6's psychopharmacological medications as it would be to her benefit. During interview on 9/18/14, at 10:41 a.m., RN-C stated no formal behavior monitoring was completed for R6. RN-C further stated daily charting should be completed for someone taking	F 329	**The correction will be monitored by:** **Consultant Pharmacist and DON**	

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F 329	Continued From page 79 psychotropic medications, and a progress note should be completed at least every third week indicating a resident's psychotropic medication regimen. RN-C stated R6's medical record did not contain any progress notes regarding her medication regimen and/or plan for behavior monitoring, or reduction. A subsequent interview was held with RN-A on 9/18/14, at 10:45 a.m. regarding R6's psychotropic medication regimen. RN-A stated R6's care plan does not address specific target behaviors for R6. RN-A stated because R6 was felt to be stable in condition, she was not monitored for behavior. Further, RN-A stated R6 might not require all of her psychotropic medications, however staff are not sure because they are not monitoring her regimen. During interview on 9/18/14, at 12:45 p.m., the director of nursing (DON) stated target behaviors should be indicated in R6's care plan and contain individualized interventions to reduce them. Further, the DON stated R6 should have been referred to psychiatry to provide additional care and oversight given R6's history of schizophrenia and psychotropic medication use. A policy on medication monitoring and GDR was requested, but none was provided.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	F 353		

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F 353	Continued From page 80 individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet the on-going, assessed resident care needs and services for residents in the 200, 300 and 400 wings' of the nursing facility, and other residents, as identified during the quality indicator survey, (R36, R6, R77, R50, R48, R2 and R68) and reviewed for staffing concerns. This had the potential to affect all residents who required assistance of staff to meet their needs, but not all residents within the facility. Findings include: LACK OF TIMELY CARE AND SERVICES REPORTED BY RESIDENTS AND FAMILIES: R36's admission Minimum Data Set (MDS) dated	F 353	F353 **Immediate corrective action:** Immediate reviews of staffing levels for all Units was completed and while the ratio of caregiver to resident meets or exceeds the industry standards with current census and acuity, some opportunities to rearrange duties for certain associates was identified	

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F 353	Continued From page 81 7/23/2014 indicated severe cognition impairment, and that R36 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers and ambulation. During an interview on 9/15/2014 at 7:40 p.m., R36's family member (FM)-A stated "...it makes him feel bad" when he soils himself, because [R36] did get the help he needed when in the bathroom, because it takes "too long for staff to respond." FM-A stated that she has assisted R36 to he bathroom, against the wishes of the nursing home, because the staff "were not responding soon enough." R6's quarterly MDS dated 8/19/2014, indicated intact cognition, and also that R6 required extensive assistance, with 2-person assistance for bed mobility, transferring, dressing, toileting and completing personal hygiene. When interviewed on 9/16/2014 at 4:37 p.m., R6 stated, "Wing 2 is really bad, they only have 2 staff for 20 people." R6 further stated she/has had "bathroom accident" and was "very embarrassed about it." R6 said she had been told "...hold on, there are a few a head of you," after putting the call light on for assistance. R77's quarterly MDS dated 8/22/2014, indicated moderately impaired cognition. The MDS further indicated R77 required extensive staff assistance for bed mobility, transferring, locomotion, dressing, toileting and personal hygiene. During an interview on 9/16/2014 at 9:51 a.m., R77 stated "I find myself waiting frequently for help, 'wait and wait', especially in the afternoon.." R50's quarterly MDS dated 7/14/2014, indicated intact cognition. R50 required extensive assistance from two staff with bed mobility,	F 353	**Action as it applies to others:** The facility will assure the third NAR on 200 wing, who works 11A-7P is not involved providing Restorative Nursing Program based on census and acuity. A float will be added at peak times between Units 300-400 based upon census and acuity. The duties of the Hospitality Aides will be reviewed with all staff to assure a better understanding of what they can and cannot do is achieved. More Hospitality Aides will be hired to assist the nursing staff and assure the position is filled when Hospitality is off or ill. All residents who are interviewable will be interviewed to assure their needs are being met satisfactorily. Families will be interviewed when resident is unable.	

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F 353	Continued From page 82 transfers, dressing, toileting, and completing personal hygiene. When interviewed on 9/16/2014 at 8:47 a.m., R50 said "Sometimes I have to wait over 30 minutes to get to bed." R48's quarterly MDS dated 6/17/2014 indicated she had intact cognition. R48 required extensive assistance with dressing//, walking and toileting, but limited staff assistance for transferring and dressing. During an interview on 9/16/2014 at 8:45 a.m., R48 stated she frequently had to wait 30 minutes for assistance to use the bathroom, and that it "usually happened in the evening." R48 said that because her her medical condition, she frequently had 'accidents', but was unsure if waiting too long was the cause. "It certainly doesn't help," R48 stated. R2's quarterly MDS dated 6/10/2014, indicated intact cognition. The MDS further indicated R2 required extensive assist staff for bed mobility and dressing, and required two staff for transferring and toileting. In an interview on 9/15/2014 at 7:48 p.m., R2 stated that on the 200's wing, she would have to wait 20 minutes for assistance, but said "on the 400's wing, I wait 45 minutes before staff come to help me. It's because they only have one on during the week to help." R68's quarterly MDS, dated 7/18/2014, indicated intact cognition. R68 was totally dependent on staff for all ADLs, including bed mobility, transferring, dressing, eating, toileting and personal hygiene. In an interview on 9/18/2014 at 11:35 a.m., while waiting to get up for lunch, R68 stated "I always have to wait until they have tome to take care of me. I can't get up when I want to...I have been waiting a while this morning."	F 353	Staffing will continue to be discussed each day by the DON Administrator, and Supervisor, Scheduler and Nurse Managers and adjustments made where needed. **Date of completion: 10/27/14** **Recurrence will be prevented by:** Random interviews will be completed monthly and evaluated quarterly and reviewed at QA & A meeting to ensure the needs of the residents are being met and they are satisfied with care and service. **The correction will be monitored by:** **DON or Designee**	

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F 353	Continued From page 83 STAFFING CONCERNS AS IDENTIFIED BY FACILITY PRACTICES Refer to F310: Based on observation, interview and document review, the facility failed to ensure each resident was provided with ambulation services when recommended, and assessed when ambulation ability declined for 1 of 9 residents (R20) reviewed fro ambulation services. This resulted in actual harm for R20, when he experienced a decline in ability to ambulate. Refer to F311: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain residents' ambulation abilities for 8 of 9 residents (R27, R48, R22, R24, R53, R139, R14 and R18) who required ambulation services. Refer to F314: Based on observation, interview and document review, the facility failed to comprehensively assess and provide timely repositioning for 1 of 3 residents (R36) reviewed for pressure ulcers. R36's care plan indicated the resident needed to be repositioned as assessed every two hours, and was at risk to develop pressure sore, but was not repositioned after 2 hours and 49 minutes during observation. Refer to F312: Based on observation, interview and document review, the facility failed to provide necessary grooming for 1 of 3 residents reviewed in the sample, who were dependent upon staff for their activities of daily living (ADLs).	F 353		

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F 353	Continued From page 84 Refer to F282: Based on observation, interview and document review, the facility failed to follow the plan of care to provide ambulation services for 1 of 9 residents reviewed, (R20), who was not provided ambulation services as recommended and assessed, which resulted in actual harm for R20 In addition, the facility failed to follow the plan of care and provide ambulation services for 8 of 9 residents (R27, R48, R22, R24, R53, R139, R14 and R18) in order to prevent a decline or improve ambulation. Also, the facility failed to follow the plan of care to prevent pressure ulcers for 1 of 3 residents (R36) reviewed who had a healed pressure ulcer, but remained at risk to develop pressure ulcers. LACK OF SERVICES AND CARE AS REPORTED BY STAFF: During an interview on 9/17/2014 at 8:00 a.m., nursing assistant (NA)-E stated she was unable to walk her residents because she "did not have enough time on her shift." NA-D said, "I don't have time to ambulate my residents." During interview on 9/17/14 at 11:30 a.m., the director of nursing (DON) stated there was an issue with the "functional maintenance program and restorative nursing." The DON indicated the staff member, who was in charge of the program, walked off of the job the last week of august. The DON said, "No one was in charge of the program."	F 353		

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F 353	Continued From page 85 In an interview on 9/17/2014 at 7:00 a.m., licensed practical nurse (LPN)-D stated the night staffing typically consists of two nurses, one trained medication aide, and four nursing assistants. LPN-D stated if someone is unable to work, rarely is there a replacement found. LPN-D cited a recent example and said "...for the first two hours of my shift, I had no aides." LPN-D stated that several residents often complained about the time it takes for their call lights to be answered during the night. LPN-D stated there was not adequate staff to provide the needed resident care. During an interview on 9/17/2014 at 2:42 p.m., licensed practical nurse (LPN)-C stated "Staffing ratios here are not safe." LPN-C admitted that staff did get behind on their turning and repositioning [of the residents] schedules. and often have had to work 'short', with one less aide, often on the weekends. LPN-C felt the residents' "emotional needs we not being met", and that meant staff were not able to spend more quality time with the residents. LPN-C said "That is just not right." In an interview on 9/18/2014 at 10:39 a.m., registered nurse (RN)-F stated "We really often are short [staffed]....last night we were short on the unit, and had to share an aide with another unit." RN-F said that "...yesterday" was shorted part of a shift, as a replacement was only able to "pick up part of a shift." RN-F said residents here, "get the basic care, but if a resident wants to visit, well there just not time for that. I don't like that aspect of not having sufficient staff to do that." In an interview on 9/18/2014 at 10:44 a.m.	F 353		

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F 353	Continued From page 86 nursing assistant (NA)-G said "I feel we are 'consistently' short of staff. We often run late in completing resident repositionings. Many of the residents require two staff, NA-G stated, and when using a [mechanical] lift to transfer, and one aide cannot do it alone. "What can you do?" NA-G asked. In a subsequent interview at 2:38 p.m., NA-G stated food trays are frequently passed late in the morning and afternoon "because staff is not available to complete it." NA-G also resident "grooming and bathing" suffered as a result of the inadequate staffing. During an interview on 9/18/2014 at 11:24 a.m., NA-F stated that often two wings shared one aide, where there should be "two aides per wing." NA-F said that sharing of the aides, who usually work on different units, often increases wait times, as they are unfamiliar with the residents. NA-F said when that happens, "Call light wait times increase, and residents get upset." NA-F said there were 6 or 7 baths to give yesterday, and "We were short," and the result was that "it was nine-thirty when we finally had everyone up and going. We're supposed to have people up by eight for breakfast." NA-F also said residents were not toileted as they should be, and that "When it takes two to use the lift, and you only have one staff; I think there is a staffing issue." In an interview on 9/18/2014 at 1:50 p.m., NA-I stated R68 "complains all the time" about wanting to get up earlier. NA-I continued, "Today, we did have time until 11:40 or so, and lunch was already served." NA-I added, "We just don't have time to get him up when he wants." In an interview on 9/18/2014 at 11:19 a.m., hospitality aide (HA)-A, said "The aides do the	F 353		

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F 353	Continued From page 87 best they can with what they have to work with." HA-A said that if there a call in and no replacement for the staff, and on the weekends, "it can be difficult for the aides, particularly on the unit where many of the residents require use of [mechanical] lifts." HA-A said, "I see the aides struggle." In an interview on 9/18/2014 at 1:57 p.m., the director of nursing (DON) stated the staffing level in the nursing home was determined by "census and acuity," and added "...we're looking pretty good right now." The DON said "The current staffing level is adequate to meet the needs of the residents." The DON said she realized there were "quite a few residents who required a lot of care," and that they "are the first to know if we are short." The DON said the facility goal is to have call lights answered in "five minutes," and that any wait times over that "is excessive." The DON said all staff [emphasize all] can answer the lights, and determine what the immediate needs of the resident are. Further, the DON said, all [emphasize all] nursing staff can assist with transfers, or whatever the need, and "...all of nursing can and must participate." The DON also said she felt the staff was "more stable," of late, and also said the current staff "are willing to help with all tasks."	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		

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F 356	Continued From page 88 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the required daily nurse staffing information included the actual hours worked by each category of nursing staff. This had the potential to affect all 82 residents currently residing in the facility, as well as family members, or the general public who may wish to review this information.	F 356	F356 **Immediate corrective action:** The actual hours worked were added to the facility Direct Care Staff Posting when the discrepancy was identified. **Action as it applies to others:** The policy and procedure for posting of direct care hours was located and was current. The tool was updated to include actual hours worked. Staff responsible for the posting of the direct care staff hours were In serviced on the new format. **Date of completion: 10/27/14**	

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F 356	Continued From page 89 Findings include: During the initial tour on 9/16/13, at 1:00 p.m. the Direct Care Staff Posting was observed on a bulletin board located by the main entrance to the building. The posting consisted of the facility name, current date, census, and the total number of hours worked by licensed and unlicensed staff. The posting did not include the actual hours worked by staff. were not included on the posting. A subsequent observation of the Direct Care Posting, on 9/17/14 at 12:40 p.m., identified the same format being used, again lacking the actual hours being worked by each discipline of staff. When interviewed on 9/17/14, at 11:31 a.m., the director of nursing (DON) stated the facility had used the current format for the posting for awhile and will changed the form to reflect the actual hours being worked by each discipline. During interview on 9/17/14, at 2:05 p.m., the administrator stated the facility did not have a policy regarding the staff posting.	F 356	**Recurrence will be prevented by:** Visual audits of the Direct Care Staff Posting will occur 5 x weekly x90days to assure the actual hours worked have been included. The results of these audits will be shared with QA for input on the need to increase, decrease or discontinue the audits. **The correction will be monitored by:** **Scheduler/Designee**	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 **Immediate corrective action:** Resident #6 was seen by Psychiatry on 9/29/14 for review of medication regime and recommended doses. Target Behaviors to be monitored were added to her Care Plan.	

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F 428	Continued From page 90 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure irregularities identified in 1 of 5 residents (R6) medication regimen were identified and acted upon by the consulting pharmacist. Findings Include: R6's quarterly Minimum Data Set (MDS), dated 8/19/14, indicated R6 was cognitively intact, had diagnoses of depression, manic depression, and schizophrenia. Further, the MDS indicated R6 displayed no hallucinations, delusions, or other documented behaviors during the review period. R6's Psychopharmacological Drug Assessment, dated 5/14/14, indicated R6 took the following psychotropic medications: Escitalopram Oxalate (an anti-depressant medication) 40 mg daily for depressive disorder and; Lorazepam (an anti-anxiety medications) 1 mg daily at HS (hour of sleep) for paranoid schizophrenia and; Lorazepam 0.5 mg daily at 10 a.m. and; Lorazepam 1 mg twice a day as needed and; Haldol (an anti-psychotic medication) 5 mg daily in the morning and; Haldol 10 mg daily at HS for a diagnosis of paranoid schizophrenia. The assessment indicated R6 to be a new admission to the facility, and have a long history	F 428	**Action as it applies to others:** All residents receiving psychopharmacological medications will be reviewed by the Consultant pharmacist by 10/27/14 to assure recommendations for required GDR's or documentation to support dose as well as Target Behaviors needed and referrals to psychiatry if indicated. **Date of completion: 10/27/2014**	

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F 428	Continued From page 91 of paranoid schizophrenia, however did not indicate if a psychiatry referral or gradual dose reduction (GDR) should be completed for R6. A subsequent Psychopharmacological Drug Assessment, dated 7/2/14, indicated R6 continued to take Escitalopram Oxalate, Lorazepam, and Haldol at the same doses and time(s) as when assessed on 5/14/14. The form further indicated an additional antipsychotic medications, Latuda (an anti-psychotic medication), was added to R6's medication regimen, but did not indicate a reason why it had been added. In addition, the assessment indicated R6 was a new admission and did not address if or when a GDR would be attempted, or a psychiatry referral would be made for R6, as it identified R6 as a new admission to the facility still. R6's care plan, dated 6/23/14, indicated R6 had bipolar schizophrenia and received medication daily for treatment. The care plan did not indicate any intervention of having psychiatry input for R6, nor describe specific target behaviors R6 displayed. R6's monthly Medication Regimen Review's, dated 5/22/14, 6/20/14, 7/22/14, 8/18/14, and 9/17/14, indicated no irregularities were identified by the consulting pharmacist with R6's psychotropic medication regimen or care plan, aside from obtaining consent for the use of R6's Latuda medication. During interview on 9/18/14, at 9:16 a.m., the assistant director of nursing (ADON) stated she was responsible for R6's care until recently. The ADON stated nothing had been done to address	F 428	**Recurrence will be prevented by:** All residents on psychopharmacological medications will be grouped together in the report from the Consulting Pharmacist and results reviewed by the DON to assure recommendation for GDR or documentation needed to support current dosing, Target Behaviors needed, and a suggested psychiatry referral are included in the Report if indicated. This will be an ongoing practice and the results will be shared with the QA Committee monthly. **The correction will be monitored by:** **Consultant Pharmacist and DON**	

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F 428	Continued From page 92 R6's psychopharmacological medication reduction or monitoring. Further, the ADON s/he felt R6 to be stable (regarding her cognition and psyche) and s/he was not in a hurry to address R6's medication regimen as a result despite her significant psychopharmacological medication use. The ADON stated s/he was unsure the last time any referral to psychiatry was made for R6, "I'm thinking we have to work on this stuff." When interviewed on 9/18/14, at 9:27 a.m., registered nurse (RN)-A stated R6 should have been referred to a psychiatrist given her extensive history of schizophrenia. Further, RN-A stated R6 should have a plan in place to address GDR's for R6's psychopharmacological medications as it would be to her benefit. A subsequent interview was held with RN-A on 9/18/14, at 10:45 a.m. regarding R6's psychotropic medication regimen. RN-A stated R6's care plan does not address specific target behaviors for R6. RN-A stated because R6 was felt to be stable in condition, she was not monitored for behavior. Further, RN-A stated R6 might not require all of her psychotropic medications, however staff are not sure because they are not monitoring her regimen. During interview on 9/18/14, at 10:50 a.m., the consulting pharmacist (CP)-A stated s/he was surprised R6 was not being followed by psychiatry given R6's personal history of schizophrenia, and psychotropic medication use. CP-A stated s/he didn't feel addressing R6's medication regimen was of concern. Further, CP-A stated target behaviors should be listed on a resident's care plan and monitored accordingly. During interview on 9/18/14, at 12:45 p.m., the	F 428		

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F 428	Continued From page 93 director of nursing (DON) stated target behaviors should be indicated in R6's care plan and contain individualized interventions to reduce them. The DON stated the consulting pharmacist should be reviewing the medication regimen of each resident and making sure target behaviors are listed in the residents care plan when they are on psychotropic medication. Further, the DON stated the lack of psychiatry referral and target behaviors in the care plan should have been identified by the consulting pharmacist. A policy on medication monitoring and GDR was requested, but none was provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 **Immediate corrective action:** Counseling and retraining was completed for LPN –E and RN-C who did not wear gloves or wash hands when administering insulin injections for residents #52 and #145.	

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F 441	Continued From page 94 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's infection control program lacked a surveillance program and investigation of infections that occurred in the facility for tracking trends and analysis of data to determine interventions to prevent the spread of infections which had the potential to affect 83 of the 83 residents who resided in the facility. In addition the facility failed to use gloves while administering injections for 3 of the 4 resident (R52 and R145) observed who received injections. Findings include: During review of the facility's infection control program 9/17/14, at 2:05 p.m. with the director of nursing (DON), who was identified as the infection control preventions nurse, there were components of the infection control program missing. The DON explained she has been making changes to the infection control program,	F 441	**Action as it applies to others:** 1. The Infection Control Program policies and procedures were reviewed and are current. Training has begun by the Director of Education for Welcov Healthcare on hand washing/glove use prior to and following an injection administration and the Facility Surveillance practice which is to include on-going monitoring for infections among residents and personnel and subsequent documentation of infections that occur as well as analysis of the data and reports to the Infection Prevention Committee.	

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F 441	Continued From page 95 had recently started at the facility in the past few months. She stated two forms are being used one with the Line Listing of Resident Infections which indicates the room, symptoms, cultures, treatment and if it is healthcare associated infection or community acquired infection. She stated she fills out a Infection Control Log that lists the resident/wing, date, infection, action plan and if the had on infection on admission or in facility. She reports any trends to there quality assurance committee. Review of the last 4 months of facility forms from June 2014 to September 2014 indicated the Line Listing of Resident Infections. The logs did not identify residents room or the units they were on, what type of infection or what symptoms they had. The June 2014 Line Listing of Resident Infection log identified a total of seven infections in the facility, four had urinary tract infections (UTI)'s; one clostridium difficile (c-diff) ; one methcillian resistent step aurus (MRSA) and one pneumonia. The log did not consistently identify specific symptoms the residents were having, room/unit location, cultures, treatment, and community or heath care acquired infection. The July 2014 Line Listing of Resident Infection log identified a total of four infections in the facility, two YTI's, one pneumonia, and one unidentified infection. The log did not consistently identify specific symptoms the residents were having and cultures. The August 2014 Line Listing of Resident Infection log identified a total of eight infections. There were three respiratory infections, identified	F 441	2. All staff will be trained on the Infection Control Program by 10/27/2014 to include the updated practices that were not being followed. All nurses will be inserviced and perform return demonstrations on hand washing/glove use when administering injections. 3. Additional assistance by a second nurse has been instituted to assist the DON with the management of the Infection Control Program.	

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F 441	Continued From page 96 on the 300 unit, but there was no indication if these infections occurred during the same time frame, or if any cross contamination had been determined among these residents. The September 2014 Line Listing of Resident Infection log identified two infections, the date the infections occurred were missing. During interview 9/17/14, at 2:15 p.m. the DON stated the forms should have indicated where in the facility the infections were, and what symptoms they had. She stated without this data she was unable to track trends or analyze the infections to determine a potential patter or any cross contamination. During the interview the DON stated the facility had an outbreak of streptococcus (strep)symptoms infections with eight employees, who all worked down the 300 unit. None of the resident to date have had any strep symptoms. The facility provided Work/School Excuse and Restrictions forms which indicated the following: from 8/4/14 to 9/7/14 eight employees had reported to have Work/School Excuse and Restrictions forms due to step symptom illnesses. During interview 9/17/14, at 2:30 p.m. the DON stated it was strange they had so many employees that worked on the same wing develop strep symptoms. They were unable to determine, how these infections were being transmitted from one employee to another during the one month period from 8/4/14 to 9/7/14. She thought they were getting the infections from the computer key boards or the mouse's they all used but was unable to determine how the infection was transmitted. She had not completed any	F 441	**Date of completion: 10/27/2014** **Recurrence will be prevented by:** The Infection Prevention Committee will meet monthly to review all infections and analysis of surveillance monitoring and report their findings and action plans to the QA Committee. This will be an ongoing practice. All nurses will have random visual audits x 90 days of hand washing and glove use with injection administration and the results will be shared with the QA Committee for input on the need to increase, decrease or discontinue these audits. **The correction will be monitored by:** **DON or Designee**	

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F 441	Continued From page 97	F 441		

handwashing audits and increased there cleaning, made sure the staff were on there antibiotics for 24 hrs. (hours) before returning to work. She also posted a memo which indicated, "Due to the increased illness among the staff. We are asking that all staff wear a mask when entering resident rooms that are on vent [ventilators] or have trach's [tracheotomy]. Nurses need to wipe the carts with disinfecting wipes, key boards, and mouse for the computers. All staff make sure you are using the alcohol hand sanitizer and WASH YOUR HANDS, WASH YOUR HANDS OFTEN..." The DON stated other than the memo and adding extra cleaning no other tracking or trending was conducted to determine how the strep was being transmitted.

Although the facility had not consistently track and trended resident infections, they had a pattern of employee strep symptoms in a one month period on the 300 unit form 8/5 to 9/7/14. The facility had not determined how these employees were becoming ill nor how the infection was transmitted during the one month period of strep symptoms. The facility did not completed any audits or handwashing education of staff, but completed extra cleaning of the unit and told staff to wash their hands and wear a mask when entering resident rooms that have traches and ventilators.

The facility policy Infection Prevention Program Overview revised May 2014 indicated the major activities of the program are surveillance of infections with implementation of prevention of infections and control measures. The policy further indicated there is on-going monitoring for infections among residents and personnel and subsequent documentation of infections that

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F 441	Continued From page 98 occur. analysis of data is done on-going and documentation is completed and reported to the Infection Prevention Committee. R52's quarterly minimum data set (MDS) dated 8/14/14, included no cognitive impairment, with diagnoses of diabetes mellitus. During an observation of medication administration on 9/17/14 at 7:55 a.m. licensed practical nurse (LPN)-E prepared the insulin injection to be given to R52. LPN-E prepared the insulin, the first was Lantus 54 units and a second a pre-filled syringe of Novolog 18 unit. LPN-E entered R52's room, explained what she was going to do and lifted R52's shirt and gave one injection. She placed the syringe down and picked up the other syringe and gave that injection, both in the lower right quadrant of the abdomen. LPN-E did not wear gloves while administering the insulin or wash her hands before or after the injections. During an interview on 9/17/14 at 8:05 a.m. LPN-E stated, "I don't wear gloves to give insulin shots. I have never wore gloves" R145's admission minimum data set (MDS) dated 8/21/14, included a diagnosis of diabetes and required total assistance from staff for all activities of daily living. During an observation on 9/18/14 at 8:35 a.m. registered nurse (RN)-C prepared an insulin injection to be given to R145 which consisted of Lantus 24 units. RN-C entered R145's room, and explained what she was going to do. R145 lifted his shirt and RN-C injected the insulin into the	F 441		

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F 441	Continued From page 99 lower left quadrant of the abdomen without wearing gloves, nor had washed her hands before administering the insulin. An interview on 9/18/14 at 8:46 a.m. RN-C stated "I don't usually wear gloves unless I'm working with blood or a dressing change." During an interview on 9/17/14 at 11:33 a.m. the DON said gloves need to be used when giving an insulin injection. The facility policy dated January, 2014, entitled Hand washing /Hygiene procedure #5d. identified, "Before and after performing any invasive procedure." and L "Upon and after coming in contact with a resident's intact skin." The facility policy dated May 2014 entitled Glove use, identified section III, When to use Gloves #5, "When it is likely that hands will come in contact with blood, body fluids or other potentially infectious material."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure environmental factors did not contribute to acute respiratory distress for 7 of 12 residents (R154, R43, R144,	F 465	F465 **Immediate corrective action:** The construction was stopped and a plan put into place as soon as the issue was identified. Resident # 154, 43, 144, 96, 93, 143, and 19 were assessed for respiratory status per facility policy.	

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F 465	Continued From page 100 R96, R93, R143 and R19) identified with respiratory impairment, and potentially affecting all 20 residents who lived on the 300's unit. Findings include: During observation on 9/16/2014 from approximately 9:30 a.m. to 11:15 a.m., workers, using jack hammers and other tools, were removing ceramic tile from a floor, near resident rooms on the 300's wing of the nursing home. The construction area, located just beyond double doors in the southwest corner of the main dining room, was 6 and 1/2 feet wide, by 41 feet in length. The south end of the construction area intersected the nursing station, where the unit split into two hallway wings, which formed the 300's unit. On the 300's unit were seven residents with tracheostomies, four of whom also utilized ventilators. In addition, several other residents had various respiratory diagnoses. The 300's unit was also a short-term rehabilitation unit. Removal of the floor tiles resulted in intermittent noise in the facility, and created visible dust. The dust wafted from the construction area, into the adjacent dining room, and down the hallways of the 300's wing and nursing station, including into the rooms of residents with tracheostomies and ventilators. Neither the gateway at the end of the construction area nearest the dining room, nor the opposite end of the construction area, by the nursing station, were fitted with any kind of barrier to contain dust and debris during the removal of the floor tile. At about 10:15 a.m., the double doors to the dining area were observed to be closed while the floor tiles were being removed. In the construction area, there was a	F 465	**Action as it applies to others:** All residents residing on the 300 Unit were assessed for respiratory status per facility policy. A plan to create a barrier to contain dust was established with the construction workers. The policy and procedure for resident assessment pre and post construction were reviewed and remain current.	

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F 465	Continued From page 101 dust-abetment machine, with an intake tube, and an exhaust tube leading to a window and outside. Tracking marks and foot prints, from walkers, wheel chairs and shoes, were observed both in the dining area, and near the 300's wing nursing station, as residents, staff and visitors walked through the construction area. Dust was also observed throughout the 300's unit, on various surfaces and equipment: a mailbox, chair rails on the wall, light fixtures, shadow boxes, a number of mechanical lifts, and the nursing station desk. During interview on 9/16/2014 at 10:23 a.m., registered nurse (RN)-D (the nurse manager for the unit) stated she was aware there had been remodeling completed over the past weekend, as well as construction going on right now. RN-D said there have been "no barriers put up," since beginning to remove the tile floor. When asked if she had any concerns for the residents on the unit who had tracheostomies and ventilators, in light of the construction, RN-D stated "I have a little concern, with the dust." RN-D said she had not talked to anyone about the construction dust, and did nothing further to address those concerns regarding the residents on the 300's wing. RN-D identified there were currently 4 residents with ventilators, and 7 residents with tracheostomies. In an interview on 9/16/2014 at 11:00 a.m., maintenance worker (MW)-A agreed there was dust created during the removal of the tile floor this morning. MW-A stated there was work on the floor "today and some in the past two weeks." MW-A said the doors to the dining area were closed, and "the filtration system was on." During interview on 9/16/14 at 12:30 p.m. MW-B stated, they were not given any directions about	F 465	A policy was put into place to assure the Administrator and Maintenance Director would meet with any construction workers during any facility projects to assure a plan was in place to create a safe environment for any residents in close proximity and if unable to do so, a plan to move residents to another area of the facility during these times as well as barriers to contain dust. Staff will be re-educated on the Construction policy and the Pre and Post Construction Policy by 10/27/2014. **Date of completion:** 10/27/2014.	

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F 465	Continued From page 102 what barriers needed to be set up or not prior to removal of the tile floor. Review of the resident records on the 300 unit identified the following: R154's diagnoses, from the Minimum Data Set (MDS) dated 8/25/2014, included respiratory failure, with dependence on a ventilator, aphonia [inability to produce voice], and quadriplegia R154's room was approximately 50 feet from the construction area, at the end of the southwest wing. A progress note, dated 9/14/2014, indicated that at 8:00 p.m., R154 complained of pain the the ribcage and chest area. The note further indicated R154 had shortness of breath, which was not relieved by suctioning or repositioning, and that R154's lungs had rhonchi [course, rattling respiratory sounds]. On 9/14/2014 at 10:15 p.m., R154 was sent to the hospital for evaluation. A review of the emergency room (ER) notes, dated 9/14/2014, indicated R154 presented with increasing shortness of breath, coarse lungs sounds, and that he requested pain medication. During his visit in ER, R154 received respiratory treatments. R154 returned to the nursing home on 9/15/2014 at 3:40 a.m. In an interview on 9/16/2014 at 4:48 p.m., the medical director (MD) said R154 was at a "high risk" for for respiratory complications because of his ventilator status, and was "very vulnerable."	F 465	**Recurrence will be prevented by:** All future construction projects will have a plan identified prior to the start of the work that would ensure a safe, functional, sanitary and comfortable environment for residents, staff and public. **The correction will be monitored by:** Administrator or Designee	

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F 465	Continued From page 103 When asked if the construction dust could have been the reason for R154's visit the the ER, the MD stated "I can't say the inhalation of dust was the reason why [R154] was admitted to the ER for evaluation." The MD also said the breathing in of the dust "...could make [R154] short of breath, and have contributed" to his recent ER admission. The MD said, he hoped the nursing home would do "...all it could" to minimize as much dust as possible with ventilated residents, and indicated agreement that it would be best to put up barriers during construction to reduce the dust and debris in the area. R144's diagnoses, from the admission MDS dated 7/16/2014, included chronic respiratory failure, and congestive heart failure. A review of nursing progress notes from 9/6/2014 to 9/16/2014, indicated R144 requested nebulizer treatments twice each day on 9/6 and 9/7/2014, for complaints of shortness of breath. R144 resided on the 300's wing. R93's diagnoses, from the annual MDS dated 4/18/2014, included chronic airway obstruction, and tracheostomy status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory occurrences. R93 resided on the 300's wing. R43's diagnosis, from the admission MDS, dated 8/14/2014, included respiratory failure, and dependence on respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory distress or occurrences. R43 resided on the 300's wing. R96's diagnoses, from he admission MDS dated	F 465		

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F 465	Continued From page 104 9/2/2014, included respiratory failure and chronic airway obstruction. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns. R19 diagnoses, from the annual MDS dated 5/13/2014, included acute respiratory failure, and dependence on respirator status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns. R143's diagnoses, from the MDS dated, included chronic airway obstruction, dependence on respirator status, and tracheostomy status. A review of progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory concerns. During an interview on 9/16/2014 at 1:35 p.m., the facility administrator stated construction started on September 3rd, and "wall paper was worked on that week." The administrator said a construction company cut out a doorway, and cabinets were removed "at the end of last week," and the construction company "cut the wall, put studs up and steel on the same day." The administrator stated that "no barrier" was used during theses times.. When asked about how the facility was going forward to manage the construction and dust, the administrator stated "We have no plan at this point." The administrator acknowledged the removal of the tile, and maintained "...there was minimal dust in the air.. and mainly on the floor." The administrator said nursing was doing "respiratory assessments" on the residents in light of the construction.	F 465		

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F 465	Continued From page 105 In an interview on 9/16/2014 at 1:55 p.m., construction workers (CW)-A and B, who were doing construction in the facility, not employees of the nursing facility, stated they would have put up a plastic, poly barrier before starting, "To enclose and seal off both ends of the construction." CW-A also said a barrier to contain the dust, along with a hepa-filtered air purifier, would have "Taken care of the dust." During an interview on 9/18/2014 at 10:30 a.m. the environmental services director (ESD) stated the facility "does have some dust from the construction being performed." The ESD stated the facility housekeeping staff were mopping the dining room and other floor areas after meals as needed. She further stated she was "unaware that dust barriers were needed when the facility staff were removing the floor tile." During interview with the administrator about the dust down the 300 unit stated, on 9/16/14 at 1:30 p.m., "I did not have any knowledge."	F 465		

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

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OMB NO. 0938-0391

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/16/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	**2801 SOUTH HIGHWAY 169** **GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Evergreen Terrace 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person	K 000	POC ok TS 10-21-14 RECEIVED OCT 21 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 10-28-14
EXIT: 9-18-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed	DON	10-16-14

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

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

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K 000	Continued From page 1 responsible for correction and monitoring to prevent a reoccurrence of the deficiency Evergreen Terrace is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms installed in accordance with NFPA 72 "The National Fire Alarm Code 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 109 beds and had a	K 000		

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K 000	Continued From page 2 census of 81 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is not MET:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 81 of the residents and any visitors in a fire emergency. Findings include: At the conclusion of the facility tour on 9-16-14 at 10:30AM, documentation revealed that fire exit drills are not being conducted at varying times and situations. The facility is conducting more	K 050	K050 Facility Environmental Services Director will establish a yearly fire drill schedule with varying times monthly. The fire drills will be documented in accordance with NFPA 101 Life Safety Code Environmental Services Director, Administrator or designee will monitor for compliance.	10-27-14

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K 050	Continued From page 3 then the required number of drills. However, the majority of the drills on the 2nd shift are documented as being conducted at 1509. This deficient practice was confirmed by the staff (DC) and the Administrator (KH) at the time of exit.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72(99) edition. 9.6.1.4. This deficient practice could affect all building occupants. Findings include: At the conclusion of the facility tour on 9-16-14 at approximately 10:30AM review of available documentation indicated that the facility is not testing the fire alarm system at least one time per month. The system can be tested in conjunction	K 052	K052 The fire alarm will be scheduled to be tested monthly in accordance with NFPA 72 Life Safety Code. The fire alarm system will be tested and documented within 24 hours after a silent drill test is conducted on the night shift. Environmental Services Director, Administrator or designee will monitor for compliance.	10-27-14

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K 052	Continued From page 4 with the monthly fire drills. However, if the facility conducts a "silent" drill between 10:00PM and 6:00AM, the system shall be tested and documented within 24 hours of the silent drill. This deficient practice was verified by the facility staff (DC) and the administrator (KH) at the time of exit.	K 052		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation, a new 4" butterfly control valve has been recently installed on the riser of the complete automatic fire sprinkler system. The tamper function of this valve has not been wired into the fire alarm system as required by NFPA72(99) Section 2-9.1.1 and MSFC(07) Section 903.4. This deficient practice could have a negative impact on all occupants of the building. Findings include: During the facility tour on 9-16-14 at approximately 9:30AM,observation reveled that a newly install 4" butterfly water control valve has been recently installed on the riser of the automatic fire sprinkler system. The valve is not wired into the fire alarm system as such that it	K 061	10-27-14 K061 The Temper Function of a new 4" butterfly control valve has been wired into the fire alarm system. Work has been completed with verified documentation. Environmental Services Director, Administrator or designee will monitor for compliance.	

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K 061	Continued From page 5 would indicate a signal if the valve were to be tampered with. The riser is located in the basement. This deficient condition was confirmed by staff (DC) and the Administrator (KH) at the time of exit.	K 061		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency generator is being properly inspected and tested weekly and monthly as required by NFPA 110. This deficient practices could affect all residents staff and visitors. Findings include: At the conclusion of the facility tour on 9-16-14 at 10:30 AM, based on interview, and review of the documentation, with the Facility Maintenance Director, it could not be determined, if the emergency generator is being inspected weekly and or monthly in accordance with the requirements as outline in NFPA 110. It could not	K 144	10-27-14 K144 A weekly and or monthly generator inspection will be conducted under 30% load testing in accordance with NFPA 110 Life Safety Code. This inspection will be documented on forms provided at time of exit. Environmental Services, Administrator or designee will monitor for compliance.	

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K 144	Continued From page 6 be determined if all the parameters of required inspection are being met. This would include the monthly 30% load testing. The generator is a 40 KW, fueled by diesel. Forms were provided to the facility at the time of exit. This deficient practice was confirmed by the Facility Maintenance staff(DC) and (KH) Administrator at the time of exit.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted

October 6, 2014

Mr. Joseph Gubbels, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5495023

Dear Mr. Gubbels:

The above facility was surveyed on September 15, 2014 through September 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 15-18, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide adequate notice of a new roommate for 1 of 1 residents (R15) who received a new roommate. Findings include: R15's care plan, dated 5/4/14, indicated R15 was alert and orientated, with an intervention of providing reminders and cues to help R15 maintain their establish routine to promote good psychosocial health. During interview on 9/16/14, at 9:00 a.m., R15	2 435		

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2 435	Continued From page 3 stated she received a new room-mate yesterday (9/15/14). She was not given notice beforehand, and would have liked to have known she was getting a new roommate with more notice than what was provided. During interview on 9/17/2014, at 9:14 a.m., licensed social worker (LSW)-A stated R15 did receive a new roommate on 9/15/14. LSW-A stated R15 was told she would be getting a new room-mate on the same day (9/15/14) a few hours before the roommate arrived. LSW-A stated she should have been given more notice of the incoming roommate but, "It an be difficult to adjust with only a few hours notice." A review of R15's progress notes, dated 9/5/14 to 9/16/14, did not identify that R15 was notified or questioned regarding her new roommate. A facility Room Change policy, dated 4/13/12, indicated all residents and family members are notified of room changes prior to them occurring. Further, the policy stated roommate(s) would be notified of the room change prior to receiving a roommate, but did not specify a length of time to be given prior to. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review facility process for roommate changes to ensure residents are given adequate notice of a change. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		

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2 565	Continued From page 4 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan for the care areas of ambulation, rehabilitation, and pressure ulcer interventions for 11 of 59 residents, (R20, R27, R48, R22, R24, R53, R139, R14, R18, R36, R77) reviewed for these care areas. Findings include: AMBULATION R20's quarterly minimum data set (MDS) dated 7/17/14, indicated he had peripheral vascular disease, Alzheimer ' s and dementia. The MDS further indicated severe cognitive impairment and he walked in his room once or twice in his room or corridor with assist of two. R20's care plan dated 2/12/14, indicated he cannot ambulate independently due to recent toe amputation and decline in cognition. The care plan also indicated his balance while standing is unsteady and he participates in a functional maintenance program (FMP) for ambulation and supervision when able. Staff assist with FMP after supervision to ambulate 75-100 feet (ft.) up and down the hallway x2. The facilities nursing assistant care sheet undated indicated R20 to ambulate 75-100 ft. with	2 565		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5	2 565		

front wheeled walker (FWW), gait belt two times daily.
Review of the progress notes, physician notes and facility assessment from June 20, 2014 to September 18, 2014 did not identify R20 was being ambulated 75-100 ft. with a front wheeled walker (FWW), and gait belt two times daily, as directed by the Walking/Ambulation Program Guidelines Restorative Nursing/Functional Maintenance Recommendations which PT recommended for R20.
During interview 9/18/14, at 9:44 a.m. NA-D stated R20 has stopped ambulating over a month ago and that he has becoming more combative with cares.
R27's annual minimum data set (MDS) dated 6/12/14, indicated he ambulates with set up only and transfers with supervision and assist of one and was moderately cognitively intact. R27's care plan dated 6/2/14, indicated he was on a FMP which includes ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff.

R27's nursing assistant care sheet undated indicated he was to ambulate 90 to 100 ft twice daily. R27's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 10/15/13, indicated he was to ambulate 90 to 100 ft. twice daily and to increase as tolerated.

Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify R27 "ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff," which was started on 10/15/13. There was no indication this has been completed as recommend on the 10/15/13

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2 565	Continued From page 6 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R48's quarterly MDS dated 6/17/14, indicated he had a diagnoses of arthritis and cerebral vascular accident (CVA), was cognitively intact. He transferred and ambulated in his room with limited to extensive assist of one and did not ambulate in the corridor. R48's care plan dated 3/14/14, indicated he was on a FMP to ambulate 100 ft. twice daily with walker. R48's nursing assistant care sheet undated indicated he was to ambulate 100 ft. twice daily with a walker. R48's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 09/18/14, indicated he ambulated with a FWW 100 ft. with assist of two. During interview 9/17/14, at 8:20 am R48 stated he does not ambulate and the staff do not offer to ambulate him. He further stated if staff would offer to ambulate with him he would not refuse, there was no walker noted in his room. Review of the progress notes, and functional maintenance program from June 2014 to September 8, 2014 did not identify R48 had been ambulated 100 ft. twice a day with a walker, as identified by the 5/23/13 FMP. R22's annual MDS dated 7/1/14, indicated she had arthritis and osteoporosis. The MDS further indicated she was cognitively intact, transferred and ambulated independently in her room. She	2 565		

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was able to ambulate in the corridor once or twice with no set up or physical assistance from staff.

R22's care plan dated 1/20/14, indicated she can ambulate up to 100 ft. daily with a gait belt. but chooses not to, and uses a front wheeled walker (FWW). R22's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 6/10/14 indicated she uses a FWW and ambulates 100ft with stand by assistance (SBA).

Nursing assistant care sheet undated indicated to ambulate up to 100 ft. with gait belt and assist of one and FWW.

Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 100 ft. "With FWW and SBA daily" which was started on 06/10/14. There was no indication this has been completed as recommend on the 6/10/14, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT.

R24's quarterly MDS dated 7/8/14, indicated he had dementia, was cognitively intact, independent with transfers and needed supervision and assist of one to ambulate in his room and corridor.

R24's care plan dated 8/27/13, indicated he can ambulate independently in his room and he prefers to use his walker while going on outings and uses a FWW and transfer belt. The care plan indicated he was to ambulate twice daily for 400 ft.

R24's Walking/Ambulation Program Guidelines

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2 565	Continued From page 8 Restorative Nursing Functional Maintenance Recommendations dated 9/17/14, indicated he is to ambulate 400 ft. The Nursing assistant care sheet undated indicated to ambulate 400 ft. twice a day. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 400 ft. with one seated rest with FWW and SBA which was started on 8/27/13. There was no indication this has been completed as recommend on the 8/27/13, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R53's admission MDS dated 6/26/14, indicated she was cognitively intact, needed extensive assistance of two with transfers and did not ambulate in her room or corridor. R53's care plan dated 6/20/14, indicated she is on a FMP to ambulate 200 ft. with a FWW, gait belt and assist of one staff and resident is to walk on her left tiptoe due to heel wound on left heel and to take heel protector off when walking. R53's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/27/14, indicated she ambulates 200 ft. with a FWW , gait belt and contact guard assist (CGA). The nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW twice a day. During interview 9/17/14, at 8:20 a.m. R53 stated that she only walks to the bathroom and back, she stated she would need assistance from staff	2 565		

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to walk in the hall and they do not offer to walk her. R53 also stated the staff are not offering to ambulate R139, as well.

Review of the facility Evergreen Terrace Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW, gait belt and contact guard assist (CGA) twice per day a.m. and p.m." which was started on 8/27/14. There was no indication this has been completed twice a day as recommend on the 8/27/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT.

During interview 9/18/14, at 9:18 a.m. with physical therapy (PT)-A stated she had just started (R53) on FMP and she has had no decline.

R139's admission MDS dated 6/27/14, indicated he was moderately cognitively impaired, transferred with supervision/set up and ambulated in his room independently without assistance. R139's care plan dated 9/17/14, indicated he was on a FMP and ambulated 200 ft. with FWW and contact guard assist (CGA).

R139's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/29/14, indicated he was to ambulate 200 ft. with FWW and CGA. The nursing assistant care sheet undated also indicated to ambulate 200 ft. with FWW and CGA.

Review of the facility Evergreen Terrace

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2 565	Continued From page 10 Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW and contact guard assist (CGA) twice per day" which was started on 8/29/14. There was no indication this has been completed twice a day as recommend on the 8/29/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. R14's quarterly MDS dated 5/28/14, indicated she had dementia and a cerebral vascular accident (CVA), had severe cognitive impairment, and needed extensive assist of one to transfer and ambulate. R14's care plan dated 9/12/14, indicated she is on a restorative nursing program the care plan did not address her functional status with mobility. R14's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 5/28/14, indicated R14 ambulated 30 to 80 ft. with a FWW and assist of two by PT. Nursing assistant care sheet undated indicated to ambulate twice daily 30 to 80 ft. with FWW and minimal assist. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulation 30 to 80 feet with FWW twice per day" which was started on 5/28/14. There was no indication this has been completed two times a day as recommend on the 5/28/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/17/14 at 8:00 a.m. with nursing assistant (NA)-E and NA-D both stated they were	2 565		

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2 565	Continued From page 11	2 565		

unable to ambulate their residents due to not having enough time on her shift to complete this task.
During interview 9/17/14, at 11:30 a.m. the director of nursing stated they have had an issue with their FMP and restorative nursing program. The staff members who were in charge of the program had left their position the last week of August 2014 and they currently have no one in charge of the program. She was aware the program was not being completed as directed by the care plan for these residents.

Although R20, R27, R48, R22, R24, R53, R139, R14 all had a FMP of ambulation on their care plan, the facility had not implemented these programs as care planned.

REHABILITATION

R18's quarterly Minimum Data Set (MDS) identified R18 had diagnosis of dementia, with severe cognitive impairment, no behavior disturbances and needed extensive assistance for activities of daily living (ADL's) including ambulation.

Review of the Evergreen Terrace Range of Motion Guidelines sheet, dated 7/5/14 from occupational therapy (OT) identified a restorative nursing recommendation which included "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]."

R18's care plan last updated on 7/21/14 identified a problem with falls preventions due to increased weakness. The staff were directed to use a "Nu-step 15 minutes a day 6 days per week."

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2 565	Continued From page 12 During observation on 9/17/ 14 at 7:20 a.m., 11:00 a.m. and on 9/18/14 at 12:00 p.m. R18 was not observed to use the "Nu-step 15 minutes a day 6 days per week." Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 and August 2014 did not identify the use of the "Nu-Step level 1 x [times] 15 min [minutes] 6 x/wk [week]," were being implemented as recommended by occupational therapy on 7/5/14. During interview on 9/17/14 at 2:13 p.m. Certified Occupational Therapy Assistant (COTA)-A stated the facility has a functional maintenance program which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated if we don't have any staff to do the programs the program does not get completed for any of the residents. During interview on 9/18/14 at 2:30 p.m. licensed practical nurse (LPN)-P stated the resident does not receive any exercise with the Nu-Step, due to not having any staff to implement the residents functional maintenance program. PRESSURE ULCER INTERVENTIONS R36's diagnoses, identified on the care plan (CP) dated 8/1/2014, included dementia, chronic kidney disease with hemodialysis, and fracture of scapula and multiple ribs. The admission Minimum Data Set (MDS), dated 7/23/2014, indicated R36 was cognitively impaired, and required extensive, physical assistance for activities of daily living (ADLs), including	2 565		

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2 565	Continued From page 13	2 565		

two-person assist with bed mobility, transfers and ambulation. R36's CP identified pressure ulcers, and included various interventions to maintain intact skin, among which required [R36] "... to be turned and repositioned every 2 hours." The CP lacked any direction or action staff were to take when R36 refused repositioning or off-loading.

During observation on 9/17/2014 from 10:30 a.m. to 1:19 p.m. (2 hours and 49 minutes) R36 was seated in his wheel chair, without off-loading or repositioning. R36 was in the dining area prior to the noon meal at 10:30 a.m., then was relocated to his usual table at 11:22 a.m. before the meal. R36 was served, then ate his meal, during which time he continued to remain seated in the wheel chair. At 12:57 p.m., licensed practical nurse (LPN)-B approached R36, still seated in his wheel chair, and pushed him from the dining area to his room. Inside the room, LPN-B took R36's vital signs, continuing to be seated. LPN-B told R36 he was to attend a care conference meeting in a few minutes, then exited the room. LPN-B neither offered, nor repositioned or off-loaded R36 while in his room. R36 then propelled himself into the adjacent day room.

At 1:19 p.m., nursing assistant (NA)-A approached R36, and said it was time to get up and stretch. NA-A offered to assist R36 to stand, and encouraged him to ambulate and stretch. NA-D also asked R36 to use the toilet in his room. R36 refused all of NA-A's offers to move, reposition, off load, or toilet.

During an interview on 9/17/2014 at 1:22 p.m., NA-A stated R36 had been last repositioned "around 10:30 this morning. I know he had therapy and they off loaded him there for sure." NA-A said it had been "almost three hours" since

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2 565	Continued From page 14 R36 had been repositioned out of his wheel chair. NA-A stated that of late, R36 had been refusing more and more "to stand up, or repo, or do other things suggested, like brushing teeth." NA-A also said when R36 is here during the day, it was "very difficult" to get him to comply. During an interview on 9/18/2014 at 9:00 a.m., registered nurse (RN)-D stated "We usually do our repos [repositioning] at least every two hours." RN-D said that although [R36's] pressure area had resolved, he remained at risk for future pressure ulcers, and further, that [R36] "...should have been repositioned at 2 hours." RN-D said "We need to be more aggressive in follow through." During an interview on 9/18/2014 at 11:48 a.m., the director of nursing (DON) stated the plan of care "should be followed" for any resident who needed timely repositioning. R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had moderate cognitive impairment, had a stage III pressure ulcer (full thickness tissue loss), and required extensive assistance to complete transfers, bed mobility, and activities of daily living. R77's skin integrity care plan, dated 4/1/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. Further, the care plan indicated an intervention of floating R77's heels (to reduce pressure on them), and to wear protective boots (Rooke Boots) while in bed. An observation of R77, made on 9/17/14, at 7:05 a.m., revealed R77 lying in bed with his eyes closed. R77 had his blankets pulled up over his face, and had his heels laying directly on the bed.	2 565		

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2 565	Continued From page 15 R77 did not have any protective boots on to reduce the pressure on his heels or ankles. When interviewed on 9/17/14, at 2:20 p.m., nursing assistant (NA)-F stated R77 used to wear white protective boots when he was lying in bed, however she was unsure if he should still have them now or not. NA-F stated R77 wore protective boots in bed when he was in a different room, however had not seen them used for R77 since he moved rooms a couple months prior. During interview on 9/17/14, at 2:38 p.m., NA-G stated R77 has not used the protective boots in bed since moving rooms a couple months prior. When interviewed on 9/18/14, at 9:41 a.m., registered nurse (RN)-A stated R77 was supposed to be wearing protective Rooke boots while in bed to reduce the pressure to his heels and ankle. During interview on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated the care plan for R77 should have been followed. A facility Care Planning Process policy, dated 4/13, indicated implementation of the care plan occurs when disciplines read, understand, and act on the plan to deliver the residents daily care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review care plans for accuracy and audit care to ensure adherence to the established plan of care for each resident. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 16 (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet the on-going, assessed resident care needs and services for residents in the 200, 300 and 400 wings' of the nursing facility, and other residents, as identified during the quality indicator survey, (R36, R6, R77, R50, R48, R2 and R68) and reviewed for staffing concerns. This had the potential to affect all residents who required assistance of staff to meet their needs, but not all residents within the facility. Findings include: LACK OF TIMELY CARE AND SERVICES REPORTED BY RESIDENTS AND FAMILIES: R36's admission Minimum Data Set (MDS) dated 7/23/2014 indicated severe cognition impairment, and that R36 required extensive, physical assistance for activities of daily living (ADLs),	2 800		

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2 800	Continued From page 17 including two-person assist with bed mobility, transfers and ambulation. During an interview on 9/15/2014 at 7:40 p.m., R36's family member (FM)-A stated "...it makes him feel bad" when he soils himself, because [R36] did get the help he needed when in the bathroom, because it takes "too long for staff to respond." FM-A stated that she has assisted R36 to he bathroom, against the wishes of the nursing home, because the staff "were not responding soon enough." R6's quarterly MDS dated 8/19/2014, indicated intact cognition, and also that R6 required extensive assistance, with 2-person assistance for bed mobility, transferring, dressing, toileting and completing personal hygiene. When interviewed on 9/16/2014 at 4:37 p.m., R6 stated, "Wing 2 is really bad, they only have 2 staff for 20 people." R6 further stated she/has had "bathroom accident" and was "very embarrassed about it." R6 said she had been told "...hold on, there are a few a head of you," after putting the call light on for assistance. R77's quarterly MDS dated 8/22/2014, indicated moderately impaired cognition. The MDS further indicated R77 required extensive staff assistance for bed mobility, transferring, locomotion, dressing, toileting and personal hygiene. During an interview on 9/16/2014 at 9:51 a.m., R77 stated "I find myself waiting frequently for help, 'wait and wait', especially in the afternoon.." R50's quarterly MDS dated 7/14/2014, indicated intact cognition. R50 required extensive assistance from two staff with bed mobility, transfers, dressing, toileting, and completing personal hygiene. When interviewed on 9/16/2014 at 8:47 a.m., R50 said "Sometimes I have to wait over 30 minutes to get to bed."	2 800		

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2 800	Continued From page 18 R48's quarterly MDS dated 6/17/2014 indicated she had intact cognition. R48 required extensive assistance with dressing//, walking and toileting, but limited staff assistance for transferring and dressing. During an interview on 9/16/2014 at 8:45 a.m., R48 stated she frequently had to wait 30 minutes for assistance to use the bathroom, and that it "usually happened in the evening." R48 said that because her her medical condition, she frequently had 'accidents', but was unsure if waiting too long was the cause. "It certainly doesn't help," R48 stated. R2's quarterly MDS dated 6/10/2014, indicated intact cognition. The MDS further indicated R2 required extensive assist staff for bed mobility and dressing, and required two staff for transferring and toileting. In an interview on 9/15/2014 at 7:48 p.m., R2 stated that on the 200's wing, she would have to wait 20 minutes for assistance, but said "on the 400's wing, I wait 45 minutes before staff come to help me. It's because they only have one on during the week to help." R68's quarterly MDS, dated 7/18/2014, indicated intact cognition. R68 was totally dependent on staff for all ADLs, including bed mobility, transferring, dressing, eating, toileting and personal hygiene. In an interview on 9/18/2014 at 11:35 a.m., while waiting to get up for lunch, R68 stated "I always have to wait until they have tome to take care of me. I can't get up when I want to...I have been waiting a while this morning." STAFFING CONCERNS AS IDENTIFIED BY FACILITY PRACTICES	2 800		

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2 800	Continued From page 19	2 800		

Refer to F310: Based on observation, interview and document review, the facility failed to ensure each resident was provided with ambulation services when recommended, and assessed when ambulation ability declined for 1 of 9 residents (R20) reviewed fro ambulation services. This resulted in actual harm for R20, when he experienced a decline in ability to ambulate.

Refer to F311: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain residents' ambulation abilities for 8 of 9 residents (R27, R48, R22, R24, R53, R139, R14 and R18) who required ambulation services.

Refer to F314: Based on observation, interview and document review, the facility failed to comprehensively assess and provide timely repositioning for 1 of 3 residents (R36) reviewed for pressure ulcers. R36's care plan indicated the resident needed to be repositioned as assessed every two hours, and was at risk to develop pressure sore, but was not repositioned after 2 hours and 49 minutes during observation.

Refer to F312: Based on observation, interview and document review, the facility failed to provide necessary grooming for 1 of 3 residents reviewed in the sample, who were dependent upon staff for their activities of daily living (ADLs).

Refer to F282: Based on observation, interview and document review, the facility failed to follow the plan of care to provide ambulation services for 1 of 9 residents reviewed, (R20), who was not provided ambulation services as recommended

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2 800	Continued From page 20 and assessed, which resulted in actual harm for R20 In addition, the facility failed to follow the plan of care and provide ambulation services for 8 of 9 residents (R27, R48, R22, R24, R53, R139, R14 and R18) in order to prevent a decline or improve ambulation. Also, the facility failed to follow the plan of care to prevent pressure ulcers for 1 of 3 residents (R36) reviewed who had a healed pressure ulcer, but remained at risk to develop pressure ulcers. LACK OF SERVICES AND CARE AS REPORTED BY STAFF: During an interview on 9/17/2014 at 8:00 a.m., nursing assistant (NA)-E stated she was unable to walk her residents because she "did not have enough time on her shift." NA-D said, "I don't have time to ambulate my residents." During interview on 9/17/14 at 11:30 a.m., the director of nursing (DON) stated there was an issue with the "functional maintenance program and restorative nursing." The DON indicated the staff member, who was in charge of the program, walked off of the job the last week of august. The DON said, "No one was in charge of the program." In an interview on 9/17/2014 at 7:00 a.m., licensed practical nurse (LPN)-D stated the night staffing typically consists of two nurses, one trained medication aide, and four nursing assistants. LPN-D stated if someone is unable to work, rarely is there a replacement found. LPN-D cited a recent example and said "...for the first	2 800		

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2 800	Continued From page 21 two hours of my shift, I had no aides." LPN-D stated that several residents often complained about the time it takes for their call lights to be answered during the night. LPN-D stated there was not adequate staff to provide the needed resident care. During an interview on 9/17/2014 at 2:42 p.m., licensed practical nurse (LPN)-C stated "Staffing ratios here are not safe." LPN-C admitted that staff did get behind on their turning and repositioning [of the residents] schedules. and often have had to work 'short', with one less aide, often on the weekends. LPN-C felt the residents' "emotional needs we not being met", and that meant staff were not able to spend more quality time with the residents. LPN-C said "That is just not right." In an interview on 9/18/2014 at 10:39 a.m., registered nurse (RN)-F stated "We really often are short [staffed]....last night we were short on the unit, and had to share an aide with another unit." RN-F said that "...yesterday" was shorted part of a shift, as a replacement was only able to "pick up part of a shift." RN-F said residents here, "get the basic care, but if a resident wants to visit, well there just not time for that. I don't like that aspect of not having sufficient staff to do that." In an interview on 9/18/2014 at 10:44 a.m. nursing assistant (NA)-G said "I feel we are 'consistently' short of staff. We often run late in completing resident repositionings. Many of the residents require two staff, NA-G stated, and when using a [mechanical] lift to transfer, and one aide cannot do it alone. "What can you do?" NA-G asked. In a subsequent interview at 2:38 p.m., NA-G stated food trays are frequently	2 800		

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2 800	Continued From page 22 passed late in the morning and afternoon "because staff is not available to complete it." NA-G also resident "grooming and bathing" suffered as a result of the inadequate staffing. During an interview on 9/18/2014 at 11:24 a.m., NA-F stated that often two wings shared one aide, where there should be "two aides per wing." NA-F said that sharing of the aides, who usually work on different units, often increases wait times, as they are unfamiliar with the residents. NA-F said when that happens, "Call light wait times increase, and residents get upset." NA-F said there were 6 or 7 baths to give yesterday, and "We were short," and the result was that "it was nine-thirty when we finally had everyone up and going. We're supposed to have people up by eight for breakfast." NA-F also said residents were not toileted as they should be, and that "When it takes two to use the lift, and you only have one staff; I think there is a staffing issue." In an interview on 9/18/2014 at 1:50 p.m., NA-I stated R68 "complains all the time" about wanting to get up earlier. NA-I continued, "Today, we did have time until 11:40 or so, and lunch was already served." NA-I added, "We just don't have time to get him up when he wants." In an interview on 9/18/2014 at 11:19 a.m., hospitality aide (HA)-A, said "The aides do the best they can with what they have to work with." HA-A said that if there a call in and no replacement for the staff, and on the weekends, "it can be difficult for the aides, particularly on the unit where many of the residents require use of [mechanical] lifts." HA-A said, "I see the aides struggle."	2 800		

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2 800	Continued From page 23 In an interview on 9/18/2014 at 1:57 p.m., the director of nursing (DON) stated the staffing level in the nursing home was determined by "census and acuity," and added "...we're looking pretty good right now." The DON said "The current staffing level is adequate to meet the needs of the residents." The DON said she realized there were "quite a few residents who required a lot of care," and that they "are the first to know if we are short." The DON said the facility goal is to have call lights answered in "five minutes," and that any wait times over that "is excessive." The DON said all staff [emphasize all] can answer the lights, and determine what the immediate needs of the resident are. Further, the DON said, all [emphasize all] nursing staff can assist with transfers, or whatever the need, and "...all of nursing can and must participate." The DON also said she felt the staff was "more stable," of late, and also said the current staff "are willing to help with all tasks." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		

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2 830	Continued From page 24 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure environmental factors did not contribute to acute respiratory distress for 7 of 12 residents (R154, R43, R144, R96, R93, R143 and R19) identified with respiratory impairment on the 300 wing. Findings include: During observation on 9/16/2014 from approximately 9:30 a.m. to 11:15 a.m., workers, using jack hammers and other tools, were removing ceramic tile from a floor, near resident rooms on the 300's wing of the nursing home. The construction area, located just beyond double doors in the southwest corner of the main dining room, was 6 and 1/2 feet wide, by 41 feet in length. The south end of the construction area intersected the nursing station, where the unit split into two hallway wings, which formed the 300's unit. Removal of the floor tiles resulted in intermittent	2 830		

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2 830	Continued From page 25	2 830		

noise in the facility, and created visible lingering dust. The dust wafted from the construction area, into the adjacent dining room, and down the hallways of the 300's wing and nursing station, including into the rooms of residents with tracheostomies and ventilators. Neither the gateway at the end of the construction area nearest the dining room, nor the opposite end of the construction area, by the nursing station, were fitted with any kind of dust barrier to contain dust and debris during the removal of the floor tile. At about 10:15 a.m., the double doors to the dining area were observed to be closed while the floor tiles were being removed. In the construction area, there was a dust-abetment machine, with an intake tube, and an exhaust tube leading to a window and outside. Tracking marks and foot prints, from walkers, wheel chairs and shoes, were observed both in the dining area, and near the 300's wing nursing station, as residents, staff and visitors walked through the construction area. Dust was also observed throughout the 300's unit, on various surfaces and equipment: a mailbox, chair rails on the wall, light fixtures, shadow boxes, a number of mechanical lifts, and the nursing station desk.

In an interview on 9/16/2014 at 11:00 a.m., maintenance worker (MW)-A agreed there was dust created during the removal of the tile floor this morning. MW-A stated there was work on the floor "today and some in the past two weeks." MW-A said the doors to the dining area were closed, and "the filtration system was on."

There were not dust barriers observed to protect the residents who lived on 300 unit. Presently the 300's unit had seven residents with tracheostomies, four of whom also utilized ventilators. In addition, several other residents

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2 830	Continued From page 26	2 830		

had various respiratory diagnoses. The 300's unit was also a short-term rehabilitation unit.

On 9/16/14 at 12:30 p.m. 20 residents were interviewed on the 300 wing about the construction dust, and if they had any respiratory difficulties as a result of the dust. The residents interviewed stated they did not have any respiratory problem, but they did notice lots of dust on the unit.

Review of the resident records identified the following:

R154's diagnoses, from the Minimum Data Set (MDS) dated 8/25/2014, included respiratory failure, with dependence on a ventilator, aphonia (inability to produce voice}, and quadriplegia. The MDS further indicated R154 was totally dependent upon staff for activities of daily living (ADLs). The care area assessment (CAA) for ADLs, dated 8/31/2014, indicated R154 required use of a mechanical lift, with three staff, for all transfers due to inability to stand, and for safety related to tracheostomy and ventilator. R154's room was approximately 50 feet from the construction area, at the end of the southwest wing.

A progress note dated 9/14/2014, indicated that at 8:00 p.m., R154 complained of pain in the ribcage and chest area, and had shortness of breath, which at that time was not relieved by suctioning or repositioning. R154's lungs had "rhonchi" throughout. The note further indicated that staff attempted various interventions, completed assessments, and that initial offers to send R154 to the emergency room which were declined by the resident. At 10:15 p.m., R154 again requested to be suctioned; following

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2 830	Continued From page 27 additional interventions, and requested to be sent to the hospital for evaluation. A review of the emergency room (ER) nursing notes, dated 9/14/2014, indicated R154 presented with increasing shortness of breath (SOB), coarse lungs sounds, and that he requested pain medication. The ER treatment included blood work, vital sign monitoring, a chest x-ray, suctioning, and various medications including two different nebulizer treatments. R154 returned to the nursing home on 9/15/2014 at 3:40 a.m. In a telephone interview on 9/16/2014 at 4:48 p.m., R154's medical doctor (MD)-A said in a review the 9/14/14 ER visit, stated R154 had equalizer treatments, and was given a diagnoses of adelectasis (a collapse of lung tissue). Further, the MD-A stated R154 had a chest x-ray, and had been improving. When asked if the construction dust could have been the reason for R154's visit the the ER, the MD-A stated "I can't say the inhalation of dust was the reason why [R154] was admitted to the ER for evaluation." MD-A also said the breathing in of the dust "could make [R154] short of breath, and have contributed" to his recent ER admission. R154 was at a high risk for respiratory complications because of his ventilator status, and other medical issues and was "very vulnerable." The MD-A further stated, he hoped the nursing home would do "all it could" to minimize as much dust as possible with ventilated residents, and indicated agreement that it would be best to put up barriers during construction to reduce the dust and debris in the area. R144's diagnoses, from the admission MDS dated 7/16/2014, included chronic respiratory	2 830		

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2 830	Continued From page 28 failure, and congestive heart failure. A review of nursing progress notes from 9/6/2014 to 9/16/2014, indicated R144 requested nebulizer treatments twice each day on 9/6 and 9/7/2014, for complaints of shortness of breath. R144 resided on the 300's wing. R93's diagnoses, from the annual MDS dated 4/18/2014, included chronic airway obstruction, and tracheostomy status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no respiratory concerns were identified. R93 resided on the 300's wing. R43's diagnosis, from the admission MDS, dated 8/14/2014, included respiratory failure, and dependence on respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory distress or occurrences were identified. R43 resided on the 300's wing. R96's diagnoses, from he admission MDS dated 9/2/2014, included respiratory failure and chronic airway obstruction. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns. R96 resided on the 300's wing. R19 diagnoses, from the annual MDS dated 5/13/2014, included acute respiratory failure, and dependence on respirator status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no respiratory concerns were identified. R19 resided on the 300's wing. R143's diagnoses, from the MDS dated, included chronic airway obstruction, dependence on	2 830		

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2 830	Continued From page 29 respirator status, and tracheostomy status. A review of progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory concerns were identified. R143 resided on the 300's wing. During an interview on 9/16/2014 at 10:00 a.m., registered nurse (RN)-B stated she had "concerns" on the 300's unit, over the past weekend. RN-B said some residents "were complaining of shortness of breath" and "we did a lot of nebs [nebulizer treatments] over the weekend. RN-B stated there was dust on the unit over the weekend, and that "It was a lot better after I asked them to open the windows and get fans on to blow dust outside." RN-B stated that work was "going on Saturday, [the dust] bothered the vent [ventilated] residents," and the ventilated residents "required more suctioning, especially [R154]." During interview on 9/16/2014 at 10:33 a.m., registered nurse (RN)-D (the nurse manager for the unit) stated she was aware there had been remodeling completed over the past weekend, as well as construction going on right now. RN-D said there have been "No barriers put up," since they started to remove the tile floor. When asked if she had any concerns for the residents on the unit who had tracheostomies and ventilators, in light of the construction, RN-D stated "I have a little concern, with the dust." RN-D said she had not talked to anyone about the construction dust, and did nothing further to address those concerns regarding the residents on the 300's wing. SUGGESTED METHOD OF CORRECTION: The	2 830		

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2 830	Continued From page 30 director of nursing and/or designee could monitor to ensure facility projects do not imapct resident care in a negative way. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in accordance with an established care plan and physician orders, to promote healing and prevent infection for 2 of 3 residents (R77, R36) with current pressure ulcer(s). This resulted in actual harm for R77 evidenced by worsening pressure ulcer characteristics.	2 900		

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2 900	Continued From page 31 Findings include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had moderate cognitive impairment, had a diagnosis of diabetes mellitus (a metabolic disease resulting in high blood sugars over a long period of time), and required extensive assistance to complete transfers, bed mobility and activities of daily living. R77 had a stage III pressure ulcer (full thickness tissue loss, slough may be present but does note obscure the depth of tissue loss) with dimensions of 1.5 cm (centimeter) X (by) 1.5 cm X 0.2 cm, with granulation tissue (pink or red tissue with shiny, moist, granular appearance). R77's care plan, revised on 8/5/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The care plan indicated a goal of care to be free of skin breakdown, and further identified interventions of, "Treatment as ordered," "Float heels while in bed," and "I have Rooke boots to wear in bed." R77's Order Summary Report, dated 9/4/14, indicated R77 should have his right outer ankle wound (pressure ulcer) cleansed with normal saline, dressed with calcium alginate (a dressing used for wounds with significant drainage), and covered with Optifoam (a dressing used to absorb wound drainage). The Order Summary Report, signed by the medical doctor on 9/4/14, indicated R77 should have this dressing changed daily. During observation on 9/17/14, at 7:05 a.m. R77 was lying in bed with his eyes closed and had blankets pulled up over his face, with his heels lying directly on the bed. R77 did not have any	2 900		

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2 900	Continued From page 32	2 900		

protective boots (Rooke boots) on to reduce the pressure on his heels or ankles as identified in the care plan.

When interviewed on 9/17/14, at 2:20 p.m. nursing assistant (NA)-F stated R77 used to wear white boots when he was lying in bed, however, she was unsure if he should still have them now or not. NA-F stated the resident had worn protective boots in bed when he was in a different room, however, had not seen them used since R77 changed rooms a few months prior.

During interview on 9/17/14, at 2:38 p.m., NA-G stated R77 has not used the protective boots in bed since moving to a different room a few months ago.

When interviewed on 9/18/14, at 9:41 a.m., registered nurse (RN)-A stated R77 was supposed to be wearing protective Rooke boots while in bed to reduce the pressure to his heels and ankles.

During observation of pressure ulcer care on 9/18/14 at 10:05 a.m. RN-C stated the current treatment for R77's right ankle pressure ulcer was to cleanse it with normal saline, dress with calcium alginate, and cover the ulcer with Optifoam everyday. RN-C removed R77's cotton sock from his foot revealing a foam dressing to his right ankle. There was writing on the foam dressing which read, "9-19" (the following day). Further, the dressing had an illegible name written underneath the date. RN-D came into the resident's room at 10:15 a.m. to observe the ulcer with RN-C. RN-D stated it appeared as if the dressing had been placed on the ankle days prior, and the date on the dressing had been changed. However, stated it appeared the actual

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2 900	Continued From page 33	2 900		

dressing on R77's ankle had not been changed. RN-D stated the writing on the dressing appeared to be 9/15 versus 9/19. RN-A came into the room to observe the pressure ulcer at 10:19 a.m. with RN-C, and RN-D. RN-A stated she had seen the wound earlier that same week, and it that it appeared the dressing had not been changed since 9/15 according to writing on the dressing. RN-A stated the ulcer should be viewed, and the dressing changed everyday. RN-C removed the foam dressing from R77, and the pressure ulcer wound was observed by RN-A and the surveyor. RN-A measured the pressure ulcer at 1.0 cm X 1.0 cm X 0.1 cm, however stated the ulcer now had purulent drainage (primarily pus), foul odor, and the wound bed no longer had 100% granulation tissue, but now contained some slough (non-viable tissue that requires debridement [removal]). RN-A further stated the wound appeared to have increased redness around the wound edges from when she had previously viewed earlier in the week. RN-C completed the pressure ulcer treatment, and applied a new Optifoam dressing and dated it 9/18/14.

When interviewed immediately following the wound care observation, at approximately 10:45 a.m., RN-C stated the pressure ulcer dressing had not been consistently changed on a daily basis, as the physician ordered. RN-C further stated the ulcer seems to be larger than she previously had seen.

Review of R77 record identified the following:

A fax communication to the physician on 8/13/14, identified R77 developed a "fluid filled blister on [R right] outer ankle. Area measures 1.4 X 2.5 cm."

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2 900	Continued From page 34 R77's Weekly Wound Documentation Form, dated 8/27/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the ulcer to be 1.9 cm X 1.2 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, moderate serosanguinous drainage, no odor or pain associated with the ulcer. In addition, the form indicated the pressure ulcer was stable in condition with a plan to continue the current treatment of cleansing with normal saline, applying calcium alginate and covering with a foam dressing. R77's Weekly Wound Documentation Form, dated 9/2/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the ulcer to be 1.0 cm X 0.8 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, scant serosanguinous drainage, no odor or pain associated with the ulcer. Further, the form indicated the pressure ulcer was improved in overall condition with a plan to continue the current treatment. R77's most recently completed Weekly Wound Documentation Form, dated 9/9/14, indicated R77 had a stage III pressure ulcer on his right outer ankle. The form indicated the wound to be 1.0 cm X 1.0 cm X 0.2 cm in size, have 100% granulation tissue in the wound base, scant serosanguinous drainage (containing both blood and serous fluid), no odor, and no pain associated with the pressure ulcer. Further, the form indicated the pressure ulcer was stable in condition, and the plan was to continue the current treatment. R77's Braden Scale for Predicting Pressure Sore Risk, dated 8/21/14, indicated R77 had no	2 900		

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2 900	Continued From page 35 sensory perception impairments, was occasionally exposed to moisture, walked occasionally, had very limited mobility, excellent nutrition, and was potentially exposed to friction and shear. Further, the document indicated R77 had an open area (pressure ulcer) on his ankle, and a history of skin breakdown. R77's Care Area Assessment (CAA) progress note, dated 9/18/14, indicated R77 had a stage III pressure ulcer on his right outer ankle, and remained at risk for further skin breakdown related to R77's impaired mobility, being incontinent of urine, and cognitive impairments. Further, the note indicated, "staff are monitoring healing of stage 3 ulcer on right ankle daily with dressing changes and documenting weekly." During interview on 9/18/14, at 10:59 a.m. the director of nursing (DON) stated the physician orders and care plan interventions need to be followed. The DON stated R77's dressing changes should be completed per the physician orders, documented accordingly, and the care plan interventions should have been followed. R77 had a current stage III pressure ulcer, was assessed at risk for further pressure ulcer development, and had physician orders for daily dressing changes of the pressure ulcer. The facility did not implement daily dressing changes as ordered by the physician for R77's stage III pressure ulcer. The facility also did not implement pressure relieving boots while in bed to prevent additional ulcer development or worsening of the current ulcer. As a result, R77's stage III pressure ulcer on his right ankle went from 100% granulation tissue in the wound bed on 9/9/14, to having slough tissue present, developed a foul odor when none had been present before, and	2 900		

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2 900	Continued From page 36 developed purulent drainage indicative of infection on 9/18/14. A facility Prevention of Pressure Ulcers policy, dated 2/2014, indicated pressure ulcers were a serious skin condition for the resident, and the facility should have a system or procedure to assure assessments are timely, appropriate, and for changes in condition to be recognized, evaluated, and reported. Further, the policy indicated the date and time skin care was given should be recorded in the medical record. R36's diagnoses, as identified on the care plan (CP), dated 8/1/2014, included dementia, chronic kidney disease with hemodialysis, and fracture of scapula and multiple ribs. The admission MDS, dated 7/23/2014, indicated R36 was cognitively impaired, and required extensive, physical assistance for ADLs, including two-person assist with bed mobility, transfers and ambulation. A Braden Pressure Sore risk assessment, dated 8/18/2014, indicated R36 was at low risk for development of pressure sores, and further, that R36 repositioned himself. The CAA for pressure ulcers, dated 5/29/2014, indicated R36 was at risk to develop pressure ulcers related to chronic kidney disease, and needing extensive assistance with bed mobility and weakness. A nursing progress note dated 7/31/2014, indicated R36 had an open area on left buttocks, which measured 3 centimeters (cm) by 2 cm by less than 0.2 cm in depth. During observation on 9/17/2014, R36 was seated in his wheel chair from 10:30 a.m. to 1:19 p.m., a total of 2 hours and 49 minutes, without any off-loading (removing pressure to allow tissue perfusion) or repositioning. At 10:30 a.m., R36 was seated in his wheel chair at a table in the	2 900		

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2 900	Continued From page 37 dining area prior to the noon meal, visiting with other residents. At 11:37 a.m., R36 was assisted by staff, and relocated to his usual table in the dining area, and subsequently ate the noon meal. At 12:57 p.m., licensed practical nurse (LPN)-F removed R36, still seated in his wheel chair, from the dining area, and pushed him to his room. Inside the room, LPN-F took R36's vital signs, and continued to remain seated. LPN-F told R36 he was to attend a care conference meeting in a few minutes, and a staff member would help him to the meeting room. At 1:05 p.m., LPN-F then exited R36's room. LPN-F neither offered nor repositioned or off-loaded R36 while in his room. At 1:09 p.m., R36, still seated in his wheel chair, propelled himself from his room into the adjacent day room, positioning his wheel chair at a table. At 1:19 p.m., NA-A entered the day room, approached R36, and told him it was time to get up and stretch. NA-A offered R36 to assist him to stand, and encouraged him to ambulate and stretch. NA-D also asked R36 to use the toilet in his room but R36 refused all of NA-A offers to move, reposition, or off load. During an interview on 9/17/2014, at 1:22 p.m. NA-A stated R36 had been last repositioned "...at 10:30 this morning," it had been "almost three hours" since R36 had been repositioned out of his wheel chair. NA-A acknowledged that R36 had been seated in his wheelchair, without repositioning or off-loading, for nearly 2 hours and 50 minutes. NA-A stated that of late, R36 had been refusing more and more "to stand up, or repo, or do other things suggested, like brushing teeth." NA-A also said when R36 was was there during the day, it was "very difficult" to get him to comply.	2 900		

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2 900	Continued From page 38 A review of a weekly wound documentation progress noted on 8/13/2014, indicated presence of a stage 2 pressure ulcer on R36's left buttock, measuring 0.8 cm x 0.5 cm x < [less than] 0.2 cm. The ulcer was 100% granulation tissue, with scant, serous drainage, surrounding area pink, with no signs or symptoms of infection. The note also indicated R36 exhibited mild pain during treatment. A review of the weekly wound notes from 8/13/2014, to 9/10/2014, indicated the pressure ulcer was healing, and subsequently, had resolved. During observation on 9/18/2014, at 10:27 a.m. LPN-A had assisted R36 with toileting. R36's buttocks was slightly pink and had no open areas. LPN-A applied a barrier cream to R36's previously open area, during which time R36 denied any sensation of pain. During an interview on 9/18/2014, at 9:00 a.m. RN-D stated, "We usually do our repos [repositioning] at least every two hours." RN-D said that although [R36's] pressure area had resolved, he remained at risk for future pressure sores, and further, that [R36] "...should have been repositioned at 2 hours." RN-D said, "We need to be more aggressive in follow through." In a subsequent interview at 11:10 a.m., RN-D said she did not know if R36 was routinely repositioned or off loaded when off site receiving dialysis, and noted those runs can last "more than three hours." RN-D also said that recently, R36 was refusing to follow staff direction, especially on the days he does not leave the building. RN-D said R36's refusal to reposition, or get up out of the wheel chair "should be part of his assessment and care plan." RN-D said she was unaware of any repositioning schedule while R36 attended dialysis.	2 900		

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2 900	Continued From page 39 Although R36's assessments indicated he was at risk to develop pressure ulcers, the assessment did not identify R36's refusal of cares, including repositioning or off loading. The assessment did not identify if R36 was repositioned while at dialysis, even though he was gone for several hours three days a week. R36's CP identified pressure ulcers, and included various interventions to maintain intact skin, among which required [R36] "... to be turned and repositioned every 2 hours." The CP lacked further direction, or action, staff were to take either, when R36 was off-site, such as when attending dialysis, or when R36 refused repositioning or off-loading, regardless of location. During an interview on 9/18/2014, at 11:48 a.m. the DON stated the plan of care "should be followed" for any resident who needs timely repositioning. The DON agreed a resident's refusals of care also needed to be assessed, and that risks and benefits of refusal "needed to be identified." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could inservice staff and monitor for compliance with physician orders concerning pressure ulcer care and treatment(s). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		

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2 910	Continued From page 40 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident received timely assistance with toileting for 1 of 3 residents (R77) who had a toileting program; In addition, the facility failed to have medical justification of use for an indwelling urinary catheter for 1 of 1 residents (R150) who had a urinary catheter. Findings include: R77's quarterly Minimum Data Set (MDS) indicated R77 had moderate cognitive impairment, required extensive assistance with toileting, and was frequently incontinence of urine. R77's care plan, dated 10/5/13, indicated R77	2 910		

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2 910	Continued From page 41 was frequently incontinent of urine, used a toilet or urinal for elimination with staff assistance and had a goal of wanting to participate in his toileting program to become more continent. Further, the care plan indicated to offer R77 the toilet every 2 hours. During observation of personal cares on 9/17/14, at 7:08 a.m., nursing assistant (NA)-G and NA-F assisted R77 to stand with the use of a mechanical lift at his bedside. NA-F removed R77's incontinence product at the bedside and placed it in the trash. The incontinence product was saturated with urine, and had a moderate amount of stool present. NA-G sprayed R77's coccyx and buttocks with Medline Wound Cleanser, dried R77 with a disposable washcloth, and applied a new incontinence product before seating R77 on the bed. NA-G and NA-F completed the remainder of R77's cares,and left the room, without offering or assisting R77 to use the toilet or urinal. Review of R77's Bladder Assessment, dated 8/21/14, indicated R77 was incontinent of urine, and had several risk factors for continued incontinence including impaired mobility, and being dependent on staff for transfers. The assessment indicated R77 had functional incontinence resulted from mobility impairments and, "Lack of ability to get to toilet or toilet substitute...". Further, the assessment indicated staff were to assist with toileting and hygiene, but did not identify a toileting frequency for R77. During interview on 9/17/14, at 2:20 p.m., NA-F stated this was their normal routine procedure (observation that morning on 9/17/14 at 7:08 a.m.) for delivering care to R77. NA-F stated the resident should have been offered the use of the toilet versus being changed at the bedside. Also,	2 910		

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2 910	Continued From page 42 they should not have used wound cleanser on his coccyx and buttocks to provide perineal care. When interviewed on 9/17/14, at 2:38 p.m., NA-G stated R77 was not offered the toilet during the morning observation (9/17/14 at 7:08 a.m.) as R77 had already been incontinent of urine and bowel. Further, NA-G stated R77 should have been offered the toilet during care, and should not have had wound cleanser used on his coccyx and buttocks for perineal care, "That was my fault." During interview on 9/18/14, at 12:40 p.m., registered nurse (RN)-A stated R77 had been incontinent of urine for several months and should have been offered the toilet with cares. R77 was at a higher risk of further bladder function loss because he was not given the opportunity to use the toilet. During interview on 9/18/14, at 12:43 p.m., the director of nursing (DON) stated R77 should have been helped to the toilet by staff during morning cares as directed by the assessment and care plan. The DON further stated not assisting R77 to the toilet increases R77's risk of further bladder incontinence and loss of function. A facility Bowel and Bladder Retraining policy, dated 4/13, indicated the facility will ensure each resident is, whom was incontinent, is given the opportunity to achieve continence when appropriate. R150's admission minimum data set (MDS) dated 8/12/14, included a diagnosis of cerebral vascular accident (CVA), had severe cognitive impairment, an indwelling Foley catheter, extensive assistance for toileting, transferring and hygiene.	2 910		

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2 910	Continued From page 43 The urinary care area assessment (CAA) had not been completed. An observation on 9/17/14 at 8:30 a.m. in his wheelchair with an indwelling catheter hanging below his wheelchair. Review of the emergency department provider note dated 8/5/14 lists a indwelling urinary catheter and in the same document under problem list, indicates "urinary retention." Review of the progress notes, and the physician referral form from 8/5/14 to 9/2/14, did not identify a bladder assessment had been completed, nor was there any diagnosis that justified the reason R150 continued to need the indwelling catheter. The care plan updated, 8/20/14 indicates urinary catheter and than listed under problem list is "my diagnosis:urinary retention" there was no diagnosis that identified why R150 had urinary retension. During an interview on 9/18/14 at 10:29 a.m. with licensed practical nurse (LPN)-B said the catheter is because he has urinary retention. She was unsure if he just had the catheter when in the hospital, was unsure of how many cc of retension R150 experienced, or how frequently did R150 experience retension and if it still was a problem. An interview on 9/18/14 11 a.m. the DON said the history and physical from the hospital does not indicate why he has urinary retention. Policies regarding urinary catheter and/or urinary retention were requested from the facility but not received. SUGGESTED METHOD OF CORRECTION: The	2 910		

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2 910	Continued From page 44 director of nursing and/or designee could inservice staff regarding medical justification for catheter use, and use of toileting programs to promote normal bladder function. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 9 residents (R20 and R48) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The	2 915		

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2 915	Continued From page 45 decline in ability to ambulate resulted in actual harm for R20 and R48. Findings include: R20's quarterly Minimum Data Set (MDS) dated 7/17/14, indicated he had peripheral vascular disease, Alzheimer's, dementia, severe cognitive impairment, ambulated once or twice in his room or corridor with assist of two, received scheduled pain medication and had no presence of pain. R20's quarterly MDS dated 4/30/14, indicated he had severe cognitive impairment, did not walk in his room or corridor, received scheduled pain medication and had no presence of pain. The Care Area Assessment (CAA) dated 1/24/14, indicated R20 triggered for activities of daily living (ADLs) due to needing supervision with dressing, hygiene, bathing, not being steady and needs a wheelchair or walker. During interview 9/17/14, at 8:00 a.m. with nursing assistant (NA)-E and NA-D both stated they have not been able to ambulate R20 and other residents due to their work load assignments for the past several months. During observation 9/18/14, at 9:30 a.m. R20 was sitting in his room in a wheelchair, a walker was not observed in his room to assist with ambulation. During interview 9/18/14, at 9:44 a.m. nursing assistant (NA)-D who cared for R20 stated R20 has stopped ambulating over a month ago and that he has becoming more combative with cares. She also stated, "We have no time to ambulate our residents," which had been occurring for the past several months. Review of a Hospital Discharge Summary dated 1/5/14, indicated R20 was admitted for acute sepsis likely secondary to osteomyelitis, an amputation of the right second toe was completed on 1/3/14 without difficulty. R20's care plan dated 2/12/14, indicated he	2 915		

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2 915	Continued From page 46	2 915		

cannot ambulate independently due to recent toe amputation and decline in cognition. The care plan indicated R20's balance while standing was unsteady and that R20 was to participate in a functional maintenance program (FMP) to ambulate with supervision 75-100 feet (ft.) up and down the hallway times two, when able.
Review of R20's Pain Assessment 3.0 which was updated on 6/20/14, indicated when asked he had no pain presence, rarely has pain and staff assessment for pain using numeric scale from 00-10 (00 being no pain to 10 being the worst pain experienced) R20 identified their pain as a "1" mild discomfort. The assessment identified R20 received Tylenol 500 milligrams (mg) (analgesic) three times a day. The Pain Assessment 3.0 dated 7/3/14, indicated R20 had no pain presence, rarely has pain and his numeric rating was 00. The assessment identified R20 denied pain, and the Tylenol 500 mg three times a day on 6/20/14, and seems effective for pain relief. The Pain Assessment 3.0 dated 8/21/14, and 9/21/14, remained unchanged from the 7/3/14, assessment indicating resident denied pain and Tylenol extra strength seems effective for pain relief.
Review of R20's progress notes from 7/1/14 thru 9/22/14, did not indicate R20 was having any pain or discomfort from his toe amputation in January 2014.
The facility's nursing assistant care sheet undated, directed staff to ambulate R20 75-100 ft. with a front wheeled walker (FWW) and gait belt two times daily. A Walking/Ambulation Program Guidelines Restorative Nursing/Functional Maintenance Recommendations authorized by physical therapy (PT) dated 4/9/14, indicated R20 walked with a FWW and a gait belt 75-100 ft. with two self-performance and two support.
Review of the progress notes, physician notes

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2 915	Continued From page 47 and facility assessment from June 20, 2014 to September 18, 2014 did not identify R20 was being ambulated 75-100 ft. with a front wheeled walker (FWW), and gait belt two times daily, as directed by the Walking/Ambulation Program Guidelines Restorative Nursing/Functional Maintenance Recommendations which PT recommended for R20. During interview 9/18/14, at 9:01 a.m. physical therapist (PT)-A stated she hadn't been informed that R20 was not ambulating, and confirmed that he had not been seen by physical therapy since 4/9/14, when he'd started on his walking/ambulation program. PT-A then stated she would reassess his ability to ambulate. During interview 9/18/14, at 9:20 a.m. the director of nursing (DON) stated in November 2013, the facility started documenting the FMP's in a new computer system and stated she was unable to find any documentation that staff were providing R20 with his FMP that started on 4/9/14. The DON further stated the staff development nurse who left in March 2014, was supposed to be documenting quarterly on his progress with his FMP but she had not completed this. During interview on 9/17/14 at 2:13 p.m. certified occupational therapy assistant (COTA)-A stated the facility has a functional maintenance program which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated, "If we don't have any staff to do the programs, the programs have not been implemented for any of the residents." Review of the Physical Therapy Plan of Care	2 915		

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2 915	Continued From page 48 dated 9/17/14, identified reason for referral was, "[functional decline] Patient is a 86 year old male who presents with a decline in transfers and ambulation due to patient not participating in current FMP for ambulation and decreased bilateral ankle ROM [range of motion]. This since resulted in the patient now requiring significantly more assistance for the completion of transfers and ambulation." The referral indicated under initial assessment that his prior level was that he walked 100 ft. with his front wheeled walker. The current level of his assessment indicated he needs "moderate assist x 2 persons [Routinely requires 50 % physical assistance of 2 persons to transfer]." The referral under gait distance indicated his prior level was "100 feet" and his current level is "0 feet." The evaluation also indicated "Therapy is necessary for improving bilateral ankle ROM, transfers, and ambulation along with updating current FMP to make it appropriate for the patient due to his dementia with behavior disturbances. Without therapy patient is at risk for further functional decline." The referral indicated R20 received acetaminophen for pain but did not indicate R20 was currently having any pain. During interview 9/18/14, at 9:01 a.m. PT-A stated that R20 started on a FMP on 4/19/14, and that he was able to ambulate 75-100 ft. with his front wheeled walker. The PT-A stated she had attempted to ambulate R20 yesterday (9/17/14), and R20 would not ambulate with her. She had spoken to the staff and they informed her he [R20] was no longer ambulating. PT-A stated staff are supposed to inform her if a resident is declining or is no longer is able to complete their FMP, but stated she had never been informed that R20 was not ambulating anymore. PT-A stated she was going to try and get approval to pick him back up again for therapy.	2 915		

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2 915	Continued From page 49 During a phone interview 9/22/14, at 11:40 a.m. PT-A stated that if a resident was observed during her evaluation to have pain she would document that on the evaluation. Although R20 had a FMP to assist with ambulation, the facility failed to ambulate R20, which resulted in a decline in ambulation which was not reassessed, and resulted in actual harm for R20. R48's quarterly MDS dated 6/17/14, indicated he had a diagnosis of arthritis, cerebral vascular accident (CVA), was cognitively intact and transferred with limited assist of one. He ambulated in his room with extensive assist of one and did not ambulate in the corridor. R48's care plan dated 3/14/14, indicated on 5/23/13 he was placed on a FMP to ambulate 100 ft. twice daily with walker. The nursing assistant care sheet undated, indicated R48 was to ambulate 100 ft. twice daily with a walker. R48's FMP documentation dated May 2013 indicated under comments section of the FMP identified "[R48] to ambulation 100 ft. twice a day with walker and assist of one staff. he will demonstrate benefits from his program by his ability to stand & transfer with assist of one staff." During interview 9/17/14, at 8:00 a.m. with NA-E and NA-D both stated they have not been able to ambulate R48 or their other residents due to their work load assignments for the past several months. During interview and observation on 9/17/14, at 8:20 a.m. R48 stated he does not ambulate and the staff do not offer to ambulate him. He further stated if staff would offer to ambulate with him he	2 915		

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2 915	Continued From page 50 would not refuse. There was no walker observed in his room. During interview on 9/17/14 at 2:13 p.m. COTA-A stated the facility has a FMP which was to be completed by their restorative aides. But, at this time they do not have any staff that are implementing the restorative program, and have not had any for at least three weeks or longer. COTA-A stated, "If we don't have any staff to do the programs, the programs have not been implemented for any of the residents." Review of the progress notes, and FMPs from June 2014 to September 8, 2014, did not identify R48 had been ambulated 100 ft. twice a day with a walker, as identified by the 5/23/13 FMP. During interview 9/18/14, at 9:01 a.m. PT-A stated she would be reassessing R48's ability to ambulate. Review of the Physical Therapy Plan of Care Evaluation dated 9/18/14 (during survey), indicated he was re-evaluated for ambulation to check for a decline. The evaluation indicated he was able to ambulate 100 ft and now was only able to ambulate 20 ft, but wanted to continue his FMP. During phone interview 9/25/14, at 10:30 a.m. PT-A stated that when she had evaluated R48 for a decline he was only able to ambulate 20 feet, and the program initially started May 2013. PT-A stated she had recommend the facility to ambulate R48 up to 100 feet with front wheeled walker and assistance of two staff. A request was made to the facility for the May 2013 FMP and none was provided.	2 915		

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2 915	Continued From page 51 During interview 9/17/14, at 11:30 a.m. the DON stated they have an issue with their FMP and restorative nursing and indicated the staff member who was in charge of the program had walked off of the job the last week of August and they currently have no one in charge of the program. Although R48 had a FMP to assist with ambulation, the facility failed to ambulate R48, which resulted in a decline in ambulation which was not reassessed, and resulted in actual harm for R48. A Restorative Nursing Program policy revised March 2013, indicated the policy to, "promote each residents ability to adapt to or attain his or her maximum functional potential. To promote each resident's highest practicable level of physical, mental and psychosocial functioning." The policy further indicated all restorative nursing programs must be reviewed by a registered nurse and need to address how they are working and if changes are made, why the changes were made. This needs to be done quarterly. They must be individualized and address how they are maintaining or improving ambulation, range of motion (ROM), continence etc. and be specific about how this is happening for each resident. The policy also indicated the notes need to assess progress or lack of progress, changes made, why programs needed to continue (or discontinue in some cases), and why program is maintaining or restoring a function that affects the residents activity of daily living skills (ADL'S). Based on observation, interview and document review, the facility failed to provide and consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 7 of 9 residents (R27, R22, R24, R53, R139, R14 and R18) reviewed for	2 915		

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2 915	Continued From page 52 rehabilitation services. Findings include: R27's annual Minimum Data Set (MDS) dated 6/12/14, indicated he had diabetes mellitus and depression. The MDS further indicated he ambulates with set up only and transfers with supervision and assist of one and is moderately cognitively intact. R27's care plan dated 6/2/14, indicated he was on a FMP which includes ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff. R27's nursing assistant care sheet undated indicated he was to ambulate 90 to 100 ft twice daily. R27's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 10/15/13, indicated he is to ambulate 90 to 100 ft. twice daily and to increase as tolerated. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated the reason for referral for re-evaluation for appropriateness of FMP for ambulation in order to check for any possible decline. The referral indicated for Initial Assessment his prior level was stand by assist for transfer and that he ambulated 100 ft. needing contact guard, and his current level indicated he now can ambulate 175 ft. with contact guard assist. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulating 90 to 100 feet (ft.) two times daily with a front wheeled walker (FWW), gait belt and assist of one staff." this was started on 10/15/13.	2 915		

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2 915	Continued From page 53 There was no indication this has been completed as recommend on the 10/15/13 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:05 a.m. physical therapist (PT)-A stated she evaluated R27 and he now ambulates 175 ft. R22's annual MDS dated 7/1/14, indicated she had arthritis and osteoporosis. The MDS further indicated she transferred independently and ambulated independently in her room and ambulated in the corridor once or twice with no set up or physical assist from staff and is cognitively intact. R22's care plan dated 1/20/14, indicated she can ambulate although she chooses not to, and uses a FWW. The care plan further indicated she can ambulate up to 100 ft. daily with a gait belt. R22's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 6/10/14 indicated she uses a FWW and ambulates 100ft with stand by assistance (SBA). Nursing assistant care sheet undated indicated to ambulate up to 100 ft. with gait belt and assist of one and FWW. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated she was able to ambulate 70 ft. and now can ambulate 70 ft. Review of the facility Evergreen Terrace Documentation Survey Report for July 2014 to	2 915		

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2 915	Continued From page 54 September 18th, 2014, did not identify he was ambulating 100 ft. with FWW and SBA daily" which was started on 06/10/14. There was no indication this has been completed as recommend on the 6/10/14, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:10 a.m. with PT-A stated R22 has remained the same with her ambulation and has not had a decline. R24's quarterly MDS dated 7/8/14, indicated he had dementia and was independent with transfers and needed supervision and assist of one to ambulate in his room and corridor and was cognitively intact. R24's care plan dated 8/27/13, indicated he can ambulate independently in his room and he prefers to use his walker while going on outings and he uses a FWW and transfer belt. The care plan indicated he is to ambulate twice daily for 400 ft. R24's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 9/17/14, indicated he is to ambulate 400 ft. with a seated rest and FWW and stand by assist (SBA). Nursing assistant care sheet undated indicated to ambulate 400 ft. twice a day. A Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated he is currently able to ambulate 420 ft. with one seated rest and supervision stand by assist (SBA). Review of the facility Evergreen Terrace	2 915		

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2 915	Continued From page 55 Documentation Survey Report for July 2014 to September 18th, 2014, did not identify he was ambulating 400 ft. with one seated rest with FWW and SBA" which was started on 8/27/13. There was no indication this has been completed as recommend on the 8/27/13, Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:12 a.m. with PT-A stated R24 has not had a decline in his ambulation. R53's admission MDS dated 6/26/14, indicated she had a thyroid disorder and needed extensive assist of two with transfers and did not ambulate in her room or corridor. The MDS further indicated she is cognitively intact. R53's care plan dated 6/20/14, indicated she is on a FMP to ambulate 200 ft. with a FWW, gait belt and assist of one staff and resident is to walk on her left tiptoe due to heel wound on left heel and to take heel protector off when walking. R53's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/27/14, indicated she ambulates 200 ft. with a FWW , gait belt and contact guard assist (CGA). Nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW twice a day. R53's Physical Therapy Plan of Care Evaluation dated dated 9/17/14, indicated she was able to ambulate 200 ft. and now can ambulate 250 ft. Review of the facility Evergreen Terrace	2 915		

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2 915	Continued From page 56 Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW, gait belt and contact guard assist (CGA) twice per day a.m. and p.m." which was started on 8/27/14. There was no indication this has been completed twice a day as recommend on the 8/27/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/17/14, at 8:20 a.m. R53 stated that she only walks to the bathroom and back, she stated she would need assistance from staff to walk in the hall and they do not offer to walk her. R53 also stated the staff are not offering to ambulate her husband R139. During interview 9/18/14, at 9:18 a.m. with PT-A stated she had just started her on FMP and she has had no decline. R139's admission MDS dated 6/27/14, indicated he transferred with supervision and set up and ambulated in his room independently with no help and is moderately cognitively impaired. R139's care plan dated 9/17/14, indicated he is on a FMP and ambulates 200 ft. with FWW and CGA. R139's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 8/29/14, indicated he was to ambulate 200 ft. with FWW and CGA. Review of the facility Evergreen Terrace Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 200 ft with FWW and contact guard	2 915		

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2 915	Continued From page 57 assist (CGA) twice per day" which was started on 8/29/14. There was no indication this has been completed twice a day as recommend on the 8/29/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. Nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW and CGA. During interview 9/18/14, at 9:18 a.m. PT-A stated he had just started him on a FMP and he has had no decline and she did not re-evaluate him. R14's quarterly MDS dated 5/28/14, indicated she had dementia and a cerebral vascular accident (CVA) the MDS further indicated she needed extensive assist of one to transfer and ambulate and severely cognitively impaired. R14's care plan dated 9/12/14, indicated she is on a restorative nursing program the care plan did not address her functional status with mobility. R14's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 5/28/14, indicated R14 ambulated 30 to 80 ft. with a FWW and assist of two. Nursing assistant care sheet undated indicated to ambulate twice daily 30 to 80 ft. with FWW and minimal assist. R14's Physical Therapy Plan of Care Evaluation dated 9/17/14, indicated she was able to ambulate 30 ft and now can ambulate 40 ft. Review of the facility Evergreen Terrace	2 915		

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2 915	Continued From page 58 Documentation Survey Report for July 2014 to September 18th, 2014, did not identify "ambulation 30 to 80 feet with FWW twice per day" which was started on 5/28/14. There was no indication this has been completed two times a day as recommend on the 5/28/14 Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT. During interview 9/18/14, at 9:20 a.m. with PT-A stated R14 has had no decline in her mobility. During interview 9/17/14, at 8:00 a.m. with nursing assistant (NA)-E stated she is unable to ambulate her residents due to not having enough time on her shift. NA-D also stated she is unable to ambulate her residents. During interview 9/17/14, at 11:30 a.m. the director of nursing (DON) stated they had an issue with there functional maintenance (FMP) and restorative nursing she indicated the staff member who was uncharged of the program had walked off of the job the last week of august and they currently have no one in charge of the program and realized there has been no documentation that the programs are being completed. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review all restorative ambulation programs to ensure their completion as ordered/planned. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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2 920	Continued From page 59	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine grooming (nail care) for 1 of 3 residents (R77) whom was dependent on staff for care, whom was reviewed for activities of daily living and grooming. Findings Include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 had an active diagnosis of diabetes mellitus, required extensive assistance from staff for his personal hygiene, and had moderate cognitive impairment. R77's care plan, dated 9/8/14, indicated R77 required assistance with dressing, grooming, and bathing. Further, the care plan indicated R77 required weekly nail care. During observation on 9/16/14, at 9:22 a.m., R77 was seated in his wheelchair in his room. R77 had long, un-trimmed fingernails on both hands, with a dark substance underneath several of the nails.	2 920		

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2 920	Continued From page 60 Subsequent observations of R77 on 9/17/14 at 7:08 a.m., and 9/18/14 at 8:19 a.m., were made and R77 continued to have un-trimmed, dirty fingernails. When interviewed on 9/18/14, at 8:19 a.m., R77 stated he would like his fingernails to be trimmed and kept shorter. R77's family member, whom was present during interview, stated at times s/he would take an emery board (nail file) to R77's nails because they were long and not kept trimmed. During interview on 9/17/14, at 9:04 a.m., nursing assistant (NA)-D stated fingernails should be trimmed on the resident's bath day. Further, NA-D stated R77's fingernails should have been clean and trimmed. During interview on 9/18/14, at 9:29 a.m., registered nurse (RN)-A stated R77 required help from staff to complete grooming and personal cares. RN-A stated R77 had no identified preference to have long fingernails, and his fingernails should have been trimmed by a nurse. When interviewed on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated nursing staff are expected to trim and clean fingernails routinely. Further, the DON stated R77's fingernails should have been trimmed according to his preference. A facility Nursing Care Standards policy, dated 8/09, indicated standards to follow to ensure each resident is provided the highest practicable level of care. Further, the policy indicated, "Fingernails and toenails shall be clean and trimmed."	2 920		

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2 920	Continued From page 61 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could inservice staff regarding timely and consistent completion of activities of daily living for residents whom are dependent on staff for cares. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21045	Mn Rule 4658.0620 Subp. 4 Frequency of Meals; Dining Room Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident were given the choice of meal preferences for 13 of 16 residents (R102, 92, 85,18,150,107, 67, 64, 105, 51, 117, 86 and 157) in the secured dementia unit who were identified as being capable of making a choice of meal entrees. Findings include: During observation of the evenings meal on 9/15/2014 at 5:30 p.m., residents in the 100's wing, secured dementia unit, were seated at tables, awaiting the evening meal service. A cart loaded with resident meal trays, was delivered on the unit. Licensed practical nurse (LPN)-B pulled individual trays off the cart, each one for a resident, and in turn, removed the plate covers, and placed the food entree in front of the seated residents. Staff completed this for all residents in the secured dementia unit. Staff did not ask	21045		

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residents any questions related to the food entree, nor offer any choice to the residents regarding food choice.

During observation of the breakfast meal on 9/17/14 at 8:00 a.m., the dietary staff (DS)-A wheeled a metal rack of trays into the secured dementia unit where residents were seated in the dining room. The rack had trays for each of the residents in the unit, and the plates were covered with a plastic insulated dome. Nursing assistant (NA)-I and licensed practical nurse (LPN)-P removed the cover from each plate which consisted of a cheese omelet, fried potatoes and toast, and served all the resident in the secured dementia unit their plates. NA-I and LPN-P did not ask the residents prior to being served about a food choice or preference but served the food that was already provided on each of the plates. Also, there was no indication in the secured dementia unit, that a list of meal alternatives or options were available for the residents to choose.

On 9/15/2014 at 5:37 p.m. in the main dining room of the facility, nursing assistants (NA)-D, F and G were observed collecting menu slips from residents. Staff were asking residents what they wanted to eat, either lasagne with garlic toast and vegetable, or country fried steak, with potatoes and gravy. The entree choices were noted to be written on a white board on the south side of the dining room. Staff took the slips into the kitchen, and upon retuning, delivered the chosen meal to the resident.

R102's undated facility diagnosis sheet identified diagnosis of altered mental status. R102's quarterly Minimum Data Set (MDS), dated

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21045	Continued From page 63 7/23/2014, identified intact cognition. The MDS also indicated R102 was capable of making herself understood to others, and understood others. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R102] to locate radio/TV/video/music programming of choice upon request." R92's undated facility diagnosis sheet identified diagnoses of dementia and Alzheimer's disease. The quarterly MDS, dated 8/26/2014, indicated cognitive impairment. The MDS also indicated R92 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct communication. The care plan print date of 9/18/14 identified a preference about attending facility activities which needs reminders, invites and escort to participate. The interventions included, "Staff assist to transport to these activities of choice as scheduled, encourage music programs, animal visits,, 3m's discussion group and social hours." R85's undated facility diagnosis sheet identified diagnoses of Alzheimer's disease and presenile dementia. The quarterly MDS, dated 7/22/2014, indicated cognitive impairment. The MDS also indicated R85 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct communication. The care plan print date of 9/18/14 identified, I want to attend some facility activities," with the intervention of, "Staff assist [R85] with setting up videos/computer programming for him/her to view independently and return later on for additional assistance as needed." The care plan also directed staff to, "Pick up shopping needs as needed or	21045		

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21045	Continued From page 64 requested." R18's undated Self Limiting Problems and Diagnoses sheet identified diagnosis of dementia. The admission MDS, dated 6/5/2014, indicated cognitive impairment. The MDS also indicated R18 usually made himself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified wanting to attend some facility activities but also have independent activities. Staff were to assist with "I need assistance of invites, reminders and encouragement to get to the facility activities." R150's undated facility diagnosis sheet identified diagnosis of depression and cerebellar ataxis. The admission MDS, dated 8/12/2014, indicated cognitive impairment. The MDS also indicated R150: usually made himself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified, "I am able to communicate my needs", with a goal of, " I will effectively communicate needs daily." The care plan also identified "I am able to make my own decisions", with a goal of, "I want to remain in control of my care decisions", and "staff to fully inform me of my clinical status." R107's undated facility diagnosis sheet identified diagnosis of dementia and cerebrovascular disease. The admission MDS, dated 7/22/2014, indicated moderate cognitive impairment. The	21045		

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21045	Continued From page 65 MDS also indicated R107, made himself understood to others, and was able to understand others. The care plan print date of 9/18/14 identified, I want to attend some facility activities," with the intervention of, "I need assistance of reminders, escorts and invites to get to the facility activities." R67's undated facility diagnosis sheet identified diagnosis of dementia and depression. The quarterly MDS, dated 8/5/2014, indicated cognitive impairment. The MDS also indicated R67 usually made herself understood to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R67] to locate radio/TV/video/music programming of choice upon request." R64's undated facility diagnosis sheet identified diagnosis of depressive disorder. The annual MDS, dated 8/13/2014, indicated cognitive impairment. The MDS also indicated R64: made herself understood to others, and usually understood others. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R64] to locate radio/TV/video/music programming of choice upon request." R105's undated facility diagnosis sheet identified diagnosis of confusion of unspecific site. The quarterly MDS, dated 6/25/2014, indicated moderate cognitive impairment. The MDS also indicated R105 usually made himself understood	21045		

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21045	Continued From page 66 to others, usually understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R105] to locate radio/TV/video/music programming of choice upon request." R51's undated facility diagnosis sheet identified diagnosis of senile dementia. The annual MDS, dated 8/6/2014, indicated cognitive impairment. The MDS also indicated R51: usually made himself understood to others, sometimes understood others, and had difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. The care plan print date of 9/18/14 identified a choice of life activities prior to admission, with the intervention of, "Staff assist [R51] to locate radio/TV/video/music programming of choice upon request." R117's undated facility diagnosis sheet identified diagnosis of dementia with behavior disturbances. The quarterly MDS, dated 6/4/2014, indicated intact cognition. The MDS also indicated R117 made her self understood to others, and usually understood others. The care plan print date of 9/18/14 identified a preferences of attending facility activities, with the intervention of, "Staff invite/remind/assist to transport to activities of choice..." R86's admission MDS, dated 8/1/2014, indicated cognitive impairment. The MDS also indicated R86 sometimes made herself understood to others, sometimes understood others, and responded adequately to simple, direct	21045		

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communication only.

R157 undated facility diagnosis sheet identified diagnosis of altered mental status. The MDS was unavailable to the R157 being new to the facility.

During an interview on 9/17/2014 at 10:45 a.m., the dietary manager (DM) stated menu slips are printed for each meal for every resident. The DM explained the slips list each resident's preferences, "like cranberry versus apple juice;" and each resident's dietary needs, "like nectar thick liquids, a diabetic diet, and adaptive plate and spoon." The DM said the resident menu slip were printed with the day's main entree, but that "the residents can choose to have an alternate entree." The DM said the main daily entree and the alternate entree were usually written on the board in the dining room. The DM said residents in main dining room would fill out their own slips, and were "...asked by the aides what they want to eat," and had a choice of different food items.

Continuing the interview, the DM said on the secured dementia, " ...they follow a different system" in regard to the entree meal choices for residents. The DM said the daily menu slips for residents on the secured dementia unit reflected the residents' choices and preferences, based on "...what staff have learned about what each resident likes and dislikes." The DM said that resident's preferences on the secured unit, "it was difficult to get that input from the residents," and further stated, "...often we had no family input as to preferences." The DM said, "When we dish it up and put it on the tray; they [the residents in the locked unit] are not asked that day what they want to eat." The DM further added that if the resident did not like what was on the tray, the

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aides "...are good about coming back to the kitchen and can get a different entree for the resident." The DM said she did not know how many times staff actually returned to the kitchen to pick alternate meals for residents on the locked unit.

During interview on 9/17/2014 at 11:03 a.m., cook (C)-A stated she didn't know the residents on the secured dementia unit "had a choice." C-A said those residents' entrees were dished up "as to what was is on their ticket." C-A said the aides can come back to the kitchen and pick up a different entree, from the secured unit, "About once a week or less."

During interview on 9/18/14 at 10:15 a.m. licensed practical nurse (LPN)-B stated residents in the secured dementia unit were not given a choice of entrees, and were always given the main entree unless they told us differently, even though there was no listing of these meal choice found in the secured dementia unit. LPN-B continued to state, there were 16 residents in the secured dementia unit and 13 of these residents (R102, R92, R85, R18, R86, R150, R157, R107, R67, R64, R105, R51, R117) were capable of making a choice between two different main entrees, but were not given a choice as other residents were in the main facility dining room. "We serve the food the kitchen provides to them." LPN-B said.

During interview on 9/18/2014 at 2:24 p.m., the director of nursing (DON) said she had discussed "dining options" on the locked unit, and stated, no matter where the resident is in the nursing home, "each should have the choices afforded all other residents." The DON also said, we should allow

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21045	Continued From page 69 "...each resident to make their dining choices, if they can." Even though the residents (R102, 92, 85,18,150,107, 67, 64, 105, 51, 117, 86 and 157) were identified as being capable of making a choice of entrees, they were not provided that opportunity by the facility due to being in the secured dementia unit. SUGGESTED METHOD OF CORRECTION: The dietary manager and/or designee could review meal delivery service(s) to ensure resident choices are honored and respected. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21045		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in	21390		

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21390	Continued From page 70 the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's infection control program lacked a surveillance program and investigation of infections that occurred in the facility for tracking trends and analysis of data to determine interventions to prevent the spread of infections which had the potential to affect 83 of the 83 residents who resided in the facility. In addition the facility failed to use gloves while administering injections for 3 of the 4 resident (R52 and R145) observed who received injections. Findings include: During review of the facility's infection control program 9/17/14, at 2:05 p.m. with the director of nursing (DON), who was identified as the infection control preventions nurse, there were components of the infection control program missing. The DON explained she has been making changes to the infection control program, had recently started at the facility in the past few months. She stated two forms are being used one with the Line Listing of Resident Infections	21390		

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which indicates the room, symptoms, cultures, treatment and if it is healthcare associated infection or community acquired infection. She stated she fills out a Infection Control Log that lists the resident/wing, date, infection, action plan and if the had on infection on admission or in facility. She reports any trends to there quality assurance committee.

Review of the last 4 months of facility forms from June 2014 to September 2014 indicated the Line Listing of Resident Infections. The logs did not identify residents room or the units they were on, what type of infection or what symptoms they had.

The June 2014 Line Listing of Resident Infection log identified a total of seven infections in the facility, four had urinary tract infections (UTI)'s; one clostridium difficile (c-diff) ; one methcillian resistent step aurus (MRSA) and one pneumonia. The log did not consistently identify specific symptoms the residents were having, room/unit location, cultures, treatment, and community or heath care acquired infection.

The July 2014 Line Listing of Resident Infection log identified a total of four infections in the facility, two YTI's, one pneumonia, and one unidentified infection. The log did not consistently identify specific symptoms the residents were having and cultures.

The August 2014 Line Listing of Resident Infection log identified a total of eight infections. There were three respiratory infections, identified on the 300 unit, but there was no indication if these infections occurred during the same time frame, or if any cross contamination had been determined among these residents.

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21390	Continued From page 72 The September 2014 Line Listing of Resident Infection log identified two infections, the date the infections occurred were missing. During interview 9/17/14, at 2:15 p.m. the DON stated the forms should have indicated where in the facility the infections were, and what symptoms they had. She stated without this data she was unable to track trends or analyze the infections to determine a potential patter or any cross contamination. During the interview the DON stated the facility had an outbreak of streptococcus (strep)symptoms infections with eight employees, who all worked down the 300 unit. None of the resident to date have had any strep symptoms. The facility provided Work/School Excuse and Restrictions forms which indicated the following: from 8/4/14 to 9/7/14 eight employees had reported to have Work/School Excuse and Restrictions forms due to step symptom illnesses. During interview 9/17/14, at 2:30 p.m. the DON stated it was strange they had so many employees that worked on the same wing develop strep symptoms. They were unable to determine, how these infections were being transmitted from one employee to another during the one month period from 8/4/14 to 9/7/14. She thought they were getting the infections from the computer key boards or the mouse's they all used but was unable to determine how the infection was transmitted. She had not completed any handwashing audits and increased there cleaning, made sure the staff were on there antibiotics for 24 hrs. (hours) before returning to work. She also posted a memo which indicated, "Due to the increased illness among the staff. We	21390		

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are asking that all staff wear a mask when entering resident rooms that are on vent [ventilators] or have trach's [tracheotomy]. Nurses need to wipe the carts with disinfecting wipes, key boards, and mouse for the computers. All staff make sure you are using the alcohol hand sanitizer and WASH YOUR HANDS, WASH YOUR HANDS OFTEN..." The DON stated other than the memo and adding extra cleaning no other tracking or trending was conducted to determine how the strep was being transmitted.

Although the facility had not consistently track and trended resident infections, they had a pattern of employee strep symptoms in a one month period on the 300 unit form 8/5 to 9/7/14. The facility had not determined how these employees were becoming ill nor how the infection was transmitted during the one month period of strep symptoms. The facility did not completed any audits or handwashing education of staff, but completed extra cleaning of the unit and told staff to wash their hands and wear a mask when entering resident rooms that have traches and ventilators.

The facility policy Infection Prevention Program Overview revised May 2014 indicated the major activities of the program are surveillance of infections with implementation of prevention of infections and control measures. The policy further indicated there is on-going monitoring for infections among residents and personnel and subsequent documentation of infections that occur. analysis of data is done on-going and documentation is completed and reported to the Infection Prevention Committee.

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review

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21390	Continued From page 74 and amend the infection control program to include ongoing surveillance of infections, trending of collected data, and analysis of education completed to reduce or prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) risk assessment was completed for 3 of 5	21426		

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21426	Continued From page 75 employees and 2 of 5 employees received TST prior to hire, and 5 of 5 residents (R77, R90, R48, R93 and R62) did not receive TB risk assessment screening and results documented in millimeters (mm) of indurating. Findings include: Nursing assistant (NA)-B was hired 6/12/14, and received a chest x-ray 6/24/14 which indicated he did not have TB. NA-B did not have a symptom screen completed during record review. Maintenance assitant (MA)-A washired 8/28/14 and had been working at the facility , and did not receive his first step TST or symptom screen until 9/17/14. Resident Assistant (RA)-A was hired 8/6/14 and had been working at the facility, and did not receive her first step TST or symptom screen until 9/17/14 during record review. During interview 9/18/14, at 1:00 p.m. the facility administrator verified the employees did not receive there symptom screening and that they had missed completing the TST test upon hire for some of the employees. R77 was admitted 5/28/13, R77's medical record lacked evidence that a assessment for risk factors and physical screening for active symptoms of TB had been completed. R77's record also indicated that his TST test that was read on 5/29/14 and 6/12/14 was documented as negative. R90 was admitted 11/02/12, R90's medical record lacked evidence that a assessment for risk factors and physical screening for active	21426		

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21426	Continued From page 76 symptoms of TB had been completed. R90's medical record also indicated his TST test that was read on 11/02/12 and 11/16/12 was documented as negative. R48 was admitted 11/13/13, R48's medical record lacked evidence that a assessment for risk factors and physical screening for active symptoms of TB had been completed. R48's TST test that was read on 3/13/13 and 3/27/13 was documented as negative. R93 was admitted 4/12/13, R93's medical record lacked evidence that a assessment for risk factors and physical screening for active symptoms of TB had been completed. R93's TST test that was read on 4/12/13 and 4/26/13 was documented as negative. R62 was admitted 1/04/12, R62's medical record lacked evidence that a assessment for risk factors and physical screening for active symptoms of TB had been completed. R62's TST test that was read on 1/04/12 and 9/19/12 was documented as negative. During interview 9/17/14, at 12:20 p.m. with medical records indicated the facility did not measure the TST test results as they should have and verified they were documented as negative. The Facility Tuberculosis Prevention and Control Program revised July 2014, indicated Annual TB risk assessments will be completed by the infection prevention nurse. The policy further indicated all staff and volunteers of the facility will be tested prior to employment or volunteering. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review	21426		

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21426	Continued From page 77 current CDC guidelines for tuberculosis control within health care facilities and complete ongoing monitoring of new admissions to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that	21530		

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21530	Continued From page 78 the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure irregularities identified in 1 of 5 residents (R6) medication regimen were identified and acted upon by the consulting pharmacist. Findings Include: R6's quarterly Minimum Data Set (MDS), dated 8/19/14, indicated R6 was cognitively intact, had diagnoses of depression, manic depression, and schizophrenia. Further, the MDS indicated R6 displayed no hallucinations, delusions, or other documented behaviors during the review period. R6's Psychopharmacological Drug Assessment, dated 5/14/14, indicated R6 took the following psychotropic medications: Escitalopram Oxalate (an anti-depressant medication) 40 mg daily for depressive disorder and; Lorazepam (an anti-anxiety medications) 1 mg daily at HS (hour of sleep) for paranoid schizophrenia and; Lorazepam 0.5 mg daily at 10 a.m. and;	21530		

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Lorazepam 1 mg twice a day as needed and;
Haldol (an anti-psychotic medication) 5 mg daily in the morning and;
Haldol 10 mg daily at HS for a diagnosis of paranoid schizophrenia.
The assessment indicated R6 to be a new admission to the facility, and have a long history of paranoid schizophrenia, however did not indicate if a psychiatry referral or gradual dose reduction (GDR) should be completed for R6.

A subsequent Psychopharmacological Drug Assessment, dated 7/2/14, indicated R6 continued to take Escitalopram Oxalate, Lorazepam, and Haldol at the same doses and time(s) as when assessed on 5/14/14. The form further indicated an additional antipsychotic medications, Latuda (an anti-psychotic medication), was added to R6's medication regimen, but did not indicate a reason why it had been added. In addition, the assessment indicated R6 was a new admission and did not address if or when a GDR would be attempted, or a psychiatry referral would be made for R6, as it identified R6 as a new admission to the facility still.

R6's care plan, dated 6/23/14, indicated R6 had bipolar schizophrenia and received medication daily for treatment. The care plan did not indicate any intervention of having psychiatry input for R6, nor describe specific target behaviors R6 displayed.

R6's monthly Medication Regimen Review's, dated 5/22/14, 6/20/14, 7/22/14, 8/18/14, and 9/17/14, indicated no irregularities were identified by the consulting pharmacist with R6's psychotropic medication regimen or care plan, aside from obtaining consent for the use of R6's

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21530	Continued From page 80 Latuda medication. During interview on 9/18/14, at 9:16 a.m., the assistant director of nursing (ADON) stated she was responsible for R6's care until recently. The ADON stated nothing had been done to address R6's psychopharmacological medication reduction or monitoring. Further, the ADON s/he felt R6 to be stable (regarding her cognition and psyche) and s/he was not in a hurry to address R6's medication regimen as a result despite her significant psychopharmacological medication use. The ADON stated s/he was unsure the last time any referral to psychiatry was made for R6, "I'm thinking we have to work on this stuff." When interviewed on 9/18/14, at 9:27 a.m., registered nurse (RN)-A stated R6 should have been referred to a psychiatrist given her extensive history of schizophrenia. Further, RN-A stated R6 should have a plan in place to address GDR's for R6's psychopharmacological medications as it would be to her benefit. A subsequent interview was held with RN-A on 9/18/14, at 10:45 a.m. regarding R6's psychotropic medication regimen. RN-A stated R6's care plan does not address specific target behaviors for R6. RN-A stated because R6 was felt to be stable in condition, she was not monitored for behavior. Further, RN-A stated R6 might not require all of her psychotropic medications, however staff are not sure because they are not monitoring her regimen. During interview on 9/18/14, at 10:50 a.m., the consulting pharmacist (CP)-A stated s/he was surprised R6 was not being followed by psychiatry given R6's personal history of schizophrenia, and psychotropic medication use. CP-A stated s/he didn't feel addressing R6's medication regimen	21530		

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21530	Continued From page 81 was of concern. Further, CP-A stated target behaviors should be listed on a resident's care plan and monitored accordingly. During interview on 9/18/14, at 12:45 p.m., the director of nursing (DON) stated target behaviors should be indicated in R6's care plan and contain individualized interventions to reduce them. The DON stated the consulting pharmacist should be reviewing the medication regimen of each resident and making sure target behaviors are listed in the residents care plan when they are on psychotropic medication. Further, the DON stated the lack of psychiatry referral and target behaviors in the care plan should have been identified by the consulting pharmacist. A policy on medication monitoring and GDR was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could complete ongoing monitoring of drug regimens to ensure pharmacy involvement in identifying irregularities and acting promptly to resolve any identified concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending	21540		

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21540	Continued From page 82 physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide an appropriate psychiatric referral, and complete routine monitoring for 1 of 5 residents (R6) whom was given prescribed psychotropic medications. Findings include: R6's admission Minimum Data Set (MDS), dated 5/21/14, indicated R6 admitted to the facility in May 2014. R6's quarterly Minimum Data Set (MDS), dated 8/19/14, indicated R6 was cognitively intact, had diagnoses of depression, manic depression, and schizophrenia. Further, the MDS indicated R6 displayed no hallucinations, delusions, or other documented behaviors during the review period. R6's care plan, dated 6/23/14, indicated R6 had bipolar schizophrenia and received medication	21540		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 83 daily for treatment. The care plan did not indicate specific target behaviors, nor intervention(s) of having psychiatry input for R6. R6's Psychopharmacological Drug Assessment, dated 5/14/14, indicated R6 took the following psychotropic medications: Escitalopram Oxalate (an anti-depressant medication) 40 mg daily for depressive disorder and; Lorazepam (an anti-anxiety medications) 1 mg daily at HS (hour of sleep) for paranoid schizophrenia and; Lorazepam 0.5 mg daily at 10 a.m. and; Lorazepam 1 mg twice a day as needed and; Haldol (an anti-psychotic medication) 5 mg daily in the morning and; Haldol 10 mg daily at HS for a diagnosis of paranoid schizophrenia. The assessment indicated R6 was a new admission to the facility, and had a long history of paranoid schizophrenia, however the assessment did not identity if a psychiatry referral was needed or gradual dose reduction (GDR) should be completed for R6. A subsequent Psychopharmacological Drug Assessment, dated 7/2/14, indicated R6 continued to take Escitalopram Oxalate, Lorazepam, and Haldol at the same doses and time(s) as when assessed on 5/14/14. The form further indicated an additional antipsychotic medications, Latuda (an anti-psychotic medication), was added to R6's medication regimen, but did not indicate a reason why it had been added. In addition, the assessment indicated R6 was a new admission and did not address if or when a GDR would be attempted, or a psychiatry referral would be made for R6, as it identified R6 as a new admission to the facility	21540		

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21540	Continued From page 84 still. During interview on 9/18/14, at 9:16 a.m., the assistant director of nursing (ADON) stated she was responsible for R6's care until recently. The ADON stated nothing had been done to address R6's psychopharmacological medication reduction or monitoring. Further, the ADON felt R6 was stable (regarding her cognition and psyche) and she was not in a hurry to address R6's medication regimen as a result despite her significant psychopharmacological medication use. The ADON stated she was unsure the last time any referral to psychiatry was made for R6, "I'm thinking we have to work on this stuff." When interviewed on 9/18/14, at 9:27 a.m., registered nurse (RN)-A stated R6 should have been referred to a psychiatrist given her extensive history of schizophrenia. Further, RN-A stated R6 should have a plan in place to address GDR's for R6's psychopharmacological medications as it would be to her benefit. During interview on 9/18/14, at 10:41 a.m., RN-C stated no formal behavior monitoring was completed for R6. RN-C further stated daily charting should be completed for someone taking psychotropic medications, and a progress note should be completed at least every third week indicating a resident's psychotropic medication regimen. RN-C stated R6's medical record did not contain any progress notes regarding her medication regimen and/or plan for behavior monitoring, or reduction. A subsequent interview was held with RN-A on 9/18/14, at 10:45 a.m. regarding R6's psychotropic medication regimen. RN-A stated R6's care plan does not address specific target	21540		

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21540	Continued From page 85 behaviors for R6. RN-A stated because R6 was felt to be stable in condition, she was not monitored for behavior. Further, RN-A stated R6 might not require all of her psychotropic medications, however staff are not sure because they are not monitoring her regimen. During interview on 9/18/14, at 12:45 p.m., the director of nursing (DON) stated target behaviors should be indicated in R6's care plan and contain individualized interventions to reduce them. Further, the DON stated R6 should have been referred to psychiatry to provide additional care and oversight given R6's history of schizophrenia and psychotropic medication use. A policy on medication monitoring and GDR was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee can inservice staff regarding appropriate psychotropic medication monitoring and monitor for pharmacy involvement to ensure irregularities are identified and corrected promptly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and	21685		

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21685	Continued From page 86 well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure environmental factors did not contribute to acute respiratory distress for 7 of 12 residents (R154, R43, R144, R96, R93, R143 and R19) identified with respiratory impairment, and potentially affecting all 20 residents who lived on the 300's unit. Findings include: During observation on 9/16/2014 from approximately 9:30 a.m. to 11:15 a.m., workers, using jack hammers and other tools, were removing ceramic tile from a floor, near resident rooms on the 300's wing of the nursing home. The construction area, located just beyond double doors in the southwest corner of the main dining room, was 6 and 1/2 feet wide, by 41 feet in length. The south end of the construction area intersected the nursing station, where the unit split into two hallway wings, which formed the 300's unit. On the 300's unit were seven residents with tracheostomies, four of whom also utilized ventilators. In addition, several other residents had various respiratory diagnoses. The 300's unit was also a short-term rehabilitation unit. Removal of the floor tiles resulted in intermittent noise in the facility, and created visible dust. The dust wafted from the construction area, into the adjacent dining room, and down the hallways of the 300's wing and nursing station, including into the rooms of residents with tracheostomies and	21685		

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ventilators. Neither the gateway at the end of the construction area nearest the dining room, nor the opposite end of the construction area, by the nursing station, were fitted with any kind of barrier to contain dust and debris during the removal of the floor tile. At about 10:15 a.m., the double doors to the dining area were observed to be closed while the floor tiles were being removed. In the construction area, there was a dust-abetment machine, with an intake tube, and an exhaust tube leading to a window and outside. Tracking marks and foot prints, from walkers, wheel chairs and shoes, were observed both in the dining area, and near the 300's wing nursing station, as residents, staff and visitors walked through the construction area. Dust was also observed throughout the 300's unit, on various surfaces and equipment: a mailbox, chair rails on the wall, light fixtures, shadow boxes, a number of mechanical lifts, and the nursing station desk.

During interview on 9/16/2014 at 10:23 a.m., registered nurse (RN)-D (the nurse manager for the unit) stated she was aware there had been remodeling completed over the past weekend, as well as construction going on right now. RN-D said there have been "no barriers put up," since beginning to remove the tile floor. When asked if she had any concerns for the residents on the unit who had tracheostomies and ventilators, in light of the construction, RN-D stated "I have a little concern, with the dust." RN-D said she had not talked to anyone about the construction dust, and did nothing further to address those concerns regarding the residents on the 300's wing. RN-D identified there were currently 4 residents with ventilators, and 7 residents with tracheostomies.

In an interview on 9/16/2014 at 11:00 a.m., maintenance worker (MW)-A agreed there was

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dust created during the removal of the tile floor this morning. MW-A stated there was work on the floor "today and some in the past two weeks." MW-A said the doors to the dining area were closed, and "the filtration system was on."

During interview on 9/16/14 at 12:30 p.m. MW-B stated, they were not given any directions about what barriers needed to be set up or not prior to removal of the tile floor.

Review of the resident records on the 300 unit identified the following:

R154's diagnoses, from the Minimum Data Set (MDS) dated 8/25/2014, included respiratory failure, with dependence on a ventilator, aphonia [inability to produce voice], and quadriplegia R154's room was approximately 50 feet from the construction area, at the end of the southwest wing.

A progress note, dated 9/14/2014, indicated that at 8:00 p.m., R154 complained of pain the the ribcage and chest area. The note further indicated R154 had shortness of breath, which was not relieved by suctioning or repositioning, and that R154's lungs had rhonchi [course, rattling respiratory sounds]. On 9/14/2014 at 10:15 p.m., R154 was sent to the hospital for evaluation.

A review of the emergency room (ER) notes, dated 9/14/2014, indicated R154 presented with increasing shortness of breath, coarse lungs sounds, and that he requested pain medication. During his visit in ER, R154 received respiratory

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treatments. R154 returned to the nursing home on 9/15/2014 at 3:40 a.m.

In an interview on 9/16/2014 at 4:48 p.m., the medical director (MD) said R154 was at a "high risk" for for respiratory complications because of his ventilator status, and was "very vulnerable." When asked if the construction dust could have been the reason for R154's visit the the ER, the MD stated "I can't say the inhalation of dust was the reason why [R154] was admitted to the ER for evaluation." The MD also said the breathing in of the dust "...could make [R154] short of breath, and have contributed" to his recent ER admission. The MD said, he hoped the nursing home would do "...all it could" to minimize as much dust as possible with ventilated residents, and indicated agreement that it would be best to put up barriers during construction to reduce the dust and debris in the area.

R144's diagnoses, from the admission MDS dated 7/16/2014, included chronic respiratory failure, and congestive heart failure. A review of nursing progress notes from 9/6/2014 to 9/16/2014, indicated R144 requested nebulizer treatments twice each day on 9/6 and 9/7/2014, for complaints of shortness of breath. R144 resided on the 300's wing.

R93's diagnoses, from the annual MDS dated 4/18/2014, included chronic airway obstruction, and tracheostomy status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory occurrences. R93 resided on the 300's wing.

R43's diagnosis, from the admission MDS, dated 8/14/2014, included respiratory failure, and dependence on respiratory status. A review of

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nursing progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory distress or occurrences. R43 resided on the 300's wing.

R96's diagnoses, from he admission MDS dated 9/2/2014, included respiratory failure and chronic airway obstruction. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns.

R19 diagnoses, from the annual MDS dated 5/13/2014, included acute respiratory failure, and dependence on respirator status. A review of nursing progress notes from 9/2/2014 to 9/16/2014 indicated no remarkable respiratory concerns.

R143's diagnoses, from the MDS dated, included chronic airway obstruction, dependence on respirator status, and tracheostomy status. A review of progress notes from 9/1/2014 to 9/16/2014 indicated no remarkable respiratory concerns.

During an interview on 9/16/2014 at 1:35 p.m., the facility administrator stated construction started on September 3rd, and "wall paper was worked on that week." The administrator said a construction company cut out a doorway, and cabinets were removed "at the end of last week," and the construction company "cut the wall, put studs up and steel on the same day." The administrator stated that "no barrier" was used during theses times. When asked about how the facility was going forward to manage the construction and dust, the administrator stated "We have no plan at this point." The administrator acknowledged the removal of the

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tile, and maintained "...there was minimal dust in the air.. and mainly on the floor." The administrator said nursing was doing "respiratory assessments" on the residents in light of the construction.

In an interview on 9/16/2014 at 1:55 p.m., construction workers (CW)-A and B, who were doing construction in the facility, not employees of the nursing facility, stated they would have put up a plastic, poly barrier before starting, "To enclose and seal off both ends of the construction." CW-A also said a barrier to contain the dust, along with a hepa-filtered air purifier, would have "Taken care of the dust."

During an interview on 9/18/2014 at 10:30 a.m. the environmental services director (ESD) stated the facility "does have some dust from the construction being performed." The ESD stated the facility housekeeping staff were mopping the dining room and other floor areas after meals as needed. She further stated she was "unaware that dust barriers were needed when the facility staff were removing the floor tile."

During interview with the administrator about the dust down the 300 unit stated, on 9/16/14 at 1:30 p.m., "I did not have any knowledge."

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor to ensure facility projects do not imapct resident care in a negative way.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21805	Continued From page 92	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely grooming to promote dignity for 1 of 3 residents (R77), whom was reviewed for activities of daily living and grooming. Findings include: R77's quarterly Minimum Data Set (MDS), dated 8/22/14, indicated R77 required extensive assistance from staff for his personal hygiene, and had moderate cognitive impairment. R77's care plan, dated 9/8/14, indicated R77 required assistance with dressing, grooming, bathing and weekly nail care. During observation on 9/16/14, at 9:22 a.m., R77 was seated in his wheelchair in his room. with long, un-trimmed fingernails on both hands. There was a dark substance underneath several of the nails. Subsequent observations of R77 on 9/17/14 at 7:08 a.m., and 9/18/14 at 8:19 a.m., indicated R77 continued to have un-trimmed, fingernails with a black substance underneath.	21805		

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21805	Continued From page 93 When interviewed on 9/18/14, at 8:19 a.m., R77 stated he would like his fingernails to be trimmed and kept shorter and that long, dirty fingernails was embarrassing for him to be seen by others with. During interview on 9/17/14, at 9:04 a.m., nursing assistant (NA)-D who cared for R77 stated his fingernails should be trimmed on the resident's bath day. R77's Treatment Administration Record, dated 9/1/14 to 9/30/14, did not indicate R77 should have his nails trimmed by the staff. During interview on 9/18/14, at 9:29 a.m., registered nurse (RN)-A stated R77 fingernails should have been trimmed by a nurse as he was diabetic. Further, RN-A stated R77's long, dirty fingernails would be a dignity concern. When interviewed on 9/18/14, at 10:59 a.m., the director of nursing (DON) stated nursing staff are expected to trim and clean fingernails routinely and R77's fingernails should have been trimmed according to his preference. An undated facility Dignity policy indicated a purpose of ensuring all residents are treated with dignity and respect. Further, the policy indicated examples of appropriate actions to promote dignity including, "Providing grooming according to each resident's individual wishes." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could inservice staff regarding provision of care with dignity and respect. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement measures to ensure personal privacy was provided for 2 of 6 dependent residents (R68, R145) observed who were dependent upon staff to provide privacy. Findings include: R68's quarterly Minimum Data Set (MDS), dated 7/18/14, indicated R68 had a diagnosis of quadriplegia. The MDS identified R68 had no cognitive impairment, required use of an indwelling supra-pubic catheter and colostomy, and received total assistance from staff for all daily needs. During observation on 9/15/14, at 4:30 p.m., R68 was lying in bed, his door was wide open, visible from the hallway where residents,visitors and staff could see the resident exposed. R68's abdomen was exposed along with their colostomy device (equipment that collects stool, typically a	21855		

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bag) which contained stool. R68's had an incontinence brief on, with blue chux (disposable pad used to absorb fluids typically used for incontinence). R68 was unable to cover himself due to limited use of his upper body extremities. His abdomen and lower body remained exposed, and could be viewed from the hallway by other residents, visitors and staff.

When interviewed on 9/15/14, at 4:30 p.m., R68 stated he did not like the door open, and being exposed to other residents, and visitors from the hallway, but he was unable to close the door without staff assistance.

R145's admission Minimum Data Set (MDS), dated 8/21/14, indicated R145 had diabetes mellitus, was cognitively intact, dependant on oxygen, and required total assistance from staff for all their daily needs.

During an observation of medication administration, on 9/18/14 at 8:46 a.m., registered nurse (RN)-C entered R145's room and lift their shirt to provide a medication injection. RN-C left the residents door open while she administered his insulin. R145 could be viewed from the hallway where visitors were walking by during the admnistration of the insulin. RN-C did not closed the door or curtain in the resident room to provide visual privacy.

When interviewed on 9/18/14, at 8:50 a.m., RN-C stated they would typically shut the door before providing medical treatment like an injection.

A facility policy on privacy was requested, but none was provided.

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21855	Continued From page 96 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could inservice pertinent staff to provide privacy for all cares including personal cares and injections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to ensure alleged allegations of abuse, neglect, injuries of unknown origin and misappropriation of resident property incidents were immediately reported to the administrator, state agency and were thoroughly investigated for	21990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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21990	Continued From page 97 1 of 4 residents (R151) allegations reviewed. Findings include: R151's admission Minimum Data Set (MDS), dated 8/20/14, indicated R151 had severe cognitive impairment, however displayed no behaviors or wandering. R151's care plan, dated 8/13/14, indicated R151 had an altered mental status and dementia with barriers to him going home due to memory loss and inability to find home and becomes angry when he asks about going home which staff are to redirect him when agitated. The care plan further stated he was aware of his surroundings and people around him but not always to time and place. The facility's Elopement Risk Assessment dated 8/20/14, indicated R151 had no history of elopement, or history of wandering. The assessment further indicated "Resident has made no attempts to leave the building. He is staying in the same room with his wife. He will not be placed at Elopement Risk". During interview 9/17/14, at 12:30 p.m. R151 stated he does not understand why he is at the facility and wanted to go home. Review of R151's progress notes indicated on 9/5/14, at 12:59 p.m. "Res [resident] was note by staff to be outside walking, he was in employee parking lot when I caught up with him. Res very cooperative and pleasant, stating he was stretching his legs before winter comes, pointing to the main entrance door stating "I'm just going to walk over their and go in that door...walked with Res who entered building without diff and down to room to see wife". There was no indication the administrator, state agency were	21990		

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21990	Continued From page 98 immediately notified nor was the elopement thoroughly investigated. During interview 9/18/14, at 9:21 a.m. with the director of nursing (DON) stated they did not report the incident on 9/5/14 since she didn't feel he was attempting to elope. The DON verified R151 had left the building went into the parking lot unattended, and the progress note was not clear if the staff knew where he was or if they had just found him out there. The facilities Elopement policy revised July 2013, indicated nursing must report and investigate all reports of missing residents. The policy further indicated, "Any elopement where the resident is not seen leaving, or has unusual circumstances is considered a reportable incident under the Vulnerable Adult Law in Minnesota". The Facilities Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect is defined as failure of a caregiver to supply a resident with the care or services, including but not limited to food, clothing, shelter, health care or supervision which is reasonable and necessary to obtain or maintain the residents physical and mental health or safety, considering the physical or mental dysfunction of the resident which is not the result of an accident or therapeutic conduct. Although R151 had severe cognitive impaired, had left the facility and made comments that he wanted to go home. The facility did not reported the incident immediately to the administrator, state agency nor completed an investigation of	21990		

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21990	Continued From page 99 the incident. SUGGESTED METHOD OF CORRECTION: The director of nursing or administrator could inservice staff regarding timely reporting and investigation of potential maltreatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		