#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL	ID: EY5V
		I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00299
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245495	).	3. NAME AND ADD (L3) EVERGREE		ſΥ		4. TYPE OF ACTION: <u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 2801 SOUTH	HIGHWAY 169			1. Initial     2. Recertification       3. Termination     4. CHOW
(L2) <b>606318700</b>		(L5) GRAND RAI	PIDS, MN		(L6) <b>55744</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	7 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/22/	<b>2014</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a):		X A. In Complian	ice With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b) :		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	<b>109</b> (L18)		acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	7. Medical Director    8. Patient Room Size    9. Beds/Room
13.Total Certified Beds	<b>109</b> (L17)		pliance with Program ents and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
109						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL Date:
<u>Austin Fry, HFE NEI</u>	[		01/06/2015	(L19)	Mark Meath	, Enforcement Specialist 02/06/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	<b>FE AGENCY</b>
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C	IVIL		tial Solvency (HCFA-2572)
<b>X</b> 1. Facility is Eligible to Part	cipate	KIGF	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
	(121)				1	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>08/01/1987</b>	BEGINNING	DATE	ENDING DATE	3	VOLUNTARY         00           01-Merger, Closure         01	0 <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Sus	nansion Data:	(L44)			00-Active
	D. Resenia Sus	pension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)	Posted 02/09/2015 C	0.
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DAT	ГE	-	
		11/17/2014				
	(L32)			(L33)	DETERMINATION APPRO	VAL

#### 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.



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



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

Evergreen Terrace January 6, 2015 Page 2 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,

ato Comston

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.

Evergreen Terrace February 11, 2015 Page 2

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

Evergreen Terrace February 11, 2015 Page 3

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

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245495	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/22/2014
Name	of Facility		Street Address, City, State, Zip Code	
E٧	ERGREEN 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	(Y	5)	Date
ID Prefix	F0225	Correction Completed 12/15/2014	ID Prefix	F0226	Correction Completed 12/15/2014	ID Prefix			Correction Completed
Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2) -	(4)	Reg. # LSC	483.13(c)		Reg. #			_
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed				Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed	Reg. #			Correction Completed —
ID Prefix Reg. # LSC			Reg. #						Correction Completed
ID Prefix Reg. # LSC		-	ID Prefix Reg. # LSC						
Reviewed By	Reviewed I	Ву	Date:	Signature of Surve	yor:		ſ	Date:	
State Agency	BF/	KJ	1/6/2015	;	33562			12/	22/2014
Reviewed By CMS RO	Reviewed I	Ву	Date:	Signature of Surve	yor:		[	Date:	
Followup to	Survey Completed on: 9/18/2014			•		Deficiencies. Was a (CMS-2567) Sent to	-	YES	NO

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00299	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 12/22/2014
Name of Facility			Street Address, City, State, Zip Code	
EV	ERGREEN 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	(Y!	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix	21990	12/15/2014	ID Prefix		-	ID Prefix		
-	MN St. Statute 626.557 S		Reg. #			Reg. #		
LSC		_	LSC _			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		
Reg. #			Reg. #		-			
		_			-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
-					-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed			Completed	ID Profix		Completed
		_			-			
Reg. # LSC		_	Reg. #		-	Reg. #		
		_						
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		-	ID Prefix		
Reg. #			Reg. #		_	Reg. #		
LSC		_	LSC _			LSC		
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:		Da	te:
State Agency	v BF	/KJ	1/6/2015		33562			12/22/2014
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Da	te:
CMS RO								
Followup to	Survey Completed on:			-		Deficiencies. Was a	•	
	9/18/2014			Uncorrecte	d Deficiencie	s (CMS-2567) Sent to	o the Facility? Y	ES NO
STATE FORM	I: REVISIT REPORT	(5/99)		Page 1 of 1			Event ID: EY5	v13

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL	IE	D: EY5V
	PART	I - TO BE COM	PLETED BY TI	HE STAT	E SURVEY AGENCY		acility ID: 00299
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245495	Э.	3. NAME AND AD (L3) EVERGREE		Υ		4. TYPE OF ACTION:	<u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 2801 SOUTH				1. Initial 3. Termination	<ol> <li>Recertification</li> <li>CHOW</li> </ol>
(L2) <b>606318700</b>		(L5) GRAND RAI	PIDS, MN		(L6) <b>55744</b>	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After Con</li> </ol>	9. Other mplaint
6. DATE OF SURVEY 11/25/	2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION		10. THE FACILITY	IS CERTIFIED AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of T	he Following Requirements:	
To (b):		Program Re			2. Technical Personnel	6. Scope of Servic	
12. Total Facility Beds	109 (L18)	Compliance	Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNI	F) 7. Medical Director 8. Patient Room S	
12. Tom Fueling Deab	107 (110)				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>109</b> (L17)		pliance with Program ents and/or Applied V		* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
109							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):				
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL	Date:
Austin Fry, HFE NEI	I		12/10/2014	(L19)	Mark Meath	🔨 , Enforcement Specia	02/05/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	L OFFICE OR SINGLE STA	TE AGENCY	
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH CI	IVIL		ncial Solvency (HCFA-2572)	
<b>X</b> 1. Facility is Eligible to Part	icipate	RIGE	HTS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA	-1513)
2. Facility is not Eligible	(L21)						
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEME	NT	26. TERMINATION ACTION:	(I	
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	2	VOLUNTARY	00 INVOLUNT	ARY
08/01/1987					01-Merger, Closure		eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen		eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension of	of Admissions:	<i>(</i> <b>1</b> 40)		04-Other Reason for withdrawai	07-Provider S 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	20	DETERMINATION (		F	Posted 02/05/2015	Co.	
51. KO KECEIF I OF UNIS-1339	32	11/17/2014	51 ALL KU VAL DAI	ц.			
	(L32)			(L33)	DETERMINATION APPR	OVAL	

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

#### PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

#### ID: EY5V Facility ID: 00299

#### 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.



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 Evergreen Terrace December 10, 2014 Page 2

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

Evergreen Terrace December 10, 2014 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Evergreen Terrace December 10, 2014 Page 5

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 Weath

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



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 Evergreen Terrace December 11, 2014 Page 2

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

Evergreen Terrace December 11, 2014 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Evergreen Terrace December 11, 2014 Page 5

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



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

Evergreen Terrace November 26, 2014 Page 2

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

Evergreen Terrace November 26, 2014 Page 3

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

de Compton

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

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COM	E SURVEY PLETED
		245495	B. WING _		-	R 2 <b>5/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
EVERGR	EEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}		
	completed, on Nove deficiencies issued survey on Septemb were reissued as pa revisit. Because you are en signature is not req					
{F 225} SS=D	on-site revisit of you validate that substa regulations has bee your verification.	PORT	{F 22	25}		12/15/14
	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ties.				
	involving mistreatm	sure that all alleged violations ent, neglect, or abuse, unknown source and				
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

PRINTED: 12/19/2014

		AND HUMAN SERVICES				FORM	12/19/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE COMI	E SURVEY PLETED
		245495	B. WING			F 11/2	⊰ 25/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGE	EEN TERRACE			2	801 SOUTH HIGHWAY 169		
Evenar				G	GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 225}	Continued From pa	-	{F 2	25}			
	immediately to the to other officials in a	resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					
	violations are thoro	we evidence that all alleged ughly investigated, and must ential abuse while the rogress.					
	to the administrator representative and with State law (inclu certification agency incident, and if the	vestigations must be reported or his designated to other officials in accordance uding to the State survey and ) within 5 working days of the alleged violation is verified ive action must be taken.					
	by: Based on interview facility failed to ens abuse, neglect, inquimmediately reported	NT is not met as evidenced v, and document review the ure alleged allegations of uiries of unknown origin were ed to the state agency for 2 of nd R183) allegations			Immediate Corrective Action: DON/Designee, (LPN)-A and Activitie Director (AD-A) were counseled for f to ensure timely notification accordin facility abuse prevention plan.	failing	
	Findings include: The facility Evergre Plan revised 5/21/1 Administratormus and internal investig alleged violations requiredimmediat	en Terrace Abuse Prevention 2, indicated, "The st be informed of all incidents gations immediately. Report all to the State of Minnesota as sely. All staff are required to altreatment of a vulnerable			Corrective Action as it Applies to Oth The policy and procedure "Evergreen Terrace Abuse Prevention Plan" was reviewed and amended on 11/27/201 Staff will be educated on the timely reporting to the administrator and Of- by 12/15/14. Staff will be re-educated on the revis policy by 12/15/2014.	n 5 14. HFC	

Facility ID: 00299

If continuation sheet Page 2 of 8

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		BERNI IS, MONTONIBER.	A. BUILDING	i		3
		245495	B. WING		11/2	25/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGF	REEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
{F 225}	adult to Administrat are not in the buildi Supervisor, at the t R85's annual Minim 10/21/14, indicated severely cognitively extensive assist of (ADL's). R85's card indicated her short and had diagnosis dementia with depr indicated staff to m and evaluate. The facilities incide dated 11/17/14, ind resident woke up-s noticed a 6" length on her right should indicated the direct message on 11/17/ did not indicate if th the allegation. A in attached to the rep getting res ready fo her top I noticed a f before I let the train know right away." During interview 11 practical nurse (LPI the incident that oc just looked at the a abrasion was due t	or, Director of Nursing, if they ng report to the Nursing	{F 225}	Recurrence will be prevented by: Audits will be conducted daily (Monday-Friday) of all alleged viola involving mistreatment, neglect, all injuries of unknown origin and/or misappropriation of resident prope ensure incidents were reported in accordance with facility policy. Audits will be completed for a period days and audit results will be reviet the QA committee to determine the for ongoing monitoring. Dated of Completion: 12/15/2014 The Correction will be monitored be Administrator or Designee.	ouse or erty to od of 90 wed by e need	

If continuation sheet Page 3 of 8

		AND HUMAN SERVICES				FORM	: 12/19/2014 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245495	B. WING				R <b>25/2014</b>
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
EVERGE	REEN TERRACE				801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 225}	DON stated she wa 11/17/14 when it oc stated it was a large should have been in state agency and th Although R85 had s scratch/abrasion or failed to report the i state agency. R183's admission M dated 10/27/14 indivi- impairment, however did need supervision activities of daily livid dated 10/20/14 indivi- the elopement risk regarding elopement eloped from the vet The Evergreen Incir 11/11/14, "Resident with activities for Ver- was done resident v- used to live. Activity program. No injurie the DON and admir incident on 11/12/14 form did not identify notified, of the incird Review of the Minn- (MDH) report, ident report to the state a one day after the in During interview on	A sinformed of the incident on accurred. The DON further e abrasion and the incident mmediately reported to the nen investigate. A sustained a large n her right shoulder the facility incident immediately to the Minimum Data Set (MDS) cated had severe cognitive er displayed no behaviors but in with locomotion and ing (ADL)'s. R183's care plan cates history of memory loss. and the care planning int was completed after R183 terans day event on 11/24/14. dent Report identified on f [R183] attended an outing eterans day. When program walked across street where he is staff walked him back to is noted." The report identified instrator was informed of the 4, one day after the event. The is the state agency was lent. esota Department of Health ified the facility submitted a agency (MDH) on 11/12/14,	{F 2	25}			

Facility ID: 00299

If continuation sheet Page 4 of 8

		AND HUMAN SERVICES			FORM	12/19/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245495	B. WING	 		R <b>25/2014</b>
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGF	REEN TERRACE			801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225} {F 226} SS=D	event was at the arm my staff were. The when it ended, the wheelchair people a moving the wheelch The staff present di We were not aware across the street. " him, he had crosse brought back to the the house now. He clothing so she ass event" The director present during the in notified the next dat was the administration the incident until 11 elopement occurred During interview on administrator stated veterans day elopel stand up meeting". Although R185 had administrator/desig not immediately not until 11/12/14 one of 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle	mory and she wasn't there but group watched the event, staff stood up and moved the around. When they got done hair people [R183] was gone. idn't know where he had gone. that he used to own a house 'By the time my staff found d the street, and was being e armory by the lady who owns was wearing veterans sumed he belonged at the r of nursing (DON) who was interview, added, "I was y in the AM [morning]," and so tor. The AD-A acknowledged nistrator were not notified of /12/14, one day after the d. 11/24/14 at 3:58 p.m. The d, "I was notified about the ment ,the next day at the I an elopement on 11/11/14 the nee and state agency were tified of the alleged neglect day after the incident. PP/IMPLMENT , ETC POLICIES evelop and implement written	{F 22			12/15/14

Facility ID: 00299

If continuation sheet Page 5 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/19/2014 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED	
		245495	B. WING	i		R 11/25/2014		
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE			
EVERGR	EEN TERRACE				801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 226}	Continued From pa	ge 5	{F 2	26}				
	by: Based on interview facility failed to ensu- their policy for alleg injuries of unknown reported to the adm and thoroughly inve (R85,and R183) alle Findings include: The facility Evergre Plan revised 5/21/1 administrator is ultin Prohibition plan and alleged or substantin neglect, or maltreat case of the Adminis Designee will be no state Agency must a immediately" R85's annual Minim 10/21/14, indicated severely cognitively extensive assist of (ADL's). R85's care indicated her short and had diagnosis of dementia with depro- indicated staff to me and evaluate. The facilities incider	mately in charge of the Abuse I must be informed of all lated incidents of abuse, ment immediately. In the strator being unavailable, the tified in this timeframe. The			Immediate Corrective Action: DON/Designee and Activities Direct (AD-A) were counseled for failing to implement facility policy for abuse prevention. Corrective Action as it Applies to Ot The policy and procedure "Evergree Terrace Abuse Prevention Plan" wa reviewed and amended on 11/27/20 include naming the DON/SS Director the appointed designees and the "administrative authority of the Desi in the absence of the administrator' Staff will be educated on the timely reporting to the administrator and O by 12/15/14. Staff will be re-educated on the revi- policy by 12/15/2014. Recurrence will be prevented by: Audits will be conducted daily (Monday-Friday) of all alleged violar involving mistreatment, neglect, abi injuries of unknown origin and/or misappropriation of resident proper ensure incidents were reported in accordance with facility policy. Audits will be completed for a perio days and audit results will be review the QA committee to determine the for ongoing monitoring. Date of Completion: 12/15/2014	tions use or ty to d of 90 ved by		
		staff got her changed and			The Correction will be monitored by	/:		

Facility ID: 00299

If continuation sheet Page 6 of 8

		AND HUMAN SERVICES				FORM	12/19/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING				੨ 25/2014
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
EVERGR	EEN TERRACE				801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	on her right shoulde the director of nursi message on 11/17/ did not indicate if th the state agency. A attached to the repo getting res ready fo her top I noticed a r before I let the train know right away." administrator/desig immediately notified policy. During interview 11, DON/designee state incident when it occ further stated it was incident should hav to the state agency was not. Although R85 had s scratch/abrasion or failed to immediated regarding the allege R183's admission M dated 10/27/14 indi impairment, howev did need supervisio activities of daily live The Evergreen incid 11/11/14, "Resident	x 2.5 " width scratch/abrasion er. The report further indicated ing (DON) received a 14, at 9:25 p.m. There report be administrator was notified or A interview statement was ort which indicated "I was in bed. When I was changing red scratch that I hadn't seen bed medical assistant (TMA) There was no indication if the nee and state agency were d as directed by the facility /25/2014, at 8:05 a.m. the ed she was informed of the curred on 11/17/14. The DON is a large abrasion and the re been reported immediately according to their policy and it sustained a large in her right shoulder the facility ly report to the state agency ed abuse for R85. Minimum Data Set (MDS) cated had severe cognitive er displayed no behaviors but on with locomotion and ing (ADL)'s. dent report identified on t [R183] attended an outing	{F 22	26}	Administrator or Designee		
	with activities for Ve	eterans day. When program walked across street where he					

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES				FORM	: 12/19/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245495	B. WING	·			R <b>25/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGE	REEN TERRACE				801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 226}	used to live. Activity program. No injurie the DON and admir incident on 11/12/14 form did not identify notified, Review of the Minn (MDH) report, ident report to the state a one day after the in immediately to the st the facility policy. During interview on the director of nursi (AD)-D, the DON st day in the AM [morr administrator. The J and administrator w until 11/12/14, one o occurred.	age 7 y staff walked him back to is noted." The report identified histrator were informed of the 4, one day after the event. The y the state agency was esota Department of Health tified the facility submitted a agency (MDH) on 11/12/14, icident occurred, and was not state agency as directed by 11/24/14 at 4:02 p.m. with ing (DON) and activity director tated she was notified the next ning]," and so was the AD-A acknowledged the DON vere not notified of the incident day after the elopement I an elopement on 11/11/14 the nee and state agency were tified of the alleged neglect day after the incident.	{F 2	26}			

Facility ID: 00299

If continuation sheet Page 8 of 8

Minneso	ta Department of He	alth			
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00299	B. WING		R <b>11/25/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
EVERGR	EEN TERRACE		TH HIGHWA APIDS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
{2 000}	Initial Comments		{2 000}		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	nether a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon			
	result in the assess	ny item of multi-part rule will ment of a fine even if the item Iring the initial inspection was			
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.			
Ainconsta	November 25, 2014 orders related to the September 18, 201	S: visit survey was completed, on to follow up on licensing licensing survey on Licensing orders were y assessment may be		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to

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

TITLE

(X6) DATE

Electronically Signed

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING		R <b>11/25/2014</b>	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VERGR	EEN TERRACE		UTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
{2 000}	Continued From pa	ge 1	{2 000}			
				The assigned tag number appears in t far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute, 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 wh are in violation of the state statute afte statement, "This Rule is not met as evidenced by." Following the surveyo findings are the Suggested Method of Correction and the Time Period For Correction.	rule ch r the	
				PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THI WILL APPEAR ON EACH PAGE.		
				THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION F VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.		
{21990}	MN St. Statute 626 Maltreatment of Vul	557 Subd. 4 Reporting - nerable Adults	{21990}		12/12/1	
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	X3) DATE SURVEY COMPLETED		
00299				R	
		B. WING	11/25/2014		
AME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE	
VERGR	EEN TERRACE		JTH HIGHW/ RAPIDS, MN		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
21990}	Continued From pa	ge 2	{21990}		
	maltreatment, any e maltreatment, the n reporter, the time, c incident, and any ot reporter believes m the suspected maltr reporter may disclosion in section 13.02, an section 144.335, to comply with this sub This MN Requirement by: Uncorrected based original licensing or remain in effect. Per recommended. Based on interview, facility failed to ensu- abuse, neglect, inqui immediately reporter	ent is not met as evidenced on the following findings. The der issued on 9/18/14, will		Please see above plan of correction	
	Plan revised 5/21/1 Administratormus and internal investic alleged violations1 requiredimmediat report suspected m adult to Administrate are not in the building	t be informed of all incidents gations immediately. Report all to the State of Minnesota as rely. All staff are required to altreatment of a vulnerable or, Director of Nursing, if they ng report to the Nursing			
	Supervisor, at the ti	me of suspicion." num Data Set (MDS) dated			

EY5V12

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·	СОМ	PLETED
		00299	B. WING			R <b>25/2014</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
EVERGF	EEN TERRACE					
(X4) ID	SUMMABY STA		RAPIDS, MN 5	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	COMPLETE
{21990}	Continued From pa	ge 3	{21990}			
	severely cognitively extensive assist of (ADL's). R85's care indicated her short and had diagnosis of dementia with depri- indicated staff to me and evaluate. The facilities incide dated 11/17/14, ind resident woke up-s noticed a 6" length on her right shoulde indicated the director message on 11/17/ did not indicate if th the allegation. A int attached to the repo- getting res ready fo her top I noticed a r before I let the train know right away."	she had dementia was impaired and needed one with activity of daily living e plan dated 11/06/14, term memory was impaired of Alzheimer disease and ession. The care plan further onitor for confusion or delirium nt form Evergreen Terrace icated at 5:30 p.m. "when staff got her changed and x 2.5 " width scratch/abrasion er." The report further or of nursing (DON) received a 14, at 9:25 p.m. The report te state agency was notified of terview statement was ort which indicated "I was r bed. When I was changing red scratch that I hadn't seen led medical assistant (TMA)				
	practical nurse (LPI the incident that occ just looked at the al abrasion was due to had pushed the class injury. During interview 11, DON stated she wa 11/17/14 when it oc stated it was a large	N)-A stated she was aware of curred on 11/17/14 and she rea today and thought the o her bra clasp and that she sp back to prevent anymore /25/2014, at 8:05 a.m. the as informed of the incident on curred. The DON further e abrasion and the incident mmediately reported to the				

EY5V12

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00299	B. WING			R <b>25/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
EVERGF	REEN TERRACE		UTH HIGHWAY RAPIDS, MN 🖇			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21990}	Continued From pa	ge 4	{21990}			
		n her right shoulder the facility incident immediately to the				
	dated 10/27/14 indi impairment, howev did need supervisio activities of daily liv dated 10/20/14 indi The elopement risk regarding elopement	Minimum Data Set (MDS) cated had severe cognitive er displayed no behaviors but on with locomotion and ing (ADL)'s. R183's care plan cates history of memory loss. and the care planning nt was completed after R183 terans day event on 11/24/14.				
	11/11/14, "Resident with activities for Ve was done resident used to live. Activity program. No injurie the DON and admin incident on 11/12/14	dent Report identified on t [R183] attended an outing eterans day. When program walked across street where he y staff walked him back to s noted." The report identified histrator was informed of the 4, one day after the event. The y the common entry point was ncident.				
	(MDH) report, ident	esota Department of Health ified the facility submitted a agency (MDH) on 11/12/14, cident occurred.				
	activities director (A event was at the ar my staff were. The when it ended, the wheelchair people a	11/24/14 at 4:02 p.m. The AD-A) stated the Veterans day mory and she wasn't there but group watched the event, staff stood up and moved the around. When they got done nair people [R183] was gone.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00299	B. WING		R 11/25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
EVERGF	REEN TERRACE		UTH HIGHWAY RAPIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21990}	We were not aware across the street. ' him, he had crosse brought back to the the house now. He clothing so she ass event" The directo present during the notified the next da was the administra the DON and admin the incident until 11 elopement occurred During interview on administrator stated veterans day elope stand up meeting". Although R185 had administrator/desig were not immediate	idn't know where he had gone. that he used to own a house 'By the time my staff found d the street, and was being armory by the lady who owns was wearing veterans umed he belonged at the r of nursing (DON) who was interview, added, "I was y in the AM [morning]," and so tor. The AD-A acknowledged nistrator were not notified of /12/14, one day after the		DEFICIENC	Υ)	

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00299	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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) D	ate
ID Prefix		Correction Completed 10/27/2014	ID Prefix		Correction Completed 10/27/2014	ID Prefix		Correction Completed 10/27/2014
Reg. # LSC	MN Rule 4658.0210 Subp.	2 A.I - -	Reg. # LSC	MN Rule 4658.0405 Subp.	3	Reg. #	MN Rule 4658.0510 Subp.	1
ID Prefix Reg. # LSC	MN Rule 4658.0520 Subp.	Correction Completed 10/27/2014	ID Prefix Reg. # LSC	20900 MN Rule 4658.0525 Subp.	Correction Completed 10/27/2014 3		20910 MN Rule 4658.0525 Subp.	Correction Completed 10/27/2014 5 A.I
ID Prefix Reg. # LSC	20915 MN Rule 4658.0525 Subp.	Correction Completed _10/27/2014 6 A	ID Prefix Reg. # LSC	20920 MN Rule 4658.0525 Subp.	Correction Completed 10/27/2014 6 B	ID Prefix Reg. # LSC	21045 Mn Rule 4658.0620 Subp.	Correction Completed 10/27/2014
ID Prefix Reg. # LSC	21390 MN Rule 4658.0800 Subp.	Correction Completed _10/27/2014 4 A-I	ID Prefix Reg. # LSC	21426 MN St. Statute 144A.04 Su	Correction Completed 10/27/2014 bd. 4	ID Prefix Reg. # LSC	21530 MN Rule 4658.1310 A.B.C	Correction Completed 10/27/2014
ID Prefix Reg. # LSC	_21540 MN Rule 4658.1315 Subp.	Correction Completed _10/27/2014 2	ID Prefix Reg. # LSC	21685 MN Rule 4658.1415 Subp.	Correction Completed 10/27/2014 2	ID Prefix Reg. # LSC	21805 MN St. Statute 144.651 Su	Correction Completed 10/27/2014 bd. £
Reviewed By State Agency Reviewed By	y BF/mr	n	Date: 12/10/201 Date:	Signature of Surve	925		Date: 11/25 Date:	5/2014
CMS RO	א: REVISIT REPORT (נ	5/99)		Page 1 of 2			Event ID: EY5V12	

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00299	<b>(Y2) Multiple Construction</b> A. Building B. Wing	(Y3) Date of Revisit 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).

Correction	
Correction	
Completed           ID Prefix         21855         10/27/2014	
Reg. # MN St. Statute 144.651 Subd. 1	
LSC	
Reviewed By     Date:     Signature of Surveyor:     Date:	1001 (
State Agency         BF/mm         12/10/2014         33925         11/25/	2014
Reviewed By         Reviewed By         Date:         Signature of Surveyor:         Date:	
CMS RO	
Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of	
Linear rest of Deficiencies (CMS 2567) Sent to the Equility 2	NO
STATE FORM: REVISIT REPORT (5/99) Page 2 of 2 Event ID: EY5V12	-

	-	ID HUMAN SERVICES					APPROVED
			()(0) MUU	TIDI			D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
			A. DOILDI	. UNI			R
		245495	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	I	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
					2801 SOUTH HIGHWAY 169		
EVERGRE	EVERGREEN TERRACE				GRAND RAPIDS, MN 55744		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG					DEFICIENCY)		COMPLETED R 11/25/2014 (X5) COMPLETION
{F 000}	INITIAL COMMENTS		{F 0	000	}		
	A Post Certification F	Revisit (PCR) was					
		nber 25, 2014 to follow up on					
		lated to the recertification					
		18, 2014. Deficiencies					
		t of this post certification					
	revisit.						
	Because you are enro	alled in ePOC, your					
	, ,	red at the bottom of the first					
	·	7 form. Your electronic					
	submission of the PO						
	verification of complia	ance.					
	I Inon receipt of an ac	ceptable electronic POC, an					
		facility will be conducted to					
		ial compliance with the					
		attained in accordance with					
	your verification.						
{F 225}			{F 2	225]	}		
SS=D	INVESTIGATE/REPC						
	ALLEGATIONS/INDI	/IDUALS					
	The facility must not e	employ individuals who have					
		ibusing, neglecting, or					
		by a court of law; or have					
		into the State nurse aide					
	registry concerning al	buse, neglect, mistreatment					
		propriation of their property;					
		edge it has of actions by a					
		n employee, which would					
		service as a nurse aide or ne State nurse aide registry					
	or licensing authoritie						
		are that all alleged violations					
	involving mistreatmer						
	including injuries of u	nknown source and					

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

TITLE

(X6) DATE

PRINTED: 12/10/2014

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING _				२ <b>25/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 225}	misappropriation of re immediately to the ad to other officials in act through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in prog The results of all inve to the administrator of representative and to with State law (includic certification agency) v incident, and if the all appropriate corrective This REQUIREMENT by: Based on interview, a facility failed to ensure abuse, neglect, inquir immediately reported 5 residents (R85, and reviewed. Findings include: The facility Evergreen Plan revised 5/21/12, Administratormust b and internal investiga alleged violationsto requiredimmediately	esident property are reported ministrator of the facility and cordance with State law rocedures (including to the ification agency). e evidence that all alleged hly investigated, and must ial abuse while the gress. stigations must be reported r his designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified e action must be taken. T is not met as evidenced and document review the e alleged allegations of ies of unknown origin were to the state agency for 2 of R183) allegations	{F 2.	25}			

Facility ID: 00299

If continuation sheet Page 2 of 8

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		0. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
			D 14/11/0		R	
		245495	B. WING		11	/25/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169		
EVERGRE	EEN TERRACE			GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
{F 225}	adult to Administrator are not in the building Supervisor, at the tim R85's annual Minimu 10/21/14, indicated sl severely cognitively in extensive assist of or (ADL's). R85's care p indicated her short te and had diagnosis of dementia with depress indicated staff to more and evaluate. The facilities incident dated 11/17/14, indica resident woke up- stanoticed a 6" length x on her right shoulder. indicated the director message on 11/17/14 did not indicate if the the allegation. A inter attached to the report getting res ready for ther top I noticed a red before I let the trained know right away." During interview 11/2 practical nurse (LPN) the incident that occu- just looked at the are abrasion was due to	r, Director of Nursing, if they g report to the Nursing le of suspicion." Im Data Set (MDS) dated he had dementia was mpaired and needed he with activity of daily living blan dated 11/06/14, rm memory was impaired Alzheimer disease and ssion. The care plan further hitor for confusion or delirium form Evergreen Terrace ated at 5:30 p.m. "when aff got her changed and 2.5 " width scratch/abrasion " The report further of nursing (DON) received a 4, at 9:25 p.m. The report state agency was notified of	{F 225			

Facility ID: 00299

If continuation sheet Page 3 of 8

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE SURVEY COMPLETED	
		245495	B. WING				R <b>25/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN TERRACE				2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 225}	DON stated she was 11/17/14 when it occu stated it was a large a should have been imm state agency and then Although R85 had sus scratch/abrasion on h failed to report the ind state agency. R183's admission Min dated 10/27/14 indica impairment, however did need supervision activities of daily living dated 10/20/14 indica The elopement risk an regarding elopement eloped from the veter The Evergreen Incide 11/11/14, "Resident [F with activities for Vete was done resident was used to live. Activity s program. No injuries n the DON and adminis incident on 11/12/14, form did not identify th notified, of the incider Review of the Minness (MDH) report, identifier report to the state age one day after the incide	informed of the incident on urred. The DON further abrasion and the incident mediately reported to the n investigate. stained a large her right shoulder the facility cident immediately to the himum Data Set (MDS) ated had severe cognitive displayed no behaviors but with locomotion and g (ADL)'s. R183's care plan ates history of memory loss. nd the care planning was completed after R183 rans day event on 11/24/14. ent Report identified on R183] attended an outing erans day. When program alked across street where he staff walked him back to noted." The report identified strator was informed of the one day after the event. The he state agency was nt. sota Department of Health ed the facility submitted a ency (MDH) on 11/12/14,	{F 2	225}	}		

Facility ID: 00299

If continuation sheet Page 4 of 8

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
			A. BUILD	ING _			R
		245495	B. WING				25/2014
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EVERGREEN TERRACE				801 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE	
{F 225} {F 226} SS=D	my staff were. The grownen it ended, the staff wheelchair people are moving the wheelchair The staff present didr We were not aware the across the street. "By him, he had crossed to brought back to the air the house now. He we clothing so she assume event" The director of present during the inter- notified the next day if was the administrator the DON and administ the incident until 11/12 elopement occurred. During interview on 11 administrator stated, " veterans day elopement stand up meeting". Although R185 had an administrator/designer not immediately notifi- until 11/12/14 one day 483.13(c) DEVELOP/ ABUSE/NEGLECT, E The facility must developed policies and procedur	bry and she wasn't there but oup watched the event, aff stood up and moved the bund. When they got done ir people [R183] was gone. I't know where he had gone. I't was notified down who was erview, added, "I was In the AM [morning]," and so I't he AD-A acknowledged It that the AD-A acknowledged I't and abuse of residents I't was notified about the end, the next day at the I't was notified about the end state agency were ed of the alleged neglect y after the incident. I'MPLMENT ITC POLICIES Elop and implement written res that prohibit t, and abuse of residents		225}			

If continuation sheet Page 5 of 8

PRINTED: 12/10/2014

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/10/2014 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245495	B. WING				F 11/:	२ <b>25/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
EVERGRE	EN TERRACE				801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
{F 226}	Continued From page	5	{F 2	226}				
	by: Based on interview a facility failed to ensure their policy for allegati	is not met as evidenced nd document review the e the facility implemented ions of abuse, neglect and rigin were immediately						
	reported to the admin and thoroughly invest	istrator or the state agency igated for 2 of 5 resident's ations that were reviewed.						
	Findings include:							
	Plan revised 5/21/12, administrator is ultima Prohibition plan and n alleged or substantiat neglect, or maltreatme case of the Administra	ately in charge of the Abuse nust be informed of all ed incidents of abuse, ent immediately. In the ator being unavailable, the ied in this timeframe. The						
	10/21/14, indicated sh severely cognitively in extensive assist of on (ADL's). R85's care p indicated her short ter and had diagnosis of dementia with depres	npaired and needed e with activity of daily living						
	dated 11/17/14, indica	form Evergreen Terrace ated that at 5:30 p.m. "when ff got her changed and						

If continuation sheet Page 6 of 8

CENTER	-		(22) MU		E CONSTRUCTION		FORM	0: 12/10/2014 APPROVED 0: 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			COMPLETED		
		245495	B. WING					、 25/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
EVERGRE	EEN TERRACE				2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
{F 226}	noticed a 6" length x 2 on her right shoulder. the director of nursing message on 11/17/14 did not indicate if the the state agency. A in attached to the report getting res ready for b her top I noticed a rec before I let the trained know right away." Th administrator/designe immediately notified a policy. During interview 11/29 DON/designee stated incident when it occur further stated it was a incident should have b to the state agency ac was not. Although R85 had sus scratch/abrasion on h failed to immediately b regarding the alleged R183's admission Min dated 10/27/14 indica impairment, however did need supervision activities of daily living The Evergreen incide 11/11/14, "Resident [F with activities for Vete	2.5 " width scratch/abrasion The report further indicated g (DON) received a 4, at 9:25 p.m. There report administrator was notified or nterview statement was t which indicated "I was bed. When I was changing d scratch that I hadn't seen d medical assistant (TMA) here was no indication if the ee and state agency were as directed by the facility 5/2014, at 8:05 a.m. the t she was informed of the rred on 11/17/14. The DON a large abrasion and the been reported immediately ccording to their policy and it stained a large her right shoulder the facility report to the state agency abuse for R85. himum Data Set (MDS) ated had severe cognitive displayed no behaviors but with locomotion and g (ADL)'s.	{F 2	226}				

Facility ID: 00299

If continuation sheet Page 7 of 8

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOR	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245495	B. WING			R / <b>25/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 226}	used to live. Activity s program. No injuries r the DON and adminis incident on 11/12/14, form did not identify th notified, Review of the Minness (MDH) report, identifier report to the state age one day after the incid immediately to the state the facility policy. During interview on 1° the director of nursing (AD)-D, the DON state day in the AM [mornin administrator. The AD and administrator wer until 11/12/14, one da occurred. Although R185 had an administrator/designe	taff walked him back to noted." The report identified trator were informed of the one day after the event. The ne state agency was ota Department of Health ed the facility submitted a ency (MDH) on 11/12/14, dent occurred, and was not ate agency as directed by 1/24/14 at 4:02 p.m. with ( DON) and activity director ed she was notified the next ag]," and so was the D-A acknowledged the DON re not notified of the incident y after the elopement n elopement on 11/11/14 the e and state agency were ed of the alleged neglect	{F 226			

Facility ID: 00299

If continuation sheet Page 8 of 8

Form Approved

#### Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245495	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 11/25/2014
Name	of Facility		Street Address, City, State, Zip Code	
ΕV	ERGREEN 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	۲)	5) Date	(Y4) Item		(Y5)	Date	(Y4)	ltem	ſ	Y5)	Date
		Correction				Correction					Correction
ID Prefix	F0164	Completed 10/27/2014	ID Prefix	F0241		Completed 10/27/2014		ID Prefix	F0242		Completed 10/27/2014
Reg. #	483.10(e), 483.75(l)(4)		Reg. #	483.15(a)				Reg. #	483.15(b)		
LSC		_	LSC					LSC			_
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0246	10/27/2014	ID Prefix	F0247		10/27/2014		ID Prefix	F0282		10/27/2014
-	483.15(e)(1)			483.15(e)(2)					483.20(k)(3)(ii)		
LSC		_	LSC					LSC			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		10/27/2014		F0311		10/27/2014		ID Prefix			10/27/2014
Reg. # LSC	483.25(a)(1)			483.25(a)(2)					483.25(a)(3)		_
								130			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0314	10/27/2014	ID Prefix	F0315		10/27/2014		ID Prefix	F0328		10/27/2014
-	483.25(c)			483.25(d)					483.25(k)		_
LSC			LSC					LSC			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0329	10/27/2014	ID Prefix	F0353		10/27/2014		ID Prefix	F0356		10/27/2014
-	483.25(I)			483.30(a)					483.30(e)		_
LSC		_	LSC					LSC			_
Reviewed By			Date:	Signature of	Surve	•				Date:	
State Agenc	y BF/m	m	12/10/202	4		3392	5			11/2	5/2014
Reviewed By	/ Reviewe	d By	Date:	Signature of	Surve	yor:				Date:	
CMS RO											
				D 4 40							

#### Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245495	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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)	ltem		(Y5)	Date
			Correction					Correction					Correction
ID Prefix	F0428		Completed 10/27/2014		ID Prefix	F0441		Completed 10/27/2014		ID Prefix	F0465		Completed 10/27/2014
	483.60(c)		10/21/2014		Reg. #			10/21/2014			483.70(h)		
LSC	403.00(0)				LSC	403.05				LSC	405.70(11)		_
Reviewed By		Reviewed E			nte: 2/10/201		re of Surve	yor:	,	2025		Date:	E/2014
State Agency		BF/mn							•	33925			5/2014
Reviewed By	·	Reviewed E	Ву	Da	ite:	Signatur	re of Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl										a Summary of to the Facility?		
	9/18/	/2014								5-2507) Sellt	to the raciity?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245495	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 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	(Y	5) 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
-	NFPA 101 K0050		-	NFPA 101 K0052	-	-	NFPA 101 K0061	
	<b>NFPA 101</b> K0144	Correction Completed 10/29/2014	Reg. #		Correction Completed	D //		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	_		Correction Completed			
ID Prefix Reg. # LSC					Correction Completed			
Reg. #			Dog #			D //		
Reviewed I State Agen Reviewed I	DC/	nm	Date: 12/10/1- Date:	4 Signature of Sur Signature of Sur	03005		Date	10/30/14
CMS RO Followup t	o Survey Completed 9/16/2014	on:		Check for any Unco Uncorrected Defic				5 NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		ICARE/MEDICA I - TO BE COMI								D: EY5V acility ID: 00299
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245495           2.STATE VENDOR OR MEDICAID NO.         (L2)           606318700	0.	3. NAME AND ADD (L3) EVERGR (L4) 2801 SOU (L5) GRAND	REEN TERRA UTH HIGHW	ACE VAY 16		(L6)	55744	1. Initia 3. Term 5. Valid	iination lation	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Cit
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	- <del>02</del> 13 ptip	(L7)	22 CLIA	7. On-S 8. Full S	ite Visit Survey After Co	9. Other mplaint
6. DATE OF SURVEY     09/1       8. ACCREDITATION STATUS:       0 Unaccredited     1 TJC       2 AOA     3 Other	<b>8/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI	CE			EAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF	109 <sup>(L18)</sup> 109 <sup>(L17)</sup> 19 SNF	B. Not in Comp	ce With quirements	aivers:	2. 3. 4. 5. * Code: 15. FACILIT	Techni 24 Hou 7-Day Life Sa <b>F</b>	RN (Rural SNF) afety Code <b>3</b>	6. \$ 7. 1 8. 1	quirements: Scope of Servic Medical Direct Patient Room S Beds/Room (L15)	or
109 (L37) (L38)	(L39)	(L42)	(L43)				0, ( )			
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE Austin Fry, HFE N	EII	Date :	10/31/2014		K <u>ate Jo</u>	<u>hns'</u>		orcemen		Date: list 11/17/2014 (L20)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Part</li> <li>2. Facility is not Eligible</li> </ol>			PLIANCE WITH CIV ITS ACT:	VIL	21.	2. Ow	atement of Financi vnership/Control I th of the Above :			-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)	<ul> <li>23. LTC AGREEME BEGINNING I (L41)</li> <li>27. ALTERNATIVE A. Suspension o B. Rescind Susp</li> </ul>	DATE E SANCTIONS of Admissions:	4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	IT	<u>VOLUNTA</u> 01-Merger, 02-Dissatist 03-Risk of I	<u>.RY</u> Closure faction V nvolunta	DN ACTION: 00 ; W/ Reimbursemen ary Termination r Withdrawal	-	INVOLUNT 05-Fail to Me 06-Fail to Me <u>OTHER</u>	L30) <u>ARY</u> eet Health/Safety eet Agreement Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C.	ARRIER NO.	(L31)	30. REMAI		11/17/20	)14 Co.		
31. RO RECEIPT OF CMS-1539	32. (L32)	DETERMINATION C	DF APPROVAL DATE	E (L33)	DETERN	/INAT	TION APPRO	VAL		



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:

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

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

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

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

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

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

# DEPARTMENT CONTACT

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

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.

Evergreen Terrace October 8, 2014 Page 4

## 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

Evergreen Terrace October 8, 2014 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Evergreen Terrace October 8, 2014 Page 6

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

Sincerely,

>Y ale Compton

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

10-17-'14 13:21 FROM- Evergreen Terrace

218-327-3217

T-222 P0002/0002 F-292



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

2801 Highway 169 South • Grand Rapids, MN 55744 • 218.326.3431 • www.welcov.com

### RECEIVED

		ND HUMAN SERVICES		OCT 1 7 2014	PRINTED: 10/08/2 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION MN Dept of Health St.Cloud	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	EN TERRACE			2801 SOUTH HIGHWAY 169	
EVERGRE	ENTERRAGE		(	GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC
F 000	INITIAL COMMENTS		F 000		
				F164	
	as your allegation of	correction (POC) will serve compliance upon the ance. Because you are		Immediate corrective action	:
	enrolled in ePOC, yo	ur signature is not required irst page of the CMS-2567		Personal privacy was immedi	ately
	form. Your electronic be used as verification	submission of the POC will on of compliance.		provided for resident (R68).	
				RN-C received coaching and r	
		cceptable electronic POC, an		education on 8/22/14 for fail	ing to
	-	facility may be conducted to tial compliance with the		provide privacy when admini	stering
		attained in accordance with		an injection to resident #145	•
F 164 SS=D	483.10(e), 483.75(l)(4	4) PERSONAL NTIALITY OF RECORDS	F 164	Action as it applies to others	:
				All residents will be interview	/ed to
		right to personal privacy and		ensure their right to personal	1
	records.	or her personal and clinical		privacy is maintained by staff	F.
				Residents with concerns rega	Irding
		udes accommodations,		their right to privacy will have	e
	medical treatment, w	ritten and telephone sonal care, visits, and		grievance concerns complete	d with
	meetings of family an	id resident groups, but this facility to provide a private		necessary follow up and reso	lution.
	room for each reside			The policy and procedure, Re	sident
		n paragraph (e)(3) of this		Privacy, was reviewed on	
		may approve or refuse the nd clinical records to any		9/23/2014 and remains curre	ent.
	individual outside the			Staff will be re-educated on t	he
		-		Resident Privacy policy by	
	and clinical records d	o refuse release of personal oes not apply when the		10/27/2014.	
		d to another health care elease is required by law.			
ORATORY I	DIRECTOR'S OR PROVIDER	OPPLIER REPRÉSENTATIVE'S SIGNATUR	RE	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.

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245495	B. WING		09	18/2014
NAME OF P	ROVIDER OR SUPPLIER	· · ·		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 164	The facility must kee	e 1 p confidential all information dent's records, regardless of	F 16	Date of completion: 1		
		nethods, except when		Recurrence will be pre	evented by:	
	healthcare institution	; law; third party payment		Random weekly reside		
	contract; or the resid	ent.		and visual observation	s will be	
				conducted on each un		Í
		T is not met as evidenced		staff implement measu		
	by: Record on observativ	on, interview, and document		ensure personal privac	cy for	Í
	review, the facility fa	iled to implement measures rivacy was provided for 2 of		residents.		
		ts (R68, R145) observed	1	Audits will be complete		
		t upon staff to provide		period of 90 days and a	audit results	
	privacy.			will be reviewed by the	QA	
	Findings include:			committee to determin		
	7/18/14, indicated Re quadriplegia. The M	num Data Set <u>(</u> MDS), dated 58 had a diagnosis of DS identified R68 had no		for ongoing monitoring	ξ.	
		, required use of an ic catheter and colostomy, sistance from staff for all		The correction will be by:	monitored	
				Director of Nursin	ng and/or	
During observation on 9/15/14, at 4:30 p.m., was lying in bed, his door was wide open, vis from the hallway where residents, visitors and staff could see the resident exposed. R68's abdomen was exposed along with their colos		door was wide open, visible ere residents,visitors and sident exposed. R68's		designee.		
	device (equipment th bag) which contained incontinence brief on pad used to absorb f incontinence). R68	at collects stool, typically a d stool. R68's had an , with blue chux (disposable luids typically used for was unable to cover himself	131/2	A WAY AND A WAY		
	due to limited use of His abdomen and lov	his upper body extremities.		YNX		

PRINTED: 10/08/2014

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

PRINTED: 10/08/2014 FORM APPROVED

24495     b. WHO	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				CONSTRUCTION		(X3) DATE SURV COMPLETE		
NAME: DP PROVIDER 0R SUPPLIER     STREET ADDRESS, CITY, STATE, JP 200E       EVEROREEN TERRACE     281 SOUTH HIOMWAY 195       (MAI)     SUMMARY STATEMENT OF DEPICIENCIES REFIX     In previous and previous a			245495	B. WING			09	/18/2014	
PRETRY Tool         (EACH OPERCIENCY MULTI SE PRECEDED BY FULL REQUATORY OR USCIDENTIFYING INFORMATION)         PRETRY Tool         Continued From set (Continued From set (Cont				28	2801 SOUTH HIGHWAY 169				
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 lisection. RN-C left the residents door open while she administered his insulin. R145 could be viewed from the hallway where visions were walking during the administration 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 225         S8=D         INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	PREFIX	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRÉFIX	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP		ULD BE COMPLETION		
none was provided.     F 225       483.13(c)(1)(ii)-(iii), (c)(2) - (4)     F 225       SS=D     INVESTIGATE/REPORT       ALLEGATIONS/INDIVIDUALS     F 225	F 164	and could be viewed residents, visitors and When interviewed on stated he did not like exposed to other resi- hallway, but he was u without staff assistand R145's admission Mir dated 8/21/14, indicat mellitus, was cognitive oxygen, and required for all their daily need During an observation administration, on 9/1 nurse (RN)-C entered shirt to provide a med the residents door op his insulin. R145 coul hallway where visitors administration of the ir the door or curtain in visual privacy. When interviewed on stated they would typi providing medical treat	A From page 2 be viewed from the hallway by other visitors and staff. erviewed on 9/15/14, at 4:30 p.m., R68 did not like the door open, and being o other residents, and visitors from the tut he was unable to close the door aff assistance. Imission Minimum Data Set (MDS), 1/14, indicated R145 had diabetes vas cognitively intact, dependant on nd required total assistance from staff r daily needs. observation of medication ation, on 9/18/14 at 8:46 a.m., registered I)-C entered R145's room and lift their ovide a medication injection. RN-C left ints door open while she administered . R145 could be viewed from the here visitors were walking by during the tion of the insulin. RN-C did not closed r curtain in the resident room to provide acy. rviewed on 9/18/14, at 8:50 a.m., RN-C y would typically shut the door before		DEFICIEN				
The facility must not employ individuals who have		none was provided. 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPO	)(2) - (4) RT	F 225					
		The facility must not e	mploy individuals who have						

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMP	LETED
			5.4010				
		245495	B. WING			09/	18/2014
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH HIGHWAY 169		
EVERGRE	EN TERRACE				RAND RAPIDS, MN 55744		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	BATE
F 225	Continued From page	e 3	F	225	F225		
	been found guilty of a	busing, neglecting, or					
		by a court of law; or have			Immediate corrective action	1.	
		into the State nurse aide buse, neglect, mistreatment			Resident R151 no longer resi	des	
		propriation of their property;			in the facility.		
		edge it has of actions by a					
		n employee, which would service as a nurse aide or			Action as it applies to other	5:	
		ne State nurse aide registry			The most recent elopement		
	or licensing authoritie	S.			assessment for all other		
	The facility must ensu	ure that all alleged violations			residents will be reviewed.		
	involving mistreatmer				Residents noted to have any		
•	including injuries of u	nknown source and esident property are reported			change to their current		
		Iministrator of the facility and			assessment will be reassesse	ed	
	•• •••••	cordance with State law			and those found to be at risl	<b>‹</b>	
	through established p State survey and cert	procedures (including to the			will have appropriate		
					interventions in place to		
		e evidence that all alleged			prevent elopement.		
	prevent further potent	hly investigated, and must tial abuse while the					
	investigation is in pro				The policy and procedure fo		
		e e it i i i i i			Abuse Prevention was revie	wed	
	to the administrator o	stigations must be reported			on 9/23/2014 and remains		
		other officials in accordance			current.		
	with State law (includ	ing to the State survey and			The policy and procedure fo	r	
		within 5 working days of the eged violation is verified			Elopement was reviewed or		
		e action must be taken.			9/23/2014 and remains curr		
					3/23/2014 driu Ternains curr	unu ,	
					Staff will be re-educated on	the	•
	This REQUIREMENT	is not met as evidenced			abuse prevention and		
	by:				elopement policies by		
Į		and document review the			10/27/2014.		
	facility failed to ensur	e alleged allegations of					

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

Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 4 of 106

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 | Continued From page 4 F 225 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. Date of completion: 10/27/2014. Findings include: Recurrence will be prevented R151's admission Minimum Data Set (MDS), dated 8/20/14, indicated R151 had severe by: cognitive impairment, however displayed no behaviors or wandering. R151's care plan, dated Random weekly chart reviews 8/13/14, indicated R151 had an altered mental and resident interviews will be status and dementia with barriers to him going conducted on each unit to home due to memory loss and inability to find home and becomes angry when he asks about ensure alleged allegations of going home which staff are to redirect him when abuse, neglect, injuries of agitated. The care plan further stated he was unknown origin, statements aware of his surroundings and people around him but not always to time and place. regarding elopement and elopement attempts and The facility's Elopement Risk Assessment dated misappropriation of resident 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 Facility ID: 00299 If continuation sheet Page 5 of 106 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EY5V11

PRINTED: 10/08/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245495 B. WING 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 5 F 225 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 property were immediately immediately notified nor was the elopement thoroughly investigated. reported in accordance with facility policy. A facility designated staff person will During interview 9/18/14, at 9:21 a.m. with the maintain, on an ongoing basis, a director of nursing (DON) stated they did not report the incident on 9/5/14 since she didn't feel log of reported allegations of he was attempting to elope. The DON verified abuse. R151 had left the building went into the parking lot unattended, and the progress note was not Audits will be completed for a clear if the staff knew where he was or if they had just found him out there. period of 90 days and audit results will be reviewed by the The facilities Elopement policy revised July 2013, QA committee to determine the indicated nursing must report and investigate all reports of missing residents. The policy further need for ongoing monitoring. indicated, "Any elopement where the resident is not seen leaving, or has unusual circumstances The correction will be is considered a reportable incident under the monitored by: Vulnerable Adult Law in Minnesota". Director of Nursing and/or The Facilities Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated designee. 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. Facility ID: 00299 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 6 of 106

PRINTED: 10/08/2014

Event ID: EY5V11

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 245495 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 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 226 F226 F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES SS=D Immediate corrective action: The facility must develop and implement written policies and procedures that prohibit Resident R151 no longer resides in mistreatment, neglect, and abuse of residents the facility. and misappropriation of resident property. Action as it applies to others: The most recent elopement This REQUIREMENT is not met as evidenced assessment for all other residents by: Based on interview and document review the will be reviewed. Residents noted facility failed to ensure the facility implemented to have any change to their their policy for allegations of abuse, neglect, injuries of unknown origin and misappropriation of current assessment will be resident property incidents were immediately reassessed and those found to be reported to the administrator, state agency and at risk for elopement will have thoroughly investigated for 1 of 4 residents (R151) whose allegations was reviewed. appropriate interventions in place to prevent elopement. Findings include: The policy and procedure for The Facilities Evergreen Terrace Abuse Prevention Plan revised 5/21/12, indicated, "The Abuse Prevention was reviewed on Administrator...must be informed of all incidents 9/23/2014 and remains current. and internal investigations immediately. Report all alleged violations ... to the State of Minnesota as The policy and procedure for required...immediately ... " The policy also Elopement was reviewed on identified, "...that the internal investigation begins immediately ... " 9/23/2014 and remains current.

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

Facility ID: 00299

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PRINTED: 10/08/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245495 **B** WING 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 Continued From page 7 F 226 Staff will be re-educated on the The facilities Elopement policy revised July 2013, Abuse Prevention and the indicated nursing must report and investigate all Elopement policies by 10/27/2014. reports of missing residents. The policy further indicated "any elopement where the resident is not seen leaving, or has unusual circumstances Date of completion: 10/27/2014 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 **Recurrence will be prevented by:** 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 Random weekly chart reviews and dementia and barriers to him going home due to resident interviews will be memory loss and inability to find home. The care conducted on each unit to ensure plan further indicated he becomes angry when he asks about going home and staff are to redirect alleged allegations of abuse, him when agitated. The care plan further stated neglect, injuries of unknown origin he is aware of his surroundings and people and misappropriation of resident around him but not always to time and place. property were immediately The facilities Elopement Risk Assessment dated reported and investigated in 8/20/14, indicated R151 had no history of accordance with facility policy. A elopement, has no history of wandering. The assessment further indicated "Resident has facility designated staff person will made no attempts to leave the building. He is maintain, on an ongoing basis, a staying in the same room with his wife. He will log of reported allegations of not be placed at Elopement Risk". abuse. 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 Event ID: EY5V11 Facility ID: 00299 If continuation sheet Page 8 of 106 FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/08/2014

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 245495 B. WING 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1 F 226 F 226 Continued From page 8 Audits will be completed for a before winter comes, pointing to the main period of 90 days and audit results entrance door stating "I'm just going to walk over will be reviewed by the QA their and go in that door". Walked with Res who committee to determine the need entered building without diff and down to room to see wife". There was no indication the for ongoing monitoring. administrator, and state agency were immediately notified nor was the elopement thoroughly The correction will be monitored investigated as identified by the facility policy. by: Director of Nursing and/or During interview 9/18/14, at 9:21 a.m. with the director of nursing (DON) who stated they did not designee. 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 241 483.15(a) DIGNITY AND RESPECT OF F 241 INDIVIDUALITY SS=D The facility must promote care for residents in a F241 manner and in an environment that maintains or enhances each resident's dignity and respect in Immediate corrective action: full recognition of his or her individuality. **Resident R77 received** immediate assistance with This REQUIREMENT is not met as evidenced fingernail care. by: Based on observation, interview, and document review, the facility failed to complete timely grooming to promote dignity for 1 of 3 residents

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

(X4) ID

PREFIX

TAG

Event ID: EY5V11

Facility ID: 00299

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PRINTED: 10/08/2014 FORM APPROVED

OMB NO. 0938-0391

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING			09/	18/2014
	COF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2801 SOUTH HIGHWAY 169       2801 SOUTH HIGHWAY 169         GRAND RAPIDS, MN 55744       GRAND RAPIDS, MN 55744						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 241	<ul> <li>(R77), whom was rev living and grooming.</li> <li>Findings include:</li> <li>R77's quarterly Minim 8/22/14, indicated R7 assistance from staff and had moderate co</li> <li>R77's care plan, date required assistance v bathing and weekly n</li> <li>During observation of was seated in his who long, un-trimmed fing There was a dark sub of the nails. Subsequ 9/17/14 at 7:08 a.m., indicated R77 continu- fingernails with a blace</li> <li>When interviewed on stated he would like h and kept shorter and was embarrassing for with.</li> <li>During interview on 9 assistant (NA)-D who fingernails should be bath day.</li> <li>R77's Treatment Adm</li> </ul>	num Data Set (MDS), dated 7 required extensive for his personal hygiene, gnitive impairment. d 9/8/14, indicated R77 vith dressing, grooming, ail care. n 9/16/14, at 9:22 a.m., R77 eelchair in his room. with ernails on both hands. ostance underneath several ent observations of R77 on and 9/18/14 at 8:19 a.m., ued to have un-trimmed, ck substance underneath. 9/18/14, at 8:19 a.m., R77 his fingernails to be trimmed that long, dirty fingernails r him to be seen by others /17/14, at 9:04 a.m., nursing o cared for R77 stated his trimmed on the resident's hinistration Record, dated not indicate R77 should	F	241	Action as it applies to other All residents will receive fingernail care according to their personal preference. A nursing assistant care cards be reviewed to assure reside grooming needs, to include care preferences, are include The policy and procedure fo Resident Dignity was review on 9/23/2014 and remains current. Nursing staff will be re- educated on the policy Reside Dignity by 10/27/2014. Date of completion: 10/27/2014. Recurrence will be prevente by:	All will ent nail ed. r ed	

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Facility ID: 00299

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		ND HUMAN SERVICES MEDICAID SERVICES		-	FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRI	EEN TERRACE			01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 241 F 242 SS=E	should have been trin diabetic. Further, RN fingernails would be When interviewed on director of nursing (D expected to trim and and R77's fingernails according to his prefe An undated facility D purpose of ensuring a dignity and respect. examples of appropri dignity including, "Pro to each resident's inc 483.15(b) SELF-DET MAKE CHOICES The resident has the schedules, and healt her interests, assess interact with member inside and outside the about aspects of his are significant to the This REQUIREMENT by: Based on observation review, the facility fail	<ul> <li>a dignity concern.</li> <li>b)-A stated R77 fingernails mmed by a nurse as he was a l-A stated R77's long, dirty a dignity concern.</li> <li>b)-A stated R77's long, dirty a dignity concern.</li> <li>c)-A stated R77's long, dirty a concern.</li> <li>c)-A stated R77's long, dirty a should have been trimmed erence.</li> <li>ignity policy indicated a all residents are treated with Further, the policy indicated inte actions to promote coviding grooming according lividual wishes."</li> <li>TERMINATION - RIGHT TO</li> <li>right to choose activities, h care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that</li> </ul>	F 241	<ul> <li>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 whice maintains or enhances each resident's dignity.</li> <li>The correction will be monitored by:</li> <li>Director of Nursing and/or designee.</li> <li>F242</li> <li>Immediate corrective action:</li> <li>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 meal entrée at the observed meals from 9/15/2014 – 9/17/2014, with the resolutio reviewed by the ID Team of</li> </ul>	th D, of

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Facility ID: 00299

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
ID PLAN OP	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>	
		245495	B. WING		09/18/2014
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EN TERRACE			01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	
	CLIMMADY C	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIC
F 242	Continued From pag	e 11	F 242	Action as it applies to other	5:
	making a choice of n	neal entrees.		All residents will receive	
				preferences for meal choice	
	Findings include:			with each meal.	
	During observation o	of the evenings meal on		with each mean.	
		m., residents in the 100's		The policy and procedure for	-
		ntia unit, were seated at		Resident Choice was reviewe	
:		evening meal service. A cart		on 9/23/2014 and remains	
		meal trays, was delivered on ractical nurse (LPN)-B pulled			
		e cart, each one for a		current.	
		removed the plate covers,		Staff will be re-educated	
	·	entree in front of the seated		regarding the policy and	
		pleted this for all residents in			
		a unit. Staff did not ask ons related to the food		procedure Resident Choice b	'Y
		choice to the residents		10/27/2014.	
	regarding food choic			Date of completion:	
				10/27/2014.	
		of the breakfast meal on		10/27/2014.	
		, the dietary staff (DS)-A k of trays into the secured		Recurrence will be prevente	d
		residents were seated in the		by:	
	v v	k had trays for each of the		~y.	
		and the plates were covered		Random weekly audits will b	e
	•	ed dome. Nursing assistant practical nurse (LPN)-P		completed, at meal time, to	
	removed the cover fr			ensure staff offer residents	
		e omelet, fried potatoes and		choices regarding meal	
	-	the resident in the secured		preferences.	
	•	lates. NA-I and LPN-P did		preferences.	
		s prior to being served about ference but served the food		Audits will be completed for	a
		vided on each of the plates.		period of 90 days and audit	
	Also, there was no ir	ndication in the secured		results will be reviewed by the	he
		list of meal alternatives or		QA committee to determine	
		le for the residents to		•	
	choose.			need for ongoing monitoring	3.

Facility ID: 00299

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		ID HUMAN SERVICES		~	_	FORM APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			Ç	MB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		X3) DATE SURVEY COMPLETED
		245495	B. WING			09/18/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	
			ļ	2801 SOUTH HIGHWAY 16	9	
EVERGRE				GRAND RAPIDS, MN 5	5744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	
F 242	Continued From page	<b>a</b> 12	F 2	42		
1 6. 16.	Continued From page			72		
				The corr	rection will be	
		1		monitor	ed bv:	
3	On 9/15/2014 at 5:37	p.m. in the main dining			,-	
	room of the facility, nu and G were observed residents. Staff were wanted to eat, either I vegetable, or country and gravy. The entre written on a white boa dining room. Staff too	ursing assistants (NA)-D, F d collecting menu slips from e asking residents what they lasagne with garlic toast and fried steak, with potatoes ee choices were noted to be ard on the south side of the ok the slips into the kitchen, elivered the chosen meal to		Dietary	Manager/Designee	2
ŋ	R102's undated facilit diagnosis of altered n	ty diagnosis sheet identified nental status. R102's				
	also indicated R102 v	intact cognition. The MDS was capable of making others, and understood				
	identified a choice of	life activities prior to htervention of, "Staff assist /TV/video/music		. •		
3	diagnoses of dementi The quarterly MDS, d cognitive impairment.	y diagnosis sheet identified ia and Alzheimer's disease. lated 8/26/2014, indicated . The MDS also indicated a barself understood to				-
	others, sometimes un responded adequatel communication. The 9/18/14 identified a pr facility activities which	nderstood others, and				
DRM CMS-256	others, sometimes un responded adequatel communication. The 9/18/14 identified a pr facility activities which	y to simple, direct care plan print date of reference about attending h needs reminders, invites pate. The interventions	:Y5V11	Facility ID: 00299	if continuati	on sheet Pa

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

### PRINTED: 10/08/2014 FORM APPROVED OMB NO, 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMPI	SURVEY
		245495	B. WING	······································	·	09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				TH HIGHWAY 169 RAPIDS, MN 55744		
	CUMMADY C				PROVIDER'S PLAN OF CORREC		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x .	(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 242	Continued From pag	e 13	F	242			
		st to transport to these				1	
	,	s scheduled, encourage					
	music programs, ani group and social hou	mal visits,, 3m's discussion ırs.''					
		(* 7 F (4.1.1 (177 )					
		y diagnosis sheet identified ner's disease and presenile					
		erly MDS, dated 7/22/2014,					
		npairment. The MDS also					
	indicated R85 some						
		, sometimes understood					
		ed adequately to simple,					
		n. The care plan print date of					
		vant to attend some facility itervention of, "Staff assist					
	[R85] with setting up						
		/her to view independently					
		or additional assistance as					
		blan also directed staff to,					
	"Pick up shopping ne	eeds as needed or					
	requested."						
	R18's undated Self L	imiting Problems and					
		ntified diagnosis of dementia.					
		, dated 6/5/2014, indicated					
		. The MDS also indicated					
		mself understood to others,					
		others, and had difficulty e words or finishing thoughts,		ļ		ļ	
		e words or mishing thoughts,					
		8/14 identified wanting to					
		activities but also have					
	independent activitie	s. Staff were to assist with "I					
		nvites, reminders and					
	encouragement to g	et to the facility activities."					
RM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: EY5	V11	Facility ID: 0	0299 If co	ontinuation sheet F	Page 14 of 1

		ID HUMAN SERVICES			FC	NO, 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D	ATE SURVEY OMPLETED
		245495	B. WING			09/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE SIENCY)	(X5) COMPLETION DATE
F 242	R150's undated facilit diagnosis of depressi The admission MDS, cognitive impairment. R150: usually made h usually understood of communicating some but was able, if promy plan print date of 9/18 communicate my nee effectively communicat plan also identified "I decisions", with a goa control of my care de inform me of my clinic R107's undated facilit diagnosis of dementia disease. The admissi indicated moderate c MDS also indicated F understood to others, others. The care plan identified, I want to at with the intervention of reminders, escorts ar activities." R67's undated facility diagnosis of dementia quarterly MDS, dated cognitive impairment. R67 usually made he usually understood of communicating some	y diagnosis sheet identified on and cerebellar ataxis. dated 8/12/2014, indicated The MDS also indicated nimself understood to others, hers, and had difficulty words or finishing thoughts, oted or given time. The care 8/14 identified, "I am able to ds", with a goal of, "I will ate needs daily." The care am able to make my own al of, "I want to remain in cisions", and "staff to fully cal status." ty diagnosis sheet identified a and cerebrovascular on MDS, dated 7/22/2014, ognitive impairment. The 1107, made himself and was able to understand in print date of 9/18/14 tend some facility activities," of, "I need assistance of ind invites to get to the facility a diagnosis sheet identified a and depression. The	F 24	42		
	activities prior to adm	8/14 identified a choice of life ission, with the intervention				
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: EY5\	/11	Facility ID: 00299	If continuation sh	eet Page 15 of 106

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245495	B. WING_		0	9/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 5574		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S P (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
	of, "Staff assist [Re	-	F 2	242		
	diagnosis of depres MDS, dated 8/13/2 impairment. The M herself understood understood others. 9/18/14 identified a admission, with the [R64] to locate radi	lity diagnosis sheet identified ssive disorder. The annual 014, indicated cognitive MDS also indicated R64: made to others, and usually The care plan print date of a choice of life activities prior to a intervention of, "Staff assist io/TV/video/music oice upon request."				
	diagnosis of confus quarterly MDS, dat moderate cognitive indicated R105 usu to others, usually u difficulty communic thoughts, but was a The care plan print choice of life activit intervention of, "Sta	cility diagnosis sheet identified sion of unspecific site. The ed 6/25/2014, indicated a impairment. The MDS also ually made himself understood nderstood others, and had eating some words or finishing able, if prompted or given time. date of 9/18/14 identified a ies prior to admission, with the aff assist [R105] to locate sic programming of choice				
	diagnosis of senile dated 8/6/2014, ind The MDS also indic himself understood understood others, communicating som	ility diagnosis sheet identified dementia. The annual MDS, licated cognitive impairment. cated R51: usually made to others, sometimes and had difficulty ne words or finishing thoughts, mpted or given time. The care				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 245495 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 242 Continued From page 16 F 242 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

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Facility ID: 00299

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO: 0938-0391

		MEDICAID SERVICES	<u>,                                     </u>				0.0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS			E SURVEY PLETED
		245495	B. WING			09	/18/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	• •	<del></del>
EVEDODE				2801 SO	UTH HIGHWAY 169		
EVERGRE				GRAND	RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 242	Continued From page						
1 272	· -			242			
		oose to have an alternate					
· .		d the main daily entree and					
		vere usually written on the					
		om. The DM said residents vould fill out their own slips,					
	and were " acked by	/ the aides what they want to	1				
		e of different food items,					
	out, and had a choic	e or amerent food items,		1			
	Continuing the intervi	ew, the DM said on the	1				
		they follow a different					
		he entree meal choices for					
		aid the daily menu slips for					
		ired dementia unit reflected					
	the residents' choices	and preferences, based on					
8		rned about what each					
	resident likes and dis	likes." The DM said that					
	resident's preferences	s on the secured unit, "it was					}
		ut from the residents," and					
		n we had no family input as					
		DM said, "When we dish it					
		ay; they [the residents in the					
		sked that day what they					
		I further added that if the					
		hat was on the tray, the					
		but coming back to the					
		different entree for the aid she did not know how					
		ally returned to the kitchen s for residents on the locked					
	unit.	a for residents on the locked					
2	General Contraction of the second						
	During interview on 9	/17/2014 at 11:03 a.m., cook					
		't know the residents on the					
	• •	t "had a choice." C-A said					
		es were dished up "as to					
		cket." C-A said the aides					
		kitchen and pick up a					
		the secured unit, "About					
	once a week or less."						
	7(02-99) Previous Versions Obs	olete Event ID: EY5V11		Facility ID: 0	0000	ontinuation sheet	

Facility ID: 00299

If continuation sheet Page 18 of 106

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 242 Continued From page 18 F 242 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 246 F 246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES SS=D

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

Facility ID: 00299

If continuation sheet Page 19 of 106

		MEDICAID SERVICES	- 1		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EN TERRACE			I SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETI
F 246	Continued From pag	ue 19	F 246		
		ght to reside and receive		F246	
a k	accommodations of	individual needs and when the health or safety of		Immediate corrective action	on:
		er residents would be		Resident R150 no longer re	esides
	endangered.			in the facility.	
		T is not met as evidenced		Action as it applies to othe	ers:
	by:	T is not met as evidenced		All residents will be evalua	ted
		on, interview, and document		on their need for the use o	f
		iled to provide adaptive te safe independent eating		adaptive equipment to pro	
		1 residents (R150) who		safe independent eating a	
	utilized a padded bo	ard on his lap for his meal		drinking. Equipment will b	
		Ity drinking fluids with a		provided for those residen	
	standard cup/glass.			found to benefit from the	
	Findings include:			of adaptive equipment by	
				10/27/2014.	
		inimum Data Set (MDS) ated R150 had a diagnosis of		10/2//2014.	
		cident (CVA [stroke]) and		The policy Special Equipme	ent
		erated forward rounding of the		needs was reviewed and	
		MDS indicated R150 had pairment, and required		remains current. Staff will	be
	supervision with eat			re-educated on the policy l	by
	1			10/27/2014.	
	R150's care plan, la R150 was independ	st updated 8/20/14, indicated ent with eating.		Date of completion:	
	R150 was seated at	on on 9/15/14, at 5:10 p.m., a table in the main dining dementia unit. R150 had a		10/27/2014.	
	padded board seate	dementia unit. R150 nad a d on his lap which was not vheelchair or the dining room			
	table allowing it to m	ove freely on his lap with any evening meal was placed on			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WNG 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 246 Continued From page 20 F 246 Recurrence will be prevented the padded board by unidentified staff and R150 by: began to eat independently. The padded board kept moving while R150 proceed to eat and drink 3 Random weekly visual audits his fluids. R150 had coffee, which was sloshing will be completed during the several times in the cup while sitting on the dining service and in each padded board on his lap. R150 struggled to drink his liquids and was unable to get the last 1/4 of dining room to ensure residents the coffee in the bottom of his cup due to his requiring the use of adaptive severe kyphosis. R150 was not offered a straw to drink his liquids or a tray to stabilize the plate of equipment to promote safe food sitting on the padded board on his lap. independent eating and drinking are provided the A subsequent observation was made of R150 in the dining room on 9/17/14 at 8:13 a.m., R150 necessary equipment to had the padded board on his lap, which moved enhance their dining freely, Nursing assistant (NA)-M placed R150 experience. breakfast plate on the padded board and place coffee, milk and juice on the table in front of Audits will be completed for a R150. He started to eat his meal, and tried reaching for the fluids on the table in front of him. period of 90 days and audit R150 made several times to reach the fluids but results will be reviewed by the was unable to and began to eat his breakfast. OA committee to determine the After a few minutes, he unlocked his wheelchair and rolled himself forward to reach the fluids on need for ongoing monitoring. 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 The correction will be kyphosis, and not being able to lift his head back monitored by: to drink all the coffee. He then held the cup, against his chest and used a teaspoon to spoon Dietary Director/Designee 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 Facility ID: 00299 If continuation sheet Page 21 of 106 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EY5V11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		00/48/2044	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169	09/18/2014	
	T			GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPL	
F 246	lift his head back to c a.m. (a minimum of 1 served his breakfast) (LPN)-B offered R150 and proceeded to drin the use of a straw. An additional observa 9/17/14 at 12:04 p.m. recliner chair in his ro and back of the reclin backwards so as to re eating using the same the dining room in the R150 did not have a c shirt had spills on it. S with a straw to drink a practical nurse (LPN)- R150 finished his mea During interview on 9/ stated he was unable cups of liquid and wou his coffee when he was	Arink all the juice. At 8:27 4 minutes after being licensed practical nurse 0 a straw which he accepted nk 100% of the fluids with ation was made of R150 on R150 was seated in his oom with his legs elevated, her chair slightly leaned ecline R150. R150 was e same padded board from e same manner as above. Clothing protector on, and his Staff had not provided him all his fluids. Licensed -B entered R150's room as al and offered him a straw. (17/14, at 12:24 p.m., R150 to reach the table for his uld like to be able to reach anted it. 9/17/14, at 1:32 p.m., as unable to get close to	F 246			

Event ID; EY5V11

Facility ID: 00299

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245495	B. WING		09/18/2014	
	ROVIDER OR SUPPLIER	L /= 0.00 = 0.000 mm	2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 246 F 247 SS=D	director of nursing (D if anything had been ability to eat independ equipment. A facility Special Equi 3/2013, indicated all in facility are assessed special equipment ne highest practicable le the policy indicated si monitor for potential in report them on an on- 483.15(e)(2) RIGHT ROOM/ROOMMATE A resident has the rig the resident's room o changed. This REQUIREMENT by: Based on interview, facility failed to provide	ON) stated she was unsure tried to improve R150's dently with use of adaptive pment Needs policy, dated residents residing in the and provided with the cessary to reach their vel of functioning. Further, taff are responsible to needs of residents and going basis. FO NOTICE BEFORE	F 246	F247 Immediate corrective action Resident R15 was interviewe on 9/17/2014 and expressed concern with receiving a new roommate. Action as it applies to other	ed I no V	
	alert and orientated, providing reminders a			The policy: Room Change wa reviewed on 9/24/2014 and remains current. Staff will b re-educated on the policy by 10/27/2014. <b>Date of completion:</b>	e	

Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 23 of 106

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	DNSTRUCTION	OMB NO	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED	
		245495	B. WING			09/	18/2014
			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169				
VERGRE	EEN TERRACE			GR/	AND RAPIDS, MN 55744	<del> ,</del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
E 0.47			_	0.17	Recurrence will be prevente	d	
F 247		e 23 i new room-mate yesterday	F	247	by:		
j.		ot given notice beforehand,			Chart audits and resident	-	
getting a new what was pro During interv licensed soc receive a new		to have known she was			interviews will be completed		
	getting a new roommate with more notice than what was provided. During interview on 9/17/2014, at 9:14 a.m.,				with each room change or		
					roommate change to ensure		
		r (LSW)-A stated R15 did			timely notice was given to th		
		nate on 9/15/14. LSW-A			involved resident(s) and the		
		she would be getting a new me day (9/15/14) a few			notice is documented		
	hours before the room	nmate arrived. LSW-A			accordingly.		
		ve been given more notice of ate but, "It an be difficult to			Audits will be completed for	а	
Į.	adjust with only a few				period of 90 days and audit	a	
	A review of R15's pro	gress notes, dated 9/5/14 to			results will be reviewed by the	ne	
	9/16/14, did not ident	ify that R15 was notified or			QA committee to determine		
	questioned regarding	her new roommate.			need for ongoing monitoring		
		ge policy, dated 4/13/12,			The correction will be		
		s and family members are ges prior to them occurring.			monitored by:		
	Further, the policy sta	ated roommate(s) would be			-		
		hange prior to receiving a t specify a length of time to			Social Services		
	be given prior to.				Director/Designee		
F 282 SS=E	1	/ICES BY QUALIFIED RE PLAN	F	282			
X	must be provided by	d or arranged by the facility qualified persons in n resident's written plan of					
	This REQUIREMENT	is not met as evidenced					

Facility ID: 00299

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE C	ONSTRUCTION	(X3) DAT	<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COM	PLETED
		245495	B. WING _			09	/18/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	:	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 282	Continued From page	e 24	F 2	82			
		on, interview, and document			F282		
	review, the facility fai	led to implement the care					
	plan for the care area rehabilitation, and pro			Immediate corrective action	on:		
	11 of 59 residents, (F	R20, R27, R48, R22, R24,			Residents R20 was reasses	sed	
	R53, R139, R14, R18 these care areas.	8, R36, R77) reviewed for			by therapy and new		
					recommendations were		
					received. The care plan an	ıd	
	Findings include:				nursing assistant care shee	ets	
	AMBULATION				have been updated.		
		num data set (MDS) dated had peripheral vascular				od by	
	-	s and dementia. The MDS			Resident R27 was reassess	euby	
	further indicated sev	ere cognitive impairment			therapy and ambulation		
	and he walked in his room or corridor with	room once or twice in his			guidelines have been re-	and	
					established. The care plan		
		d 2/12/14, indicated he			nursing assistant care shee		
		ependently due to recent toe ne in cognition. The care			have been updated. Daily		
		is balance while standing is			documentation guidelines		
		ticipates in a functional			been implemented to indi	Late	
		m (FMP) for ambulation and le. Staff assist with FMP			completion of the task.		
		imbulate 75-100 feet (ft.) up			Resident's R24, 22, 139, 14	4 and	
	and down the hallwa	y x2.			R48 were reassessed by th		
	The facilities surging	accistant care sheet			and ambulation guidelines		
		assistant care sheet 20 to ambulate 75-100 ft. with			been re-established. The		
	front wheeled walker	(FWW), gait belt two times			plans and nursing assistan		
	daily.	ss notes, physician notes			sheets have been updated		
		ent from June 20, 2014 to			Daily documentation guid		
	September 18, 2014	did not identify R20 was			have been implemented t		
		100 ft. with a front wheeled gait belt two times daily, as			indicate completion of the		
		ing/Ambulation Program			mandate compression of an		I

Facility ID: 00299

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WNG		09/18/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 282	Continued From page	a 25	F 28	Resident R48 received	a walker
	Guidelines Restorativ	e Nursing/Functional		to assist with ambulat	ion.
	recommended for R2			Resident R53 was reas	sessed by
		/14, at 9:44 a.m. NA-D		therapy and ambulation	on .
		ed ambulating over a month		guidelines have been i	re-
	with cares.	becoming more combative		established. The care	plan and
		m data set (MDS) dated		nursing assistant care	sheets
		ambulates with set up only		have been updated. D	
		pervision and assist of one cognitively intact. R27's care		documentation guidel	-
		dicated he was on a FMP		been implemented to	
	times daily with a fror	lating 90 to 100 feet (ft.) two ht wheeled walker (FWW),		completion of the task	
	gait belt and assist of	one staff.		Resident R18 was reas	sessed by
	R27's nursing assista	nt care sheet undated		Occupational therapy	and
	daily. R27's Walking//	-		rehabilitation guidelin	
	Guidelines Restorativ	-		been re-established.	The care
		mendations dated 10/15/13, mbulate 90 to 100 ft. twice		plan and nursing assis	tant care
	daily and to increase	as tolerated.		sheets have been upd	ated.
	Deview of the feature	Evergreen Terress		Daily documentation g	guidelines
	Review of the facility Documentation Surve	Evergreen Terrace ay Report for July 2014 to		have been implement	ed to
	September 18th, 2014			indicate completion of	f the task.
	with a front wheeled v	walker (FVWV), gait belt and		Resident R36's care pl	an was
	assist of one staff," w	hich was started on no indication this has been		updated to include dir	ection for
	completed as recomm			staff to take when R36	refuses
	Walking/Ambulation F Functional Maintenan			repositioning.	I
	by PT.				
		dated 6/17/14,`indicated he thritis and cerebral vascular			

Facility ID: 00299

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMBN	IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		IE SURVEY MPLETED
		245495	B. WING		0	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 557	744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page		F	282		
	limited to extensive a ambulate in the corric			failing to offe	ed counseling for r or reposition	
	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.			failing to offe repositioning	received new	
	he does not ambulate ambulate him. He fu	/14, at 8:20 am R48 stated and the staff do not offer to ther stated if staff would him he would not refuse, noted in his room.		the plan of ca	r failing to follow	
	maintenance program September 8, 2014 d	id not identify R48 had been ce a day with a walker, as		therapy and a on the therap rehabilitation programs will	will be screened by as indicated, based by screens, nursing and ambulation I be established,	
	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.			•	accordingly and s recommended by	
	ambulate up to 100 ft	d 1/20/14, indicated she can . daily with a gait belt. but Ises a front wheeled walker				

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245495       B. WING         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP O         EVERGREEN TERRACE       STREET ADDRESS, CITY, STATE, ZIP O         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       SUMMARY OR LSC IDENTIFYING INFORMATION)       TAG         F 282       Continued From page 27       F 282	(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP C       EVERGREEN TERRACE     2801 SOUTH HIGHWAY 169       GRAND RAPIDS, MN 55744     GRAND RAPIDS, MN 55744       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACT       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO T       F 282     Continued From page 27     F 282	
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY       F 282     Continued From page 27     F 282	ODE
EVERGREEN TERRACE     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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 282     Continued From page 27     F 282	
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACT         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO T         Image: F 282       Continued From page 27       F 282	
	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE
(FWW). R22's Walking/Ambulation Program Guidelines Restorative Nursing Functional Meintenance Recommendations dated 6/10/14 Indicated she uses a FWW and ambulates 100ft with stand by assistance (SBA).The most recent ski assessment will be a each resident. Any r noted to be at risk f tissue integrity will appropriately care p interventions. The r assistant care sheet undated indicated to ambulate up to 100 ft. with gait belt and assist of one and FWW.The most recent ski assessment will be r each resident. Any r noted to be at risk f tissue integrity will appropriately care p interventions. The r assistant care sheet updated and the int 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 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.The policy and proces, w on 9/23/2014 and re current. Staff will br educated on the pol 10/27/2014.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 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.The policy and proces, w on 9/23/2014 and re current. Staff will br educated on the pol 10/27/2014.R24's Walking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendations dated 9/17/14, indicated he is to am	n risk reviewed for resident or impaired have blanned bursing s will be erventions s care ent impaired be assessed d registered ropriate entions are edure, Care as reviewed emains e re- icy by

Facility ID: 00299

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		D HUMAN SERVICES		~	FORM APPROVED OMB NO. 0938-0391
	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1	B	COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
EVEDODE				2801 SOUTH HIGHWAY 169	
EVERGRE				GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 282	Continued From page	28	F 28	32	
	Review of the facility	Evergreen Terrace		Recurrence will be p	revented
1		y Report for July 2014 to		by:	
		4, did not identify he was			
		h one seated rest with		Random weekly visu	al audits
		was started on 8/27/13. on this has been completed		will be completed or	n each unit
	as recommend on the			to ensure staff are fo	ollowing the
	Walking/Ambulation F	•		resident's plan of ca	re for
		ce Recommendations sheet		pressure ulcer preve	ntion,
	by PT.			rehabilitation and ar	
				services.	
		6 dated 6/26/14, indicated			
,	-	itact, needed extensive transfers and did not		Audits will be compl	eted for a
	ambulate in her room			period of 90 days an	d audit
				results will be review	ved by the
		6/20/14, indicated she is		QA committee to de	termine the
		e 200 ft. with a FWW, gait staff and resident is to walk		need for ongoing mo	onitoring.
	<b>)</b>	to heel wound on left heel			
	and to take heel prote	ector off when walking.		The correction will b	e
	DE21a Molking (Ambul	ation Program Guidelines		monitored by:	
		unctional Maintenance		Director of Nursing a	and for
	Recommendations da	ated 8/27/14, indicated she		Director of Nursing a	
		a FWW , gait belt and		designee.	1.5ml
	contact guard assist ( assistant care sheet u				$\sim \sqrt{2}$
1	ambulate 200 ft. with			Ner .	
				AL WA	to billy.
		/14, at 8:20 a.m. R53 stated		I we a	× ' W' , ×
		the bathroom and back, need assistance from staff		1 1X X X	N. Contraction of the second sec
	4	I they do not offer to walk		1 1 1 10 00	
	her. R53 also stated	the staff are not offering to		$\downarrow \qquad \gamma' \land \gamma$	
	ambulate R139, as w	ell.		designee. All adder for All Address of the address	
EORM CMS-256	37(02-99) Previous Versions Obs	volete Event ID: EY5	 V11	Facility ID: 00299	If continuation sheet Page 29 of 106

PRINTED: 10/08/2014

Event ID: EY5V11

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Facility ID: 00299

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/08/2014 FORM APPROVED

			(X2) MUT		ONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		245495	B. WING			09/	18/2014
NAME OF PR	ROVIDER OR SUPPLIER	L		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				280	1 SOUTH HIGHWAY 169		
EVERGRE	EN TERRACE			GR	AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From page	e 29	F	282	•		
	September 18th, 201 "ambulation 200 ft wi contact guard assist and p.m." which was was no indication this a day as recommend Walking/Ambulation I Functional Maintenar by PT. During interview 9/18 physical therapy (PT)	ey Report for August 2014 to 4, did not identify th FWW, gait belt and (CGA) twice per day a.m. started on 8/27/14. There has been completed twice on the 8/27/14					
	he was moderately c transferred with super ambulated in his roor assistance. R139's c indicated he was on with FWW and conta R139's Walking/Amb Restorative Nursing Recommendations d was to ambulate 200 The nursing assistant indicated to ambulate CGA.	rvision/set up and m independently without care plan dated 9/17/14, a FMP and ambulated 200 ft. ct guard assist (CGA). ulation Program Guidelines Functional Maintenance ated 8/29/14, indicated he ft. with FWW and CGA. t care sheet undated also e 200 ft. with FWW and					
	September 18th, 201	ey Report for August 2014 to					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 Continued From page 30 F 282 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 If continuation sheet Page 31 of 106 Event ID; EY5V11 Facility ID: 00299 FORM CMS-2567(02-99) Previous Versions Obsolete

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245495 B. WING 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 31 F 282 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00299

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245495 B. WING 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 Continued From page 32 F 282 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 Facility ID: 00299 If continuation sheet Page 33 of 106 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EY5V11

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVE B NO. 0938-039	
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
	245495		B, WING			09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		_ <u>_</u>	STREET ADDRESS, CITY,	STATE, ZIP CODE		
				2801 SOUTH HIGHWAY	169		
EVERGRE	EN TERRACE			GRAND RAPIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	ambulation. R36's C and included various intact skin, among w turned and reposition lacked any direction when R36 refused re During observation c	th bed mobility, transfers and P identified pressure ulcers, interventions to maintain hich required [R36] " to be ned every 2 hours." The CP or action staff were to take epositioning or off-loading. on 9/17/2014 from 10:30 a.m.					
	seated in his wheel of repositioning. R36 w the noon meal at 10: to his usual table at R36 was served, the time he continued to chair. At 12:57 p.m (LPN)-B approached chair, and pushed hi room. Inside the root signs, continuing to b he was to attend a c few minutes, then ex- neither offered, nor r	and 49 minutes) R36 was chair, without off-loading or vas in the dining area prior to 30 a.m., then was relocated 11:22 a.m. before the meal. In ate his meal, during which oremain seated in the wheel licensed practical nurse R36, still seated in his wheel m from the dining area to his m, LPN-B took R36's vital be seated. LPN-B told R36 are conference meeting in a ited the room. LPN-B epositioned or off-loaded n. R36 then propelled cent day room.					
	At 1:19 p.m., nursing approached R36, an and stretch. NA-A o and encouraged him NA-D also asked R3 room. R36 refused a reposition, off load, o	assistant (NA)-A d said it was time to get up ffered to assist R36 to stand, to ambulate and stretch. 6 to use the toilet in his all of NA-A's offers to move,					
		been last repositioned					

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				ONDINC	1. 0930-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY		
		245495	B. WING			09/	18/2014		
NAME OF PROVIDER OR SUPPLIER				28	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 282	NA-A said it had been R36 had been reposi NA-A stated that of la more and more "to st things suggested, like said when R36 is her difficult" to get him to During an interview o registered nurse (RN our repos [repositioni hours." RN-D said th area had resolved, he pressure ulcers, and have been reposition "We need to be more through."	oaded him there for sure." n "almost three hours" since tioned out of his wheel chair. te, R36 had been refusing and up, or repo, or do other a brushing teeth." NA-A also e during the day, it was "very comply. n 9/18/2014 at 9:00 a.m., )-D stated "We usually do ng] at least every two at although [R36's] pressure e remained at risk for future further, that [R36] "should ed at 2 hours." RN-D said aggressive in follow n 9/18/2014 at 11:48 a.m., g (DON) stated the plan of wed" for any resident who	F	282					
a	8/22/14, indicated R7 impairment, had a sta thickness tissue loss assistance to comple and activities of daily R77's skin integrity c indicated R77 had a his right outer ankle. indicated an interven	num Data Set (MDS), dated 77 had moderate cognitive age III pressure ulcer (full ), and required extensive te transfers, bed mobility, living. are plan, dated 4/1/14, stage III pressure ulcer on Further, the care plan tion of floating R77's heels on them), and to wear							

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Facility ID: 00299

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ITE SURVEY MPLETED
		245495	B. WING			9/18/2014
	ROVIDER OR SUPPLIER		2	ITREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 BRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 282 F 310 SS=G	protective boots (Roo An observation of R7 a.m., revealed R77 Iy closed. R77 had his i face, and had his hee R77 did not have any reduce the pressure of When interviewed on nursing assistant (NA white protective boots however she was uns them now or not. NA protective boots in be room, however had n since he moved room During interview on 9 stated R77 has not us bed since moving roo When interviewed on registered nurse (RN supposed to be wear while in bed to reduce and ankle. During interview on 9 director of nursing (D R77 should have bee A facility Care Plannin 4/13, indicated implet occurs when disciplin act on the plan to del 483.25(a)(1) ADLS D	ke Boots) while in bed. 7, made on 9/17/14, at 7:05 ying in bed with his eyes blankets pulled up over his lis laying directly on the bed. protective boots on to on his heels or ankles. 9/17/14, at 2:20 p.m., )-F stated R77 used to wear is when he was lying in bed, sure if he should still have -F stated R77 wore id when he was in a different ot seen them used for R77 is a couple months prior. /17/14, at 2:38 p.m., NA-G sed the protective boots in ims a couple months prior. 9/18/14, at 9:41 a.m., )-A stated R77 was ing protective Rooke boots is the pressure to his heels /18/14, at 10:59 a.m., the ON) stated the care plan for	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F310 F 310 F 310 Continued From page 36 Immediate corrective action: Based on the comprehensive assessment of a resident, the facility must ensure that a resident's Resident R20 was reassessed by abilities in activities of daily living do not diminish therapy and new unless circumstances of the individual's clinical recommendations were condition demonstrate that diminution was unavoidable. This includes the resident's ability received. The care plan and to bathe, dress, and groom; transfer and nursing assistant care sheets ambulate; toilet; eat; and use speech, language, have been updated. or other functional communication systems. Resident R48 was reassessed by This REQUIREMENT is not met as evidenced therapy and ambulation by: guidelines have been re-Based on observation, interview, and document review, the facility failed to provide ambulation established. The care plan and services to prevent loss of function for 2 of 9 nursing assistant care sheets. residents (R20 and R48) who required physical have been updated. Daily assistance with ambulation, and were not reassessed upon a decline in ambulation. The documentation guidelines have decline in ability to ambulate resulted in actual been implemented to indicate harm for R20 and R48. completion of the task. Findings include: R20's quarterly Minimum Data Set (MDS) dated Resident R48 received a walker 7/17/14, indicated he had peripheral vascular disease, Alzheimer's, dementia, severe cognitive to assist with ambulation. impairment, ambulated once or twice in his room or corridor with assist of two, received scheduled Action as it applies to others: pain medication and had no presence of pain. R20's guarterly MDS dated 4/30/14, indicated he All residents will be screened by had severe cognitive impairment, did not walk in therapy and as indicated, based his room or corridor, received scheduled pain medication and had no presence of pain. The on the therapy screens, Care Area Assessment (CAA) dated 1/24/14, ambulation programs will be indicated R20 triggered for activities of daily living established, care planned (ADLs) due to needing supervision with dressing, hygiene, bathing, not being steady and needs a accordingly and carried out as wheelchair or walker. recommended by 10/27/2014. During interview 9/17/14, at 8:00 a.m. with

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	S FOR MEDICARE &				DMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
			2801	SOUTH HIGHWAY 169		
EVERGRE	EN TERRACE		GRA	ND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 310	Continued From pag	e 37	F 310	The policy Restorative Nursin	ng	
1 010		A)-E and NA-D both stated	1 310	Program was reviewed and		
		able to ambulate R20 and		remains current. Staff will b	<u>م</u>	
	other residents due t					
	assignments for the	past several months.		re-educated on the policy by		
		)/18/14, at 9:30 a.m. R20 was a wheelchair, a walker was		10/27/2014.		
	not observed in his r			Date of completion:		
	ambulation.	3/14, at 9:44 a.m. nursing		10/27/2014.		
		cared for R20 stated R20			.a.	
		ting over a month ago and		Recurrence will be prevente	a	
		g more combative with cares.		by:		
		e have no time to ambulate		2 Dandam weekh wievel aud	ite	
		had been occurring for the		3 Random weekly visual aud		
	past several months.	Discharge Summary dated		and documentation review		
	1/5/14, indicated R2	D was admitted for acute		audits will be completed on		
		ary to osteomyelitis, an		each unit to ensure ambulat	on	
	amputation of the rig completed on 1/3/14			programs are implemented a	bne	
		d 2/12/14, indicated he		carried out to prevent a decl		
		ependently due to recent toe		·	ine	
		ine in cognition. The care		in ambulation and that any		
		balance while standing was		resident is appropriately		
		20 was to participate in a nce_program (FMP) to		reassessed upon a decline in	,	
		vision 75-100 feet (ft.) up and		ambulation.		
	down the hallway tim					
	Review of R20's Pair	n Assessment 3.0 which was				
		indicated when asked he				
		e, rarely has pain and staff using numeric scale from				
		bain to 10 being the worst				
		20 identified their pain as a				
	"1" mild discomfort.	The assessment identified				
		l 500 milligrams (mg)				
	(analgesic) three tim	-				
	Assessment 3.0 date no pain presence, ra	ed 7/3/14, indicated R20 had				

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		
•		245495	B. WING		09/18/2014
AME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
VERGRE	EEN TERRACE			801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 310	Continued From pag	o 38	F 310		
	numeric rating was C identified R20 denied mg three times a day effective for pain reli- dated 8/21/14, and 9 from the 7/3/14, asse denied pain and Tyle effective for pain reli- Review of R20's pro- 9/22/14, did not indi pain or discomfort fro- January 2014. The facility's nursing undated, directed sta with a front wheeled two times daily. A W Guidelines Restorati Maintenance Recom physical therapy (PT walked with a FWW two self-performance Review of the progre and facility assessm September 18, 2014 being ambulated 75- walker (FWW), and directed by the Walk Guidelines Restorati Maintenance Recom recommended for R During interview 9/1 therapist (PT)-A sta that R20 was not am he had not been see 4/9/14, when he'd st	<ul> <li>No. The assessment</li> <li>d pain, and the Tylenol 500</li> <li>y on 6/20/14, and seems</li> <li>ef. The Pain Assessment 3.0</li> <li>N/21/14, remained unchanged</li> <li>essment indicating resident</li> <li>enol extra strength seems</li> <li>ef.</li> <li>gress notes from 7/1/14 thru</li> <li>cate R20 was having any</li> <li>pom his toe amputation in</li> <li>assistant care sheet</li> <li>aff to ambulate R20 75-100 ft.</li> <li>walker (FWW) and gait belt</li> <li>alking/Ambulation Program</li> <li>ve Nursing/Functional</li> <li>mendations authorized by</li> <li>dated 4/9/14, indicated R20</li> <li>and a gait belt 75-100 ft. with</li> <li>e and two support.</li> <li>ess notes, physician notes</li> <li>ent from June 20, 2014 to</li> <li>did not identify R20 was</li> <li>100 ft. with a front wheeled</li> <li>gait belt two times daily, as</li> <li>ing/Ambulation Program</li> <li>ve Nursing/Functional</li> <li>mendations which PT</li> <li>20.</li> <li>8/14, at 9:01 a.m. physical</li> <li>ted she hadn't been informed</li> <li>abulating, and confirmed that</li> <li>en by physical therapy since</li> <li>arted on his</li> <li>program. PT-A then stated</li> </ul>		Audits will be completed for period of 90 days and audit results will be reviewed by t QA committee to determine need for ongoing monitorin <b>The correction will be</b> <b>monitored by:</b> Director of Nursing and/or designee.	the e the

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A, BUILDING 245495 B. WING 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE **GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 310 | Continued From page 39 F 310 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 Facility ID: 00299 If continuation sheet Page 40 of 106 Event ID: EY5V11 FORM CMS-2567(02-99) Previous Versions Obsolete

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/08/2014 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245495	B, WING_		0	9/18/2014
NAME OF P	ROVIDER OR SUPPLIER	<b>1</b>		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
EVERGRE	EEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETION DATE
F 310	current level is "0 fee indicated "Therapy is bilateral ankle ROM, along with updating of appropriate for the pa- with behavior disturba- patient is at risk for fu The referral indicated acetaminophen for pa- was currently having During interview 9/18 stated that R20 started that he was able to a front wheeled walker, attempted to ambulat and R20 would not a spoken to the staff ar [R20] was no longer staff are supposed to declining or is no long FMP, but stated she that R20 was not am stated she was going pick him back up aga During a phone inter PT-A stated that if a during her evaluation document that on the Although R20 had a ambulation, the facili which resulted in a d was not reassessed, for R20. R48's quarterly MDS had a diagnosis of all accident (CVA), was transferred with limite	t." The evaluation also necessary for improving transfers, and ambulation urrent FMP to make it atient due to his dementia ances. Without therapy orther functional decline." R20 received ain but did not indicate R20 any pain. /14, at 9:01 a.m. PT-A ed on a FMP on 4/19/14, and mbulate 75-100 ft. with his . The PT-A stated she had the R20 yesterday (9/17/14), mbulate with her. She had had they informed her he ambulating. PT-A stated o inform her if a resident is ger is able to complete their had never been informed bulating anymore. PT-A g to try and get approval to ain for therapy. view 9/22/14, at 11:40 a.m. resident was observed to have pain she would e evaluation. FMP to assist with ty failed to ambulate R20, ecline in ambulation which and resulted in actual harm		B10	If continuation she	et Page 41 of 106

		D HUMAN SERVICES			F	TED: 10/08/2014 ORM APPROVED NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		245495	B. WING	-		09/18/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 310	Continued From page		F 3 <sup>.</sup>	10		
, , ,	5/23/13 he was place ft. twice daily with wa care sheet undated, i ambulate 100 ft. twice R48's FMP documen indicated under comr identified "[R48] to ar with walker and assis demonstrate benefits ability to stand & tran During interview 9/17 and NA-D both stated ambulate R48 or thei	e daily with a walker. tation dated May 2013 nents section of the FMP nbulation 100 ft. twice a day				
	8:20 a.m. R48 stated the staff do not offer stated if staff would o would not refuse. The in his room. During interview on S stated the facility has completed by their re- time they do not hav- implementing the res- not had any for at lea COTA-A stated, "If w	storative program, and have ast three weeks or longer. re don't have any staff to do				
	implemented for any	ess notes, and FMPs from		Facility ID: 00299	16 45	sheet Page 42 of 106

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		245495	B. WING			09/18/2014
NAME OF P	ROVIDER OR SUPPLIER		··· •	STREET ADDRESS, CITY	STATE, ZIP CODE	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY GRAND RAPIDS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI/ DEFICIENCY)	
F 310	June 2014 to Septem R48 had been ambul a walker, as identified During interview 9/18 stated she would be ambulate. Review of the Physic Evaluation dated 9/10 indicated he was re-ec check for a decline. was able to ambulate	nber 8, 2014, did not identify ated 100 ft. twice a day with d by the 5/23/13 FMP. B/14, at 9:01 a.m. PT-A reassessing R48's ability to al Therapy Plan of Care	F 3	10	, ,	
	PT-A stated that whe a decline he was only and the program initia stated she had recon ambulate R48 up to walker and assistanc A request was made	100 feet with front wheeled e of two staff. to the facility for the May				
	stated they have an i restorative nursing at member who was in walked off of the job they currently have n program. Although R48 had a ambulation, the facilit which resulted in a do was not reassessed, for R48.	7/14, at 11:30 a.m. the DON ssue with their FMP and nd indicated the staff charge of the program had the last week of August and o one in charge of the				
	7(02-99) Previous Versions Ob		///	Facility ID: 00299	if continue	tion sheet Page 43 of <sup>-</sup>

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING	09/18/2014			
NAME OF PROVIDER OR SUPPLIER			STF			
EVERGRE	EN TERRACE			1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE CO	(X5) MPLETIO DATE
F 310	attain his or her max promote each reside of physical, mental a The policy further inco programs must be re- and need to address changes are made, y This needs to be doo individualized and a maintaining or impro- motion (ROM), conti about how this is ha The policy also indic assess progress or I made, why program discontinue in some maintaining or resto residents activity of 483.25(a)(2) TREAT IMPROVE/MAINTAI A resident is given th services to maintain specified in paragra This REQUIREMEN by: Based on observati review, the facility fa consistently implem services to improve ambulation ability for	ad the policy to, ents ability to adapt to or imum functional potential. To nt's highest practicable level nd psychosocial functioning." dicated all restorative nursing eviewed by a registered nurse how they are working and if why the changes were made. The quarterly. They must be ddress how they are ving ambulation, range of nence etc. and be specific opening for each resident. ated the notes need to ack of progress, changes is needed to continue (or cases), and why program is ring a function that affects the daily living skills (ADL'S). MENT/SERVICES TO N ADLS the appropriate treatment and or improve his or her abilities oh (a)(1) of this section. T is not met as evidenced on, interview and document tiled to provide and ent restorative ambulation and/or maintain the resident's r 7 of 9 residents (R27, R22, 4 and R18) reviewed for	F 310	F311 Immediate corrective ad Residents R27, 22, 24, 55 and 18 were reassessed therapy and ambulation guidelines have been re- established. The care pl nursing assistant care sh have been updated. Da documentation guidelin been implemented to in completion of the task.	ction: 3, 14 by ans and neets ily es have	Sold Start

Facility ID: 00299

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If continuation sheet Page 44 of 106

		D HUMAN SERVICES					PPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245495			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 09/18/2014	
		B. WING					
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
EVEDODE	EVERGREEN TERRACE			28	01 SOUTH HIGHWAY 169		
EVERGRE				GI	RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	······································				- The care plan and nursing		
F 311	Continued From page	e 44	F	311	assistant care sheets have be	en	
	Findings include:				updated. Daily documentati	on	
	R27's annual Minimu	m Data Set (MDS) dated			guidelines have been		
		had diabetes mellitus and			implemented to indicate		
	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				completion of the task.		
					Action as it applies to other	s:	
					All residents will be screened	d by	
		er (FWW), gait belt and			therapy and as indicated, ba		
	assist of one staff.				on the therapy screens, nurs	1	
		4			rehabilitation and ambulation		
		nt care sheet undated mbulate 90 to 100 ft twice			programs will be established		
	daily. R27's Walking				care planned accordingly an		
	Guidelines Restorativ				carried out as	u	
		nendations dated 10/15/13, oulate 90 to 100 ft. twice			carried out as		
	daily and to increase				The policy Restorative Nursi	ng	
					Program was reviewed and		
		lan of Care Evaluation dated reason for referral for			remains current. Staff will b	e	
		opriateness of FMP for			re-educated on the policy by	/	
	ambulation in order to	check for any possible			10/27/2014.		
1	decline. The referral						
1		level was stand by assist for mbulated 100 ft. needing			Date of completion:		
		s current level indicated he			10/27/2014.		
		'5 ft. with contact guard					
	assist.				Recurrence will be prevente	:u	
	Review of the facility Evergreen Terrace				by:		
	Documentation Surve	ey Report for July 2014 to			3 Random weekly visual aud	lits	
	September 18th, 2014, did not identify "ambulating 90 to 100 feet (ft.) two times daily				and documentation review		
		walker (FWW), gait belt and			audits will be completed on		
	assist of one staff." t	his was started on 10/15/13.			each unit to ensure ambulat	ion	
	There was no indicat	ion this has been completed			-		
FORM CMS-256	57(02-99) Previous Versions Obs	solete Event ID: EY5	V11	Fac	cility ID: 00299 If contin	uation sheet Pa	age 45 of 106

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
	245495		B. WING	······	09/18/2014		
NAME OF PROVIDER OR SUPPLIER			28	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	······································		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 311	Functional Mainter by PT. During interview 9/ therapist (PT)-A stanow ambulates 174 R22's annual MDS had arthritis and os indicated she trans ambulated indeper ambulated in the c set up or physical a cognitively intact. R22's care plan da ambulate although a FWW. The care ambulate up to 100 R22's Walking/Ami Restorative Nursin Recommendations uses a FWW and a assistance (SBA). Nursing assistant of ambulate up to 100 one and FWW. A Physical Therapy 9/17/14, indicated and now can ambu	the 10/15/13 In Program Guidelines nance Recommendations sheet 18/14, at 9:05 a.m. physical ated she evaluated R27 and he 5 ft. dated 7/1/14, indicated she steoporosis. The MDS further iferred independently and ndently in her room and orridor once or twice with no assist from staff and is ted 1/20/14, indicated she can she chooses not to, and uses plan further indicated she can oft. daily with a gait belt. bulation Program Guidelines g Functional Maintenance is dated 6/10/14 indicated she ambulates 100ft with stand by care sheet undated indicated to oft, with gait belt and assist of y Plan of Care Evaluation dated she was able to ambulate 70 ft.	F 311	programs are implement carried out to prevent a in ambulation and that a resident is appropriately reassessed upon a declin ambulation. Audits will be completed period of 90 days and au results will be reviewed QA committee to determ need for ongoing monitor <b>The correction will be monitored by:</b> Director of Nursing and/ designee.	decline any / ne in d for a udit by the nine the oring.		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONP NC	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245495		B. WING		······	09/	18/2014	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169		
EVERGREEN TERRACE					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 PROVIDER'S PLAN PREFIX (EACH CORRECTIVE / TAG CROSS-REFERENCED T DEFICI		CTION SHOULD BE	
F 311	ambulating 100 ft. w which was started or indication this has be recommend on the 6 Program Guidelines Recommendations s During interview 9/18 stated R22 has rema ambulation and has R24's quarterly MDS had dementia and w and needed supervis ambulate in his room cognitively intact. R24's care plan date ambulate independe prefers to use his wa and he uses a FVWV plan indicated he is 400 ft. R24's Walking/Ambu Restorative Nursing Recommendations of to ambulate 400 ft. w and stand by assist Nursing assistant ca ambulate 400 ft. twice A Physical Therapy 9/17/14, indicated he	4, did not identify he was ith FWW and SBA daily" n 06/10/14. There was no seen completed as /10/14, Walking/Ambulation Functional Maintenance heet by PT. 3/14, at 9:10 a.m. with PT-A ained the same with her not had a decline. 6 dated 7/8/14, indicated he as independent with transfers sion and assist of one to n and corridor and was ed 8/27/13, indicated he can ently in his room and he alker while going on outings / and transfer belt. The care to ambulate twice daily for Ulation Program Guidelines Functional Maintenance dated 9/17/14, indicated he is with a seated rest and FWW (SBA). ure sheet undated indicated to	F	31			

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

Facility ID: 00299

If continuation sheet Page 47 of 106

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
245495			B. WING_			09	/18/2014	
NAME OF PROVIDER OR SUPPLIER EVERGREEN TERRACE				280	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE	
F 311	Review of the facility Documentation Survers September 18th, 201 ambulating 400 ft. wit FWW and SBA" whice There was no indicat as recommend on the Walking/Ambulation Functional Maintenan by PT. During interview 9/18 stated R24 has not he ambulation. R53's admission MD she had a thyroid dis assist of two with trai in her room or corrid indicated she is cogr R53's care plan date on a FMP to ambulat belt and assist of one on her left tiptoe due and to take heel prof R53's Walking/Ambu Restorative Nursing Recommendations c ambulates 200 ft. with R53's Physical The dated dated 9/17/14	Evergreen Terrace ey Report for July 2014 4, did not identify he w th one seated rest with th was started on 8/27/ ion this has been comp e 8/27/13, Program Guidelines nece Recommendations 8/14, at 9:12 a.m. with I ad a decline in his S dated 6/26/14, indicated earder and needed extension for the MDS further nitively intact. d 6/20/14, indicated sh te 200 ft. with a FWW, e staff and resident is to to heel wound on left I tector off when walking plation Program Guideli Functional Maintenance lated 8/27/14, indicated th a FWW, gait belt an (CGA). re sheet undated indicated	ras 13. Deted sheet PT-A ated ensive rulate re is gait o walk heel ines re d sheed d ated to uation re to	F	311			
FORM CMS-25	67(02-99) Previous Versions Ob	osolete	Event ID: EY5V11		Fac	ility ID: 00299	If continuation shee	et Page 48 of 106

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245495	B. WING				09/18/2014
NAME OF PF	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	Continued From page	e 48	F	31	1		
	September 18th, 201 "ambulation 200 ft wi contact guard assist and p.m." which was was no indication this a day as recommend Walking/Ambulation	ey Report for August 2014 to 4, did not identify th FWW, gait belt and (CGA) twice per day a.m. started on 8/27/14. There is has been completed twice to n the 8/27/14					
Å	that she only walks t she stated she would to walk in the hall an	7/14, at 8:20 a.m. R53 stated o the bathroom and back, d need assistance from staff d they do not offer to walk I the staff are not offering to nd R139.					
	During interview 9/10 stated she had just s has had no decline.	8/14, at 9:18  a.m. with PT-A started her on FMP and she					
	he transferred with s	DS dated 6/27/14, indicated upervision and set up and m independently with no help ognitively impaired.					
J	R139's care plan da on a FMP and ambu CGA.	ted 9/17/14, indicated he is lates 200 ft. with FWW and					
	Restorative Nursing Recommendations	oulation Program Guidelines Functional Maintenance dated 8/29/14, indicated he D ft. with FWW and CGA.					
	Review of the facility	/ Evergreen Terrace					

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

Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 49 of 106

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/08/2014 FORM APPROVED

PHE/IX TX0     Description of the description of d	<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-0391
NAME OF PROVIDER OR SUPPLER     STREET ADORESS, CITY, STATE, ZIP CODE       EVERGREEN TERRACE     STREET ADORESS, CITY, STATE, ZIP CODE       (M, ID PREFIX TAG     SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL RECULTION FOLLID BE EACH CORRECTIVE ACTION SHOLD BE DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY MUST BE PRECEDED BY FULL RECULTION FOLLID BE DEFICIENCY MUST BE PRECEDED BY FULL TAG     D PREFIX TAG     D PROMERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX     D PREFIX TAG     D PROMERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF THE ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY OF CORRECTIVE ACTION SHOLD BE DEFICIENCY (EACH CORRECTIVE ACTION SHOLD BE DEFIC								
2201 SOUTH HIGHWAY 189 GRAIN RAPIDS, MN 55744       (Mail ID GRAIN RAPIDS, MN 55744       (Mail ID GRAIN RAPIDS, MN 55744       (Pach Connective Action should be REGULATORY OR LSC IDENTIFYING INFORMATION)       To a       F 311       Continued From page 49       F 311       Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 2001 with FWW and contact guard assist (CGA) twice per day" which was started on 8/2/2/14. There was no indication this has been completed twice a day as recommend on the 8/2/2/14. 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 docline and she did not re-evaluate him.       R14's quarterly MDS dated 5/28/14, indicated she had dementia and a corebral vascular accident (CVA) the MDS further indicated she needed extensive asists of one to transfer and ambulate and severely cognitively impaired.       R14's quarterly MDS dated 5/28/14, indicated she had dementia and a corebral vascular accident (CVA) the MDS further indicated she had on a restorative nursing program the care plan did not address her functional Maintenance Recommendations dated 5/28/14, indicated R14 ambulated 30 to 80 ft. with FWW and satists vith mobilify.			245495	B. WING		·	09/	/18/2014
EVERGREEN TERRACE     GRAND RAPIDS, MN 55744       OW ID PREENK TAG     SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WIST BE RECEEDED BY FULL REQULATORY OR LSC DENTIFYING INFORMATION)     ID PREENK REQULATORY OR LSC DENTIFYING INFORMATION)     ID PREENK TAG     IP CONTRICT PREEND BY INFORMATION (EACH DEPICIENCY WIST BE APPROPRIATE Decommentation 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. Waiking/Ambulation Program Guidelines Functional Maintenance Recommend on the 8/29/14. Waiking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT.     F 311       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 axtensive assist of one to transfer and ambulate and severely cognitively impaired.       R14's guarterly MDS dated 5/28/14, indicated she is on a restorative nursing program Guidelines Restorative Nursing Functional Maintenance Recommendational status with mobility.       R14's Waiking/Ambulation Program Guidelines Restorative Nursing Functional Maintenance Recommendationa dated 5/28/14, indicated R14 ambulated 30 to 80. ft. with a FWW and assist of	NAME OF PF	ROVIDER OR SUPPLIER	······································					
Primit         (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)           F 311         Continued From page 49         F 311           Documentation Survey Report for August 2014 to September 18th, 2014, did not identify "ambulation 2004 with FVWW and contact guard assist (CGA) twice per day" which was started on 8/28/14. There was no indication this has been completed twice ad ay as recommend on the 8/29/14. Walking/Ambulation Program Guidelines Functional Maintenance Recommendations sheet by PT.         F 311           Nursing assistant care sheet undated indicated to ambulate 200 ft. with FVW 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 dedine 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 Recommendations dated 5/28/14, indicated R14 ambulated 20 to 80 ft. with a FVW and assist of	EVERGRE	EN TERRACE						r
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 ambulated 714 ambulated 30 to 80 ft, with a FWW and assist of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
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	Documentation Surve September 18th, 201 "ambulation 200 ft wi assist (CGA) twice pe 8/29/14. There was completed twice a da 8/29/14 Walking/Am Functional Maintenar by PT. Nursing assistant car ambulate 200 ft. with During interview 9/18 stated he had just sta has had no decline a him. R14's quarterly MDS had dementia and a (CVA) the MDS furth extensive assist of or and severely cognitiv R14's care plan date on a restorative nurs did not address her f R14's Walking/Ambu Restorative Nursing Recommendations d ambulated 30 to 80 f two. Nursing assistant ca ambulate twice daily minimal assist.	ey Report for August 2014 to 4, did not identify th FVW and contact guard er day" which was started on in onidication this has been by as recommend on the bulation Program Guidelines nee Recommendations sheet re sheet undated indicated to FWW and CGA. 8/14, at 9:18 a.m. PT-A arted him on a FMP and he nd she did not re-evaluate dated 5/28/14, indicated she cerebral vascular accident er indicated she needed ne to transfer and ambulate vely impaired. d 9/12/14, indicated she is ing program the care plan unctional status with mobility. Idation Program Guidelines Functional Maintenance iated 5/28/14, indicated R14 t. with a FWW and assist of re sheet undated indicated to 30 to 80 ft. with FWW and	F	31	1		

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

Event ID: EY5V11

Facility ID: 00299

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 311	Review of the facility Documentation Surve September 18th, 201 "ambulation 30 to 80 day" which was starte no indication this has day as recommend of Walking/Ambulation Functional Maintenan by PT. During interview 9/18 stated R14 has had no During interview 9/17 nursing assistant (N/ ambulate her resider time on her shift. NA to ambulate her resider time of nursing (D issue with there func and restorative nursi member who was un walked off of the job they currently have r program and realized	ated she was able to bow can ambulate 40 ft. Evergreen Terrace ey Report for July 2014 to 4, did not identify feet with FWW twice per ed on 5/28/14. There was a been completed two times a on the 5/28/14 Program Guidelines nee Recommendations sheet B/14, at 9:20 a.m. with PT-A no decline in her mobility. 7/14, at 8:00 a.m. with A)-E stated she is unable to nts due to not having enough A-D also stated she is unable dents. 7/14, at 11:30 a.m. the DON) stated they had an tional maintenance (FMP) ng she indicated the staff neharged of the program had the last week of august and no one in charge of the	F 3	11	
	identified R18 had d	mum Data Set (MDS) iagnosis of dementia, with pairment, no behavior	5V11	Fadlity ID: 00299	If continuation sheet Page 51 of 106

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED

STATE SHARE OF DEPOLICIENCIES       (X1) PROVIDER VILLER LIDENTIFICATION NARRES:       021 MULTIPE 2016TRUCTION       (V3) SATE SHIFTY CONFLICT         INME OF PROVIDER OF SUPPLIER       245495       8: WANG       STREET ADDRESS, CITY, STATE, LP CODE 2015 SUPPLIER CLEAR CE       STREET ADDRESS, CITY, STATE, LP CODE 2015 SUPPLIER CLEAR CE       STREET ADDRESS, CITY, STATE, LP CODE 2015 SUPPLIER CLEAR CE       STREET ADDRESS, CITY, STATE, LP CODE 2015 SUPPLIER CLEAR CE       STREET ADDRESS, CITY, STATE, LP CODE 2015 SUPPLIER CLEAR CE       Definition of CL	CENTER	S FOR MEDICARE &	MEDICAID SERVICES	· • · · · · · · · · · · · · · · · · · ·			OMB NC	0938-0391
MARLOF ROMUER OF SUPPLIER     STREET ADDRESS, OTV, STATE, 3P CODE 2015 SUTH HIGHWAY 16 2015 SUMMARY STATEMENT OF DEFICIENCIES (RAND RAPIDS, NN 155744       (V41 ID PERCENT TSD     ISUMMARY STATEMENT OF DEFICIENCIES (RAND RAPIDS, NN 155744       (V41 ID PERCENT, RESULTORY OR LSC IDENTFYING INFORMATION)     ID PERCENT TSD       F 311     Continued From page 51 (Stuttbances and needed extensive assistance for activities of daily living (ADL's) including ambulation.     F 311       During interview on 9/17/14 at 7-45 a.m. nursing assistant (NA)-1 stated they assist R18 to antibulate. In the fallway in the afternoon, then when the next shift comes, they also help him ambulate. R18 in the afternoon.     F 311       During interview on 9/17/2014 at 12:40 p.m. trained medication assistant (TMA)-P stated they ambulate. R18 in the afternoon.     F 311       During observation on 9/17/2014 at 12:40 p.m. trained medication assistant (TMA)-P stated they ambulate. R18 in the afternoon.     F 311       During observation on 9/17/2014 at 12:40 p.m. trained medication assistant (TMA)-P stated they ambulate W18 his front wheelde waker, gat belit, and the existigance of trained medication aide (TMA)-P. His gait was unsteady, and had a limp on his right is tabe unsubale from the dining room approximately 300 feet in the hallway.       Review of the PT [physical therapy] Therapist Progress & Discharge Summary dated 7/8/14 (dentified R18 has to ambulate on TP dated 7/5/14 (dentified R18 was to ambulate with front wheeld waker and gait belit, 300 feet datify three times a	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
EVERGREEN TERACE     281 SOUTH HIGHWAY 19 GRAND RAPIDS, MN 55744       PHETR TOO     SUMMERY STATEMENT OF DEFICIENCY MUST RE PRECIDED BY FULL (EACH CORRECTING ACTION SHOULD BE REGULTORY OR ISC IDENTIFYING INFORMATION)     D PHETR TAC     D PHETR TAC     D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     0,000 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     0,0000 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY			245495	B. WING			09/	18/2014
EVERGREEN TERRACE     BRAND RAPIDS, MN 55744       (%4) D PRETIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST BE PRECIDE NT FUL REGULATION OF LISC DEMTIN-TING NUMBER REGULATION OF REGULATION OF REGULATION REFLACED AND DETINING REFLACED AND DETINING NUMBER REGULATION OF REGULATION OF REGULATION REFLACED AND DETINING NUMBER REFLACED AND DETINING REFLACED AND DETINING NUMBER REFLACED AND DET	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Prefix TxG     (EACH CERTECTION Y JULY THE INFECTION INFORMATION)     PREFIX TxG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE PROPORATE     COMMETTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE PROPORATE       F 311     Continued From page 51     F 311       disturbances and needed extensive assistance for activities of daily living (ADL's) including ambulation.     F 311       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 affermoon, then when the next shift comes, they also help him ambulate. In the hallway in the affermoon, then when the next shift comes, they also help him ambulate R18 in the affermoon.       During interview on 9/17/12014 at 12:40 p.m. trained medication assistant (TMA)-P stated they ambulate R18 in the affermoon.       During observation on 9/17/14 at 2:00 p.m. R18 was in the dning room and was assisted to ambulate with his front wheeled walker, gat 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 dning room approximately 300 feet in the hallway.       Review of the PT [physical therapy] Therapist Progress & Discharge Summary dated 7/8/14 itentified R18 had made gains in strength, transfers, and ambulation physically, however is limited to by dementia for safety awaraness. The plan was for R16 to have a restorative nursing program and functional maintenance program Guidelines Functional Maintenance Recommendations sheet from T dated 7/5/14 identified R18 was to ambulate with front wheeled walker and gait bett, 300 feet data this wheeled walker and gait bett, 300 feet data this wheeled	EVERGRE	EN TERRACE			ł			
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 sforth 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 Guidelines Functional Maintenance Recommendations sheet from PT dated 7/5/14 Identified R18 was to ambulate on PT dated 7/5/14 Identified R18 was to ambulate on throw unsing program and functional Maintenance	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 311	disturbances and nee for activities of daily I ambulation. During in interview on nursing assistant (N/ ambulate in the hallw when the next shift c ambulate. He does w no behaviors. During interview on O trained medication at ambulate R18 in the During observation of was in the dining roo ambulate with his fro and the assistance of (TMA)-P. His gait w on his right side but the dining room appu- hallway. Review of the PT [pf Progress & Discharg identified R18 had m transfers, and ambu limited to by dement plan was for R18 to program and functio ambulation. The facility Walking/ Guidelines Function Recommendations s identified R18 was to walker and gait belt,	aded extensive assistance iving (ADL's) including n 9/17/14 at 7:45 a.m. A)-I stated they assist R18 to vay in the afternoon, then omes, they also help him vell with ambulating and has 09/17/2014 at 12:40 p.m. ssistant (TMA)-P stated they afternoon. n 9/17/14 at 2:00 p.m. R18 m and was assisted to nt wheeled walker, gait belt, f trained medication aide as unsteady, and had a limp was able to ambulate from roximately 300 feet in the hysical therapy] Therapist te Summary dated 7/8/14 hade gains in strength, lation physically, however is ia for safety awareness. The have a restorative nursing nal maintenance program for Ambulation Program al Maintenance sheet from PT dated 7/5/14 to ambulate with front wheeled 300 feet daily three times a	F	31			

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

Facility ID: 00299

If continuation she 3g

<u>ENTER</u>	<u>S FOR MEDICARE &amp;</u>	MEDICAID SERVICES				OMB	NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ATE SURVEY OMPLETED
		245495	B. WING				09/18/2014
IAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 311	Continued From pag	e 52	F 3	311			
	to walk 300 feet with	FWW device"					
	on 7/8/14 identified F	e Summary sheet completed R18 had gained in strength,					
	residents ability to pe functional mobility w	d balance have impacted the erform self care, and ith a reduction in physical sistance and requires					
	frequent cues for sat instructions were to maintenance progra	ety. The discharge plan and start with functional m designed to maintain gains					
	achieved as a result	of OT.					
	a restorative nursing	ited 7/5/14 from OT identified recommendation which evel 1 x [times] 15 min					
	problem with falls pr	pdated on 7/21/14 identified a eventions due to increased were directed to "ambulate					
	to all destinations, n days per week, and FWW [front wheeled	u-step 15 minutes a day 6 ambulate 300 ft [feet] with I walker], SB [stand by] of 1 facility Pocket Care Plan (not					
	dated), which the nu identify what needs residents directed th	irsing assistants use to to be completed for the ne NA's to "ambulate 300 ft ait belt." There was no					
	indication of frequer there any mention of even though therap	ncy of ambulation nor was f the Nu-Step in the care plan y had made these					
	recommendations o	n 7/8/14.					
	Documentation Sur	y Evergreen Terrace vey Report for July 2014 on 300 ft with FWW and SBA					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			09	18/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	EN TERRACE			2801	I SOUTH HIGHWAY 169			
EVERGRE				_ GR/	AND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 311	F 311 Continued From page 53		F	311				
1	and gait belt Q [even 7/21/14 for 6-2 and 2 indication this has be	y] shift." this was started on -10 shifts. There was no een completed three times a						
		Program Guidelines nce Recommendations sheet						
	implemented until 7/2	bulation had not been 21/14, and not 7/5/14, as king/Ambulation Program al Maintenance						
	Recommendation sh Documentation Surv ambulation was com	eet. The August 2014 ey Report sheet identified pleted twice a day and not						
ł	Also, there was no ir x [times] 15 min [mir been completed as r	recommended by therapy. ndication the "Nu-Step level 1 nutes] 6 x/wk [week]," had recommended for the nce program by OT on 7/5/14.						
	During interview on	9/17/14 at 2:13 p.m.						
	the facility has a fun which was to be con	by Assistant (OTA)-A stated ctional maintenance program npleted by their restorative						
	that are implementin and have not had ar	ne they do not have any staff ng the restorative program, ny for at least three weeks or						
,	to do the programs	ed if we don't have any staff so the programs have not or any of the residents, for eks, maybe months.						
	stated they ambulate	09/17/2014 at 2:25 p.m. NA-I e R18 in the afternoon, and						
	had any restorative	II. She stated they have not aide at this time to complete enance program of some of						

CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE C	CONSTRUCTION	FORM OMB NC (X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	IG		COMP	LETED
		245495	B. WING			09/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX . TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	<u> </u>			-+-			
F 311		/18/14 at 2:30 p.m. licensed	F3	311			
	not receive any exercive receive any exercited R18 ambulate the afternoon, but will	-B stated the resident does ise with the Nu-Step and es with staff in the hallway in be adding some ambulation , along with ambulating in					
F 312	and R18 were placed to complete there pro therapy. 483.25(a)(3) ADL CA	RE PROVIDED FOR	F 3	312			
SS=D	daily living receives t	DENTS able to carry out activities of he necessary services to on, grooming, and personal			F312 Immediate corrective action Resident R77 received immediate assistance with	on:	
	by: Based on observation review, the facility fait grooming (nail care) whom was depender was reviewed for act grooming. Findings Include: R77's quarterly Minin 8/22/14, indicated R3	F is not met as evidenced on, interview, and document led to provide routine for 1 of 3 residents (R77) at on staff for care, whom ivities of daily living and num Data Set (MDS), dated 77 had an active diagnosis of quired extensive assistance			fingernail care. Action as it applies to other All residents will receive fingernail care according to their personal preference. nursing assistant care cards be reviewed to assure resid grooming needs, to include care preferences, are include	) All s will dent e nail	

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

Facility ID: 00299

If continuation sheet Page 55 of 106

		ID HUMAN SERVICES MEDICAID SERVICES		C	FORM APPROVE
ATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
AME OF PI	ROVIDER OR SUPPLIER	l	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			2801	SOUTH HIGHWAY 169	
VERGRE			GRA	ND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
F 312	Continued From page	e 55	F 312		
i		sonal hygiene, and had		The policy and procedure for	
	moderate cognitive in			Nursing Care Standards was	
		10/0/44		reviewed on 9/23/2014 and	
		ed 9/8/14, indicated R77 with dressing, grooming, and		remains current. Nursing stat	ff
	bathing. Further, the	care plan indicated R77		will be re-educated on the	
	required weekly nail	care.			
	During observation o	n 9/16/14, at 9:22 a.m., R77		policy 10/27/2014.	
		eelchair in his room. R77		Date of completion:	
	had long, un-trimmed	l fingernails on both hands, e underneath several of the		10/27/2014.	
	nails.			Recurrence will be prevente	d
		tions of R77 on 9/17/14 at		by:	
	7:08 a.m., and 9/18/14 at 8:19 a.m., were made and R77 continued to have un-trimmed, dirty fingernails.			3 Random weekly visual aud	its
				and resident interviews will	
		0/40/44 - + 0:40 - m D77		conducted on each unit to	
	When interviewed or	n 9/18/14, at 8:19 a.m., R77 his fingernails to be trimmed		ensure residents are receivir	ng
	and kept shorter. R7	77's family member, whom		assistance with grooming	0
	was present during i	nterview, stated at times s/he		according to their personal	
	would take an emery	/ board (nail file) to R77's vere long and not kept		preferences in a manner wh	ich
	trimmed.			maintains or enhances each	
		9/17/14, at 9:04 a.m., nursing		resident's dignity.	
	assistant (NA)-D sta	ted fingernails should be lent's bath day.  Further,		The correction will be	
	NA-D stated R77's fi clean and trimmed.	ngernails should have been		monitored by:	
				Director of Nursing and/or	
	registered nurse (RN from staff to complet cares. RN-A stated preference to have b	9/18/14, at 9:29 a.m., N)-A stated R77 required help te grooming and personal R77 had no identified ong fingernails, and his		designee.	
	fingernails should ha	ave been trimmed by a nurse.			

OFNED		D HUMAN SERVICES MEDICAID SERVICES		*	FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 312	Continued From page	9 56	F 312		
F 314 SS=G	director of nursing (D expected to trim and Further, the DON star have been trimmed a A facility Nursing Car 8/09, indicated stands resident is provided to of care. Further, the and toenails shall be 483.25(c) TREATMEI PREVENT/HEAL PRI Based on the compre- resident, the facility n who enters the facility does not develop pre- individual's clinical co- they were unavoidab pressure sores receiva services to promote h prevent new sores from This REQUIREMENT by: Based on observation review, the facility fail accordance with an e- physician orders, to p- infection for 2 of 3 res-	NT/SVCS TO ESSURE SORES whensive assessment of a must ensure that a resident y without pressure sores ssure sores unless the ondition demonstrates that le; and a resident having yes necessary treatment and nealing, prevent infection and om developing.	F 314	F314 Immediate corrective acti Resident #77 dressing was changed per MD order on 9/18/14. All nurses assigned care for resident #77 on 9/ and 9/17 were counseled re-educated on following the MD order of viewing and changing the dressing dail	ed to /16 and the y.

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

Facility ID: 00299

If continuation sheet Page 57 of 106

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE COMP	
		245495	B. WING		09/	18/2014
				EET ADDRESS, CITY, STATE, ZIP CODE SOUTH HIGHWAY 169		
EVERGRE			GR/	AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From page 57 Findings include:		F 314			
	8/22/14, indicated R7 impairment, had a dia (a metabolic disease sugars over a long pe extensive assistance mobility and activities stage III pressure uld slough may be prese depth of tissue loss) (centimeter) X (by) 1, granulation tissue (pi moist, granular apper R77's care plan, revis had a stage III press ankle. The care plan be free of skin breake interventions of, "Tre heels while in bed," a wear in bed." R77's Order Summa indicated R77 should wound (pressure uld saline, dressed with used for wounds with covered with Optifoa absorb wound draina Report, signed by the indicated R77 should daily. During observation of was lying in bed with	nk or red tissue with shiny,		Resident #36 was reass completing a new Tissu Tolerance Test to confir necessary times reposit or off-loading should be performed. His refusal comply was added to the plan and resident was e and given information of Risks/Benefits of repositioning/off-loadin assessment. The results new TTT will be shared Dialysis Unit. Action as it applies to of The policy and procedur repositioning and press ulcer care were review remain current.	e m the ioning to to e care explained on the ng per s of the with the others: re for sure	

STATEMENT	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE C	ONSTRUCTION	OMB N (X3) DAT	M APPROVE <u>0. 0938-03</u> E SURVEY PLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		001	FLEIED
		245495	B. WING			09	/18/2014
				280	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HIGHWAY 169		
	·····	· · · · · · · · · · · · · · · · · · ·	· · ·	GR	AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
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		F	314	All residents with pressure ulcers or at high risk of ski breakdown will be reviewe assure their most recent assessments are current at care plans reflect their MD ordered treatments and repositioning/off-loading schedules. The nursing assistant care sheets will a be reviewed to assure they	n ed to nd Iso	
	months ago. When interviewed on registered nurse (RN supposed to be wear	a different room a few 9/18/14, at 9:41 a.m., )-A stated R77 was ing protective Rooke boots e the pressure to his heels			accurate.		
	9/18/14 at 10:05 a.m. treatment for R77's ri was to cleanse it with calcium alginate, and Optifoam everyday. sock from his foot rev his right ankle. There dressing which read, Further, the dressing written underneath th resident's room at 10 with RN-C. RN-D stat dressing had been pl	f pressure ulcer care on RN-C stated the current ght ankle pressure ulcer normal saline, dress with cover the ulcer with RN-C removed R77's cotton realing a foam dressing to a was writing on the foam "9-19" (the following day). had an illegible name e date. RN-D came into the 15 a.m. to observe the ulcer ted it appeared as if the aced on the ankle days the dressing had been			All staff will be In serviced or repositioning needs and nu will be In serviced on press ulcer treatment and follow MD orders accurately. <b>Date of completion: 10/27</b>	rses ure ing	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014	
AME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE			SOUTH HIGHWAY 169 ND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 314	changed. However, s dressing on R77's an RN-D stated the writi to be 9/15 versus 9/1 to observe the pressi RN-C, and RN-D. Ri wound earlier that sa appeared the dressin since 9/15 according RN-A stated the ulce dressing changed ev foam dressing from Fi wound was observed RN-A measured the 1.0 cm X 0.1 cm, how had purulent drainag and the wound bed ri granulation tissue, bu slough (non-viable the debridement [remova wound appeared to hi around the wound ear previously viewed ear completed the pression applied a new Optifor 9/18/14. When interviewed im wound care observa a.m., RN-C stated thi had not been consission basis, as the physicion stated the ulcer seer previously had seen Review of R77 record	stated it appeared the actual inkle had not been changed. ng on the dressing appeared 9. RN-A came into the room ure ulcer at 10:19 a.m. with N-A stated she had seen the me week, and it that it ng had not been changed to writing on the dressing. r should be viewed, and the reryday. RN-C removed the R77, and the pressure ulcer d by RN-A and the surveyor. pressure ulcer at 1.0 cm X wever stated the ulcer now the (primarily pus), foul odor, no longer had 100% ut now contained some ssue that requires al]). RN-A further stated the nave increased redness dges from when she had arilier in the week. RN-C ure ulcer treatment, and nam dressing and dated it mediately following the tion, at approximately 10:45 the pressure ulcer dressing tently changed on a daily an ordered. RN-C further ms to be larger than she rd identified the following: n to the physician on 8/13/14,	F 314	Recurrence will be prevented by: Visual audits of repositioning/off-loading per care plan and pressure ulcer treatment procedures follow will be completed 3x weekly various times on each unit for 90 days. The results of these audits will be shared with the QA Committee for input on need to increase, decrease of discontinue these audits. The correction will be monitored by: DON or Designee	r ved at or e the	
		n to the physician on 8/13/14, oped a "fluid filled blister on				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 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  $1.0\ \text{cm}\ X\ 1.0\ \text{cm}\ X\ 0.2\ \text{cm}$  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. If continuation sheet Page 61 of 106 Facility ID: 00299 Event ID: EY5V11 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICE	S					PPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICE	S					938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			CONSTRUCTION		X3) DATE SU COMPLE	
		245495	В.	WNG			09/18	/2014
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
EVEDODE	EN TERRACE			-	801 SOUTH HIGHWAY 169	·		
LVERGRE					RAND RAPIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page	e 61		F 314				
	Risk, dated 8/21/14, sensory perception ir occasionally exposed occasionally, had ver nutrition, and was po and shear. Further, had an open area (pr and a history of skin R77's Care Area Ass note, dated 9/18/14, pressure ulcer on his remained at risk for fi related to R77's impain incontinent of urine, Further, the note ind healing of stage 3 ul dressing changes ar During interview on director of nursing (I orders and care plar followed. The DON changes should be orders, documented plan interventions sh R77 had a current s assessed at risk for development, and h dressing changes of facility did not imple	d to moisture, walked ry limited mobility, exo tentially exposed to fr the document indicate ressure ulcer) on his a breakdown. sessment (CAA) progr indicated R77 had a s s right outer ankle, and further skin breakdown aired mobility, being and cognitive impairm icated, "staff are mon cer on right ankle dail nd documenting week 9/18/14, at 10:59 a.m. DON) stated the physi n interventions need to stated R77's dressing completed per the phy accordingly, and the nould have been follow tage III pressure ulcer further pressure ulcer ad physician orders for f the pressure ulcer. T ment daily dressing ch	cellent iction ed R77 ankle, ress stage III d n nents. itoring y with ly." the cian o be y sician care wed. c, was or daily he nanges					
	as ordered by the pl pressure ulcer. The pressure relieving b additional ulcer devo	hysician for R77's stag facility also did not im oots while in bed to p elopment or worsening	ge III plement revent g of the					
FORM CMS-2	current ulcer. As a r 567(02-99) Previous Versions O	esult, R77's stage III p	Event ID: EY5V11	F	acility ID: 00299	If continua	ation sheet P	age 62 of 106

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245495	B. WING		09	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
F 314	ulcer on his right ankl granulation tissue in thaving slough tissue odor when none had developed purulent d infection on 9/18/14. A facility Prevention of dated 2/2014, indicat serious skin condition facility should have a assure assessments for changes in condit evaluated, and report indicated the date an should be recorded in R36's diagnoses, as (CP), dated 8/1/2014 kidney disease with M scapula and multiple dated 7/23/2014, indi impaired, and require assistance for ADLs, with bed mobility, tra Braden Pressure Son 8/18/2014, indicated development of pres R36 repositioned hin ulcers, dated 5/29/2 risk to develop press kidney disease, and assistance with bed nursing progress not R36 had an open are	e went from 100% the wound bed on 9/9/14, to present, developed a foul been present before, and rainage indicative of of Pressure Ulcers policy, ed pressure ulcers were a in for the resident, and the system or procedure to are timely, appropriate, and ion to be recognized, ted. Further, the policy d time skin care was given in the medical record. identified on the care plan , included dementia, chronic nemodialysis, and fracture of ribs. The admission MDS, icated R36 was cognitively ed extensive, physical including two-person assist nsfers and ambulation. A re risk assessment, dated R36 was at low risk for sure sores, and further, that nself. The CAA for pressure 014, indicated R36 was at sure ulcers related to chronic	F 31	4		

١.

				T ACHIETELICTION	(X3) DATE SURVEY
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
		245495	B. WING		09/18/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 314	seated in his wheel c p.m., a total of 2 hour any off-loading (remo- perfusion) or repositi- was seated in his wh dining area prior to th other residents. At 1 by staff, and relocated dining area, and sub- At 12:57 p.m., license removed R36, still se the dining area, and Inside the room, LPN and continued to rem he was to attend a ca few minutes, and a se to the meeting room. exited R36's room. I repositioned or off-loc At 1:09 p.m., R36, st propelled himself fro day room, positionin At 1:19 p.m., NA-A e approached R36, an up and stretch. NA- stand, and encourage stretch. NA-D also a his room but R36 ref move, reposition, or During an interview NA-A stated R36 ha 10:30 this morning,"	thair from 10:30 a.m. to 1:19 rs and 49 minutes, without oving pressure to allow tissue oning. At 10:30 a.m., R36 eel chair at a table in the ne noon meal, visiting with 1:37 a.m., R36 was assisted ed to his usual table in the sequently ate the noon meal. ed practical nurse (LPN)-F eated in his wheel chair, from pushed him to his room. 4-F took R36's vital signs, nain seated. LPN-F told R36 are conference meeting in a staff member would help him . At 1:05 p.m., LPN-F then LPN-F neither offered nor waded R36 while in his room. till seated in his wheel chair, m his room into the adjacent g his wheel chair at a table. entered the day room, nd told him it was time to get A offered R36 to assist him to ged him to ambulate and asked R36 to use the toilet in fused all of NA-A offers to	F 31		

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

Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 64 of 106

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 09/18/2014 245495 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES מו (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 64 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

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

Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 65 of 106

ENTER	S FOR MEDICARE &		······				IO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		re Survey Mpleted
		245495	B. WING_			0	9/18/2014
AME OF PF	ROVIDER OR SUPPLIER	<b>.</b>	·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
VERGRE	EN TERRACE				SOUTH HIGHWAY 169 ND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314	Continued From pag	e 65	F3	314			
		w staff direction, especially on					
		t leave the building. RN-D					
		reposition, or get up out of uld be part of his assessment					
	and care plan." RN-	D said she was unaware of					
	any repositioning scl dialysis.	nedule while R36 attended					
	risk to develop press	essments indicated he was at sure ulcers, the assessment s refusal of cares, including					
	repositioning or off lo	pading. The assessment did					
		as repositioned while at h he was gone for several					
		veek. R36's CP identified					
	pressure ulcers, and	l included various					
	interventions to main	ntain intact skin, among which be turned and repositioned					
	every 2 hours." The	CP lacked further direction,		ł			
		to take either, when R36 was					
		en attending dialysis, or when ioning or off-loading, in					
		on 9/18/2014, at 11:48 a.m.					
	the DON stated the followed" for any res	plan of care "should be sident who needs timely					
	refusals of care also	DON agreed a resident's needed to be assessed, and its of refusal "needed to be					
F 315 SS=D	483.25(d) NO CATH	IETER, PREVENT UTI, ER	F	315			
		ent's comprehensive ility must ensure that a the facility without an					
	indwelling catheter i						

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245495	B. WING		0	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	• · · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 315	resident's clinical cor catheterization was r who is incontinent of treatment and servic infections and to rest function as possible. This REQUIREMENT by: Based on observation review, the facility fance review, the facility fance to addition, the facility fance review, the facility facility fance review, the facility	mum Data Set (MDS) noderate cognitive a to have medical r an indwelling urinary sidents (R150) who had a	F 3	F315 F315 Immediate corrective NA-F and NA-G were and re-educated on t offer resident #77 uri to toilet q 2 hours pe and the appropriate of be used for incontine hygiene. Resident #150 MD w contacted to obtain t appropriate diagnosi amount of retention last tested for retent order to justify the n indwelling catheter. to remove catheter a retention and amoun retention will be obt necessary document provided by discharg hospital.	counseled he need to nal or take r care plan cleanser to ence as he s and and date ion in eed for an An order and test for nt of ained if the ration is not	
	had a goal of wantin program to become care plan indicated t hours. During observation	g to participate in his toileting more continent. Further, the to offer R77 the toilet every 2 of personal cares on 9/17/14, g assistant (NA)-G and NA-F		nospital.		

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI	<u>D. 0938-03</u> E SURVEY PLETED
		245495	B. WING		09	/18/2014
	ROVIDER OR SUPPLIER	<b>1</b>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 315	mechanical lift at his R77's incontinence p placed it in the trash. was saturated with u amount of stool prese coccyx and buttocks Cleanser, dried R77's and applied a new in seating R77 on the b completed the remain the room, without offe the toilet or urinal. Review of R77's Blac 8/21/14, indicated R7 and had several risk incontinence includin being dependent on assessment indicated incontinence resulted and, "Lack of ability t substitute". Further staff were to assist w did not identify a toile During interview on 9 stated this was their r (observation that mor a.m.) for delivering ca resident should have toilet versus being ch they should not have coccyx and buttocks When interviewed on stated R77 was not o morning observation	bedside. NA-F removed roduct at the bedside and The incontinence product rine, and had a moderate ent. NA-G sprayed R77's with Medline Wound with a disposable washcloth, continence product before ed. NA-G and NA-F nder of R77's cares, and left ering or assisting R77 to use Ider Assessment, dated '7 was incontinent of urine, factors for continued g impaired mobility, and staff for transfers. The d R77 had functional I from mobility impairments o get to toilet or toilet r, the assessment indicated ith toileting and hygiene, but ting frequency for R77. /17/14, at 2:20 p.m., NA-F normal routine procedure ming on 9/17/14 at 7:08 are to R77. NA-F stated the been offered the use of the anged at the bedside. Also, used wound cleanser on his to provide perineal care. 9/17/14, at 2:38 p.m., NA-G ffered the toilet during the (9/17/14 at 7:08 a.m.) as in incontinent of urine and	F 315	Action as it applies to o The policy and procedur indwelling catheter use reviewed and remains of The policy and procedur providing incontinence toileting was reviewed a remains current. All residents with indwe catheters will be review assure the necessary dia and amount of retention applicable is documente All residents with incont care needs will be review assure their plans are ad and current.	re for was urrent. re for care and and ed to agnosis n if ed. tinence wed to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 315	been offered the toile have had wound clea buttocks for perineal of During interview on 9 registered nurse (RN) incontinent of urine for should have been offer R77 was at a higher of function loss because opportunity to use the During interview on 9 director of nursing (D been helped to the to cares as directed by plan. The DON furthet to the toilet increases incontinence and loss A facility Bowel and E dated 4/13, indicated resident is, whom wa opportunity to achiev appropriate. R150's admission mi 8/12/14, included a d accident (CVA), had an indwelling Foley of assistance for toiletin The urinary care area been completed. An observation on 9/	t during care, and should not nser used on his coccyx and care, "That was my fault." /18/14, at 12:40 p.m., )-A stated R77 had been or several months and ered the toilet with cares. risk of further bladder a he was not given the a toilet. /18/14, at 12:43 p.m., the ON) stated R77 should have illet by staff during morning the assessment and care er stated not assisting R77 a R77's risk of further bladder s of function. Bladder Retraining policy, the facility will ensure each is incontinent, is given the e continence when nimum data set (MDS) dated iagnosis of cerebral vascular severe cognitive impairment, ratheter, extensive ig, transferring and hygiene. a assessment (CAA) had not	F 3	All nursing staff will be Inserviced on the followin plans of care for each resi with toileting needs and incontinence care. Date of completion: 10/2 Recurrence will be preve by: All new or readmissions w have an indwelling cather upon admit/readmit will reviewed by the ID Team assure the appropriate re for the catheter is docum Medical records will keep of all residents with indw catheters and their reaso use. This will be an ongo system.	dent 7/14 nted vho ter be to ason ented. o a list elling ns for

DEPARTMENT OF HEALTI			-	FOR	D: 10/08/201 MAPPROVEI O. 0938-039
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED
	245495	B. WING		09	)/18/2014
NAME OF PROVIDER OR SUPPLIEF		STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
EVERGREEN TERRACE			1 SOUTH HIGHWAY 169		
		l	AND RAPIDS, MN 55744 PROVIDER'S PLAN OF CO	PRECTION	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
<ul> <li>note dated 8/5/14</li> <li>catheter and in the problem list, indice of the progress in form from 8/5/14</li> <li>bladder assessme was there any dia R150 continued for the care plan up catheter and that diagnosis: urinary diagnosis that idea retension.</li> <li>During an intervite licensed practical is because he has unsure if he just hospital, was unser R150 experience experience retension.</li> <li>An interview on S the history and p not indicate why Policies regarding retension were received.</li> <li>F 328</li> <li>F 328</li> <li>The facility must</li> </ul>	A page 69 A page 69	F 315	Visual audits of incon care and toileting tim completed 3x weekly times on all units x 90 assure each resident's toileting/incontinence being followed. The r these audits will be sl the QA Committee fo the need to increase, or discontinue the au The correction will be monitored by: DON or Designee	es will be at various days to s e plan is results of nared with r input on decrease dits.	

ATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
VERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 328	Continued From page Injections;	e 70	F 32	8	
1	Parenteral and enteral Colostomy, ureteroste	al fluids; omy, or ileostomy care;		F328	
	Tracheostomy care; Tracheal suctioning; Respiratory care;			Immediate corrective action	
	Foot care; and			The construction was stoppe and a plan put into place as	d
	Prostheses.			soon as the issue was	
	This REQUIREMENT	is not met as evidenced		identified. Resident # 154, 4	3,
	by:			144, 96, 93, 143, and 19 wer	
T	review, the facility fail	n, interview, and document ed to ensure environmental oute to acute respiratory		assessed for respiratory state per facility policy.	us
	distress for 7 of 12 re R96, R93, R143 and	sidents (R154, R43, R144, R19) identified with		Action as it applies to others	s:
	respiratory impairmer	nt on the 300 wing.		All residents residing on the	300
	Findings include:			Unit were assessed for respiratory status per facility	
	During observation or approximately 9:30 a	n 9/16/2014 from .m. to 11:15 a.m., workers,		policy. A plan to create a	
	using jack hammers a	and other tools, were		barrier to contain dust was	
		from a floor, near resident ing of the nursing home.		established with the	
	The construction area	a, located just beyond outhwest corner of the main		construction workers.	
	dining room, was 6 ar	nd 1/2 feet wide, by 41 feet		The policy and procedure for	
,		end of the construction area Ig station, where the unit		resident assessment pre and	
		wings, which formed the		post construction were reviewed and remain curren	t.
	noise in the facility, ar dust. The dust wafted	iles resulted in intermittent nd created visible lingering from the construction area, ng room, and down the			

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		ID HUMAN SERVICES MEDICAID SERVICES			·	FORM	D: 10/08/2014 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245495	B. WING			09/	18/2014
NAME OF P	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGE	EN TERRACE			1	2801 SOUTH HIGHWAY 169		
LVLNGN			· · · · · · · · · · · · · · · · · · ·	<u> </u>	GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 328	gateway at the end o nearest the dining root the construction area fitted with any kind of and debris during the about 10:15 a.m., the area were observed by tiles were being remo area, there was a dur an intake tube, and a window and outside. prints, from walkers, were observed both the 300's wing nursin and visitors walked th Dust was also observ- unit, on various surfa mailbox, chair rails o shadow boxes, a nur the nursing station de In an interview on 9/- maintenance worker dust created during t this morning. MW-A the floor "today and s MW-A said the doors closed, and "the filtra There were not dust the residents who liv 300's unit had seven tracheostomies, four ventilators. In additio	ms of residents with ventilators. Neither the f the construction area om, nor the opposite end of , by the nursing station, were dust barrier to contain dust removal of the floor tile. At e double doors to the dining to be closed while the floor oved. In the construction st-abetment machine, with n exhaust tube leading to a Tracking marks and foot wheel chairs and shoes, n the dining area, and near ig station, as residents, staff mough the construction area. ved throughout the 300's ces and equipment: a n the wall, light fixtures, nber of mechanical lifts, and esk. 16/2014 at 11:00 a.m., (MW)-A agreed there was he removal of the tile floor stated there was work on some in the past two weeks." to the dining area were tion system was on." barriers observed to protect ed on 300 unit. Presently the residents with of whom also utilized on, several other residents ony diagnoses. The 300's unit in rehabilitation unit.		328	A policy was put into place assure the Administrator an Maintenance Director woul meet with any construction workers during any facility projects to assure a plan was place to create a safe environment for any reside in close proximity and if una to do so, a plan to move residents to another area or facility during these times a well as barriers to contain d Staff will be re-educated on Construction policy and the and Post Construction Policy 10/27/2014. <b>Date of completion:</b> 10/27/2014.	nd d as in nts able f the s ust. the Pre / by	Page 72 of 106

		D HUMAN SERVICES		*	FORM APPROVED OMB NO. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
			2	2801 SOUTH HIGHWAY 169	
EVERGRE	EN TERRACE		(	GRAND RAPIDS, MN 55744	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 328	interviewed on the 30 construction dust, and difficulties as a result interviewed stated the respiratory problem, It dust on the unit. Review of the resider following: R154's diagnoses, fro (MDS) dated 8/25/200 failure, with depende (inability to produce v MDS further indicated dependent upon staff (ADLs). The care are ADLs, dated 8/31/20 use of a mechanical transfers due to inabi related to tracheostor room was approxima construction area, at wing. A progress note date at 8:00 p.m., R154 co ribcage and chest are breath, which at that suctioning or repositi "rhonchi" throughout that staff attempted v completed assessme send R154 to the em declined by the resid again requested to b	b.m. 20 residents were 0 wing about the d if they had any respiratory of the dust. The residents any but they did notice lots of the cords identified the both the Minimum Data Set 14, included respiratory nce on a ventilator, aphonia roice}, and quadriplegia. The d R154 was totally f for activities of daily living ea assessment (CAA) for 14, indicated R154 required lift, with three staff, for all lity to stand, and for safety my and ventilator. R154's tely 50 feet from the the end of the southwest d 9/14/2014, indicated that complained of pain in the ea, and had shortness of time was not relieved by oning. R154's lungs had . The note further indicated various interventions, ents, and that initial offers to rergency room which were ent. At 10:15 p.m., R154 e suctioned; following ns, and requested to be sent aluation.	F 328	Recurrence will be preventiby: All future construction projing will be conducted with daily meetings prior to each day's start of construction and will include the Administrator at Maintenance Director. The meetings will be held to dist the plan for the day, to assure barriers for dust are established, and determinations made as to whether any resident(s) wo need to be relocated to and part of the building at any to This will be an ongoing proce and will be discussed at QA each construction project month. The correction will be monitored by: Administrator or Designee	ects y 's ill ind ese cuss ure ould other ime.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245495 B. WING 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 328 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 If continuation sheet Page 74 of 106 Facility ID: 00299 Event ID: EY5V11 FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/08/2014

FORM APPROVED

ENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	938-039
TEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF COMPLET	
		245495	B. WING		09/18/	2014
AME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
VERGRE	EN TERRACE			01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 328	Continued From pag	e 74	F 328			
	nursing progress not 9/16/2014, indicated treatments twice eac	es from 9/6/2014 to R144 requested nebulizer h day on 9/6 and 9/7/2014, ortness of breath. R144				
	4/18/2014, included and tracheostomy st progress notes from	m the annual MDS dated chronic airway obstruction, atus. A review of nursing 9/2/2014 to 9/16/2014 rory concerns were identified. 300's wing.				
,	8/14/2014, included dependence on resp nursing progress no 9/16/2014 indicated	no remarkable respiratory ces were identified. R43				
	9/2/2014, included r airway obstruction. notes from 9/2/2014	om he admission MDS dated espiratory failure and chronic A review of nursing progress to 9/16/2014 indicated no ory concerns. R96 resided on				
ł	5/13/2014, included dependence on rest nursing progress no 9/16/2014 indicated	n the annual MDS dated acute respiratory failure, and birator status. A review of tes from 9/2/2014 to no respiratory concerns were led on the 300's wing.		· · ·		
	R143's diagnoses, f chronic airway obst	rom the MDS dated, included				

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

PRINTED: 10/08/2014 FORM APPROVED

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(	DMB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		245495	B. WING				09/18/2014
NAME OF PF	OVIDER OR SUPPLIER	<u>.</u>		STR	EET ADDRESS, CITY, STATE, ZIP	CODE	
EVERGRE	EN TERRACE			1	1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		TION SHOULD BE	
F 328	review of progress n 9/16/2014 indicated	e 75 d tracheostomy status. A otes from 9/1/2014 to no remarkable respiratory fied. R143 resided on the	F	328	· · · · · · · · · · · · · · · · · · ·		
	registered nurse (RN "concerns" on the 30 weekend. RN-B said complaining of short lot of nebs [nebulize] weekend. RN-B stat over the weekend, a after I asked them to fans on to blow dust work was "going on the vent [ventilated]	on 9/16/2014 at 10:00 a.m., I)-B stated she had 00's unit, over the past d some residents "were ness of breath" and "we did a r treatments] over the ted there was dust on the unit nd that "It was a lot better o open the windows and get outside." RN-B stated that Saturday, [the dust] bothered residents," and the ventilated more suctioning, especially			·		
F 329 SS=D	registered nurse (RN the unit) stated she v remodeling complete well as construction said there have bee they started to remo if she had any conce unit who had trached light of the construct little concern, with the not talked to anyone and did nothing furth regarding the reside	9/16/2014 at 10:33 a.m., N)-D (the nurse manager for was aware there had been ed over the past weekend, as going on right now. RN-D n "No barriers put up," since ve the tile floor. When asked erns for the residents on the ostomies and ventilators, in tion, RN-D stated "I have a he dust." RN-D said she had a about the construction dust, her to address those concerns ints on the 300's wing. GIMEN IS FREE FROM RUGS	F	329			
FORM CMS-25	37(02-99) Previous Versions O	bsolete Event ID: EY	5V11	Facili	ty ID: 00299	lf continua	tion sheet Page 76 of 106

		D HUMAN SERVICES			*	FOR	D: 10/08/2014 M APPROVED D. 0938-0391	
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245495	B. WING 09/*				/18/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				2801	SOUTH HIGHWAY 169			
EVERGRE	EN TERRACE			GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From page	9 76	F3	329	· · · · ·			
	Each resident's drug	regimen must be free from			F329			
I.	unnecessary drugs. drug when used in ex	An unnecessary drug is any ccessive dose (including			Immediate correctiv	e action:		
	duplicate therapy); or without adequate mo	for excessive duration; or nitoring; or without adequate			Resident #6 was see	n bv		
	indications for its use	; or in the presence of			Psychiatry on 9/29/1	•		
	adverse consequenc	es which indicate the dose		review of medicati				
	should be reduced or combinations of the r				and recommended o	-		
					Target Behaviors to be			
	Based on a compreh	ensive assessment of a			monitored were add			
	who have not used a	nust ensure that residents ntipsychotic drugs are not			Care Plan.			
	given these drugs un	less antipsychotic drug						
ļ '	therapy is necessary	to treat a specific condition			Action as it applies t	o others:		
-		cumented in the clinical who use antipsychotic			All residents receivir	nσ		
	drugs receive gradua	I dose reductions, and			psychopharmacolog			
	behavioral intervention	ons, unless clinically			medications will be			
	drugs.	n effort to discontinue these			the Consultant phar			
					10/27/14 to assure	indelise by		
					recommendations for	or required		
					GDR's or documenta			
					support dose as wel			
		⊺ is not met as evidenced			Behaviors needed a			
	by: Based on interview.	and document review, the						
	facility failed to provi	de an appropriate psychiatric			to psychiatry if indic	ateu.		
. 1	referral, and complet	e routine monitoring for 1 of			Date of completion:	:		
	psychotropic medica	m was given prescribed tions.			10/27/2014			
	Findings include:							
	R6's admission Minir 5/21/14, indicated Rf	mum Data Set (MDS), dated 6 admitted to the facility in						
FORM CMS-25	67(02-99) Previous Versions Ob	esolete Event ID: EY	5V11	Facili	ty ID: 00299	If continuation shee	et Page 77 of 106	

		& MEDICAID SERVICES			B NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	, ,	(X3) DATE SURVEY COMPLETED 09/18/2014	
		245495	B. WING			
		· · · · · · · · · · · · · · · · · · ·		ET ADDRESS, CITY, STATE, ZIP CODE SOUTH HIGHWAY 169	<u>.</u>	
		· · · · · · · · · · · · · · · · · · ·	GRA	ND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 329	Continued From pa	ae 77	F 329			
	(MDS), dated 8/19/ cognitively intact, he manic depression, a the MDS indicated hallucinations, delu behaviors during th R6's care plan, date bipolar schizophren daily for treatment. specific target beha having psychiatry in R6's Psychopharms dated 5/14/14, indic psychotropic medic Escitalopram Oxala medication) 40 mg and; Lorazepam ( an am daily at HS (hour of schizophrenia and; Lorazepam 0.5 mg Lorazepam 1 mg tw Haldol (an anti-psy in the morning and; Haldol 10 mg daily paranoid schizophr The assessment in admission to the fa paranoid schizophr did not identity if a	sions, or other documented e review period. ed 6/23/14, indicated R6 had hia and received medication The care plan did not indicate aviors, nor intervention(s) of nput for R6. acological Drug Assessment, cated R6 took the following eations: ate (an anti-depressant daily for depressive disorder ti-anxiety medications) 1 mg f sleep) for paranoid daily at 10 a.m. and; vice a day as needed and; chotic medication) 5 mg daily at HS for a diagnosis of		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 result will be shared with the QA Committee monthly.	2	
		hopharmacological Drug 7/2/14, indicated R6				

CENTER	S FOR MEDICARE	MEDICAID SERVICES				D. 0938-03	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		245495	B. WING		09	/18/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIC	
F 329	Continued From pag	ge 78	F 329				
		Idol at the same doses and					
	•	essed on 5/14/14. The form					
		additional antipsychotic		The correction will be	9		
	medications, Latuda medication), was ad	a (an anti-psychotic Ided to R6's medication		monitored by:			
	<b>u</b> .	indicate a reason why it had		Consultant Pharmaci	st and		
		lition, the assessment		DON			
		new admission and did not					
		a GDR would be attempted, or would be made for R6, as it					
		ew admission to the facility					
	still.						
		9/18/14, at 9:16 a.m., the					
		nursing (ADON) stated she					
		R6's care until recently. The g had been done to address					
		cological medication					
		ing. Further, the ADON felt	t i				
		rding her cognition and					
		s not in a hurry to address					
	-	imen as a result despite her					
		armacological medication ted she was unsure the last					
		osychiatry was made for R6,	-				
	•	e to work on this stuff."					
		n 9/18/14, at 9:27 a.m.,					
		N)-A stated R6 should have					
		sychiatrist given her schizophrenia. Further, RN-A				Ì	
		ve a plan in place to address					
	GDR's for R6's psyc						
		ould be to her benefit.					
		9/18/14, at 10:41 a.m., RN-C					
		navior monitoring was				1	
		RN-C further stated daily					
	charting should be d	completed for someone taking	· · ·			L	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>OMB NO. 0938</u>-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_ B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE **GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 329 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 353 | 483.30(a) SUFFICIENT 24-HR NURSING STAFF F 353 SS=E 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 If continuation sheet Page 80 of 106 Facility (D: 00299 Event ID: EY5V11 FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & MEDICARD SERVICES     ONI PROVIDENTIAL ONSTRUCTION     ONI PROVIDENTIAL ONSTRUCTION       AND PLAN OF CORRECTION     AND PROVIDENTIAL ON NUMBER:     A BULLINDO       AND PLAN OF CORRECTION     24495     R. WING       NAME OF PROVIDENT ON SUPPLIENCIA     24495     STREET ADDRESS, CITY STREE, 2P CODE       EVERGREEN TERRACE     STREET ADDRESS, CITY STREE, 2P CODE     23415       EVERGREEN TERRACE     STREET ADDRESS, CITY STREE, 2P CODE     23415       OPIN DURING OF STREEMENT OF DEFIDENCED BY YOULD     PREFIX     Reader to Construct To the APROPRIATE       OPIN DURING OF STREEMENT OF DEFIDENCES DET TO THE APROPRIATE     CONSTRUCT OF CONSTRUCT OF DEFIDENCES DET TO THE APROPRIATE     Construct of Construct of Construction of C			ID HUMAN SERVICES				FORM	APPROVED
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201 SOUTH HIGHWAY 158 GRAND RAPIDS, MI 55744       CAND RAPIDS, MI 55744       CAND RAPIDS, MI 55744       CONSERVEMENT OF DEFICIENCES (EACH CORRECTION SHOULD BE REDUCTION VISIO TENTRY MINIFORMATION)     DEFICIENCES (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION OF UPROPRIATE )     CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTION OF UPROPRIATE )       F 353     Continued From page 80 individual plans of care.     F 353       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:     F 353       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 duy.     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 crearrange duties for certain associates was identified       by: Based on observation, interview and document review, the facility failed to provide suffight nursing staff to meet the on-going, assessed resident care needs and services for residents in the 200, 300 and doy Wing' of the musing facility, and other residents, as identified during the quality indicator survey, (RS, RB, R7, R50, R48, R2 and R68) and reviewed for staffing rooncerns. This hal the potential to affect all resident swho required assistance of staff to meet their needs, but not all residents within			245495	B. WING			09/	18/2014
EVERGREEN TERRACE     GRAND RAPIDS, MN 55744       (PA) ID PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY WOTE SERCED BY PULL REGULTORY OR LIS (DEMIFYING INFORMATION)     ID PRETX TAG     PROVIDER'S ALL OR CORRECTIVE ACTOR SHOULD BE CROSS-REFERENCED TO THE APPROPMATE     Comment Comment Comment Comment Participation       F 353     Continued From page 80 individual plans of care.     F     F       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:     F       Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.     F       Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.     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       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 indicate survey, (RS, RG, R77, R50, R84, R2 and R68) and reviewed for staffing needs, but not all residents within the facility.       Findings include:       LACK OF TIMELY CARE AND SERVICES	NAME OF PF	ROVIDER OR SUPPLIER			SI	REET ADDRESS, CITY, STATE, ZIP CODE		
Own D. PRETRY TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH CREATENET ALLY OF CORRECTION (EACH CREATENET ALLY OF CREATENET (EACH CREATENET ALLY OF CREATENET (EACH CREATENET ALLY OF CREATENET (EACH CREATENET) (EACH CREATENET ALLY OF CREATENET (EACH CREATENET) (EACH CREATENET ALLY OF CREATENET (EACH CREATENET) (EACH CREATE	EVEDGDE							
Windly Tool       read/deficiency/water precedeb avenue result converting in the precedeb avenue result converting in the precedeb avenue result converting in the precedeb avenue precedeb avenue consistence in the precedeb avenue performance in the precede	EVENOINE	ENTENNAOE			G	RAND RAPIDS, MN 55744	· =	
<ul> <li>individual plans of care.</li> <li>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:</li> <li>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</li> <li>Except when waived under paragraph (c) of this section, licensed nurse to serve as a charge nurse on each tour of duty.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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, (RA6, R6) 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.</li> <li>Findings include:</li> <li>LACK OF TIMELY CARE AND SERVICES</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	1	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
R36's admission Minimum Data Set (MDS) dated       FORM CMS-2567(02-99) Previous Versions Obsolete       Event ID: EY5V11       Facility ID: 00299       If continuation sheet Page 81 of 106		individual plans of car The facility must prov numbers of each of th personnel on a 24-ho care to all residents in care plans: Except when waived section, licensed nurs personnel. Except when waived section, the facility m nurse to serve as a c duty. This REQUIREMENT by: Based on observation review, the facility fail nursing staff to meet resident care needs a the 200, 300 and 400 facility, and other res the quality indicator s R48, R2 and R68) a concerns. This had the residents who required their needs, but not a Findings include: LACK OF TIMELY CA REPORTED BY RES R36's admission Min	re. ide services by sufficient he following types of our basis to provide nursing h accordance with resident under paragraph (c) of this ses and other nursing under paragraph (c) of this ust designate a licensed harge nurse on each tour of T is not met as evidenced on, interview and document led to provide sufficient the on-going, assessed and services for residents in 0 wings' of the nursing idents, as identified during survey, (R36, R6, R77, R50, nd reviewed for staffing the potential to affect all ed assistance of staff to meet all residents within the facility. ARE AND SERVICES SIDENTS AND FAMILIES: imum Data Set (MDS) dated			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 opportunitie to rearrange duties for certain associates was identified	5 5 95 1	

		ID HUMAN SERVICES		-	FORM	D: 10/08/201 /I APPROVE ). 0938-039
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING		(X3) DATE COMP	SURVEY	
		245495	B. WING	······	09/	18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	and that R36 required assistance for activiti- including two-person transfers and ambula 9/15/2014 at 7:40 p.m (FM)-A stated "it ma soils himself, becaus- needed when in the k "too long for staff to m she has assisted R36 wishes of the nursing "were not responding R6's quarterly MDS of intact cognition, and a extensive assistance for bed mobility, trans and completing perso interviewed on 9/16/2 "Wing 2 is really bad, people." R6 further s "bathroom accident" about it." R6 said she there are a few a hea call light on for assist	evere cognition impairment, d extensive, physical es of daily living (ADLs), assist with bed mobility, tion. During an interview on n., R36's family member akes him feel bad" when he e [R36] did get the help he bathroom, because it takes espond." FM-A stated that b to he bathroom, against the home, because the staff soon enough." lated 8/19/2014, indicated also that R6 required , with 2-person assistance sferring, dressing, toileting onal hygiene. When 2014 at 4:37 p.m., R6 stated, they only have 2 staff for 20 tated she/has had and was "very embarrassed e had been told "hold on, ad of you," after putting the	F 35	Action as it applies to The facility will assure NAR on 200 wing, who 11A-7P is not involved providing Restorative Program based on cer acuity. A float will be peak times between L 400 based upon censu acuity. The duties of t Hospitality Aides will I reviewed with all staft a better understandin they can and cannot c achieved. More Hosp Aides will be hired to nursing staff and assu position is filled when Hospitality is off or ill.	the third o works I Nursing asus and added at Jnits 300- us and the be f to assure of what do is itality assist the are the	
	indicated R77 require for bed mobility, trans dressing, toileting an an interview on 9/16/ stated "I find myself w 'wait and wait', espec	cognition. The MDS further ed extensive staff assistance sferring, locomotion, d personal hygiene. During 2014 at 9:51 a.m., R77 vaiting frequently for help, cially in the afternoon" dated 7/14/2014, indicated		interviewable will be interviewed to assure needs are being met satisfactorily. Familie interviewed when res unable.	es will be	
	intact cognition. R50					

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		ID HUMAN SERVICES MEDICAID SERVICES		*	FORM APPROV OMB NO. 0938-03		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245495	B. WING		09/18/2014		
NAME OF P	ROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169				
EVERGRE	EN TERRACE			RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC		
F 353	transfers, dressing, to personal hygiene. W 9/16/2014 at 8:47 a.m have to wait over 30 f R48's quarterly MDS she had intact cogniti assistance with dress but limited staff assis dressing. During an 8:45 a.m., R48 stated 30 minutes for assist and that it "usually ha R48 said that becaus she frequently had 'a waiting too long was doesn't help," R48 st R2's quarterly MDS of intact cognition. The required extensive as and dressing, and re transferring and toilet 9/15/2014 at 7:48 p.r 200's wing, she woul assistance, but said ' minutes before staff because they only ha to help." R68's quarterly MDS intact cognition. R68 staff for all ADLs, inc transferring, dressing personal hygiene. In 11:35 a.m., while wai stated "I always have to take care of me. I	bileting, and completing then interviewed on n., R50 said "Sometimes I minutes to get to bed." dated 6/17/2014 indicated ion. R48 required extensive sing//, walking and toileting, tance for transferring and interview on 9/16/2014 at d she frequently had to wait ance to use the bathroom, appened in the evening." the her her medical condition, ccidents', but was unsure if the cause. "It certainly ated. dated 6/10/2014, indicated MDS further indicated R2 ssist staff for bed mobility quired two staff for ting. In an interview on n., R2 stated that on the d have to wait 20 minutes for 'on the 400's wing, I wait 45 come to help me. It's ave one on during the week , dated 7/18/2014, indicated a was totally dependent on	F 353	Staffing will continue to h discussed each day by th Administrator, and Super Scheduler and Nurse Ma and adjustments made w needed. Date of completion: 10/2 Recurrence will be prever by: Random interviews will b completed monthly and evaluated quarterly and reviewed at QA & A mee ensure the needs of the residents are being met a they are satisfied with ca service. The correction will be monitored by: DON or Designee	e DON rvisor, nagers here 7/14 nted e ting to and		

		ID HUMAN SERVICES				FORM	: 10/08/2014 APPROVED . 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE COMPI	SURVEY		
		245495	B. WING_						
NAME OF P	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE				
				280	1 SOUTH HIGHWAY 169				
EVERGRE	EN TERRACE			GRAND RAPIDS, MN 55744					
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F 353	Continued From page	∋ 83	F3	353					
	STAFFING CONCEF FACILITY PRACTIC	RNS AS IDENTIFIED BY ES			· .				
	and document review each resident was pr services when recom when ambulation abi residents (R20) revie This resulted in actua experienced a declin Refer to F311: Base and document review ambulation services maintain residents' a residents (R27, R48,	d on observation, interview v, the facility failed to ensure ovided with ambulation mended, and assessed lity declined for 1 of 9 wed fro ambulation services. al harm for R20, when he e in ability to ambulate. d on observation, interview v, the facility failed to provide in order to improve and/or mbulation abilities for 8 of 9 R22, R24, R53, R139, R14 ed ambulation services.			· · ·				
	and document review comprehensively as repositioning for 1 of for pressure ulcers. resident needed to be every two hours, and pressure sore, but w hours and 49 minute Refer to F312: Base and document review necessary grooming	ed on observation, interview w, the facility failed to sess and provide timely '3 residents (R36) reviewed R36's care plan indicated the repositioned as assessed d was at risk to develop as not repositioned after 2 es during observation. ed on observation, interview w, the facility failed to provide for 1 of 3 residents reviewed vere dependent upon staff for y living (ADLs).							
EORM CMS-24	567(02-99) Previous Versions Ol		 V11	Faci	lity ID: 00299 If contin	uation sheet	Page 84 of 106		

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 353 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."

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Facility ID: 00299

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 353 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.

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Event ID: EY5V11

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DATE	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED	
		245495	B. WING			09/	18/2014
NAME OF PR	ROVIDER OR SUPPLIER			ł	REET ADDRESS, CITY, STATE, ZIP CODE		•
VERGRE	EN TERRACE				1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 353	Continued From pag	e 86	я	353			
, 000		ک)-G said "I feel we are					
		f staff. We often run late in					
		repositionings. Many of the					
		staff, NA-G stated, and anical] lift to transfer, and one					
		ne. "What can you do?"					
	NA-G asked. In a su	Ibsequent interview at 2:38					1
		od trays are frequently orning and afternoon					
		available to complete it."					{
	NA-G also resident "	grooming and bathing"					
	suffered as a result o	of the inadequate staffing.					
	During on interview	on 9/18/2014 at 11:24 a.m.,					
		en two wings shared one					
	aide, where there sh	ould be "two aides per wing."					
		ng of the aides, who usually					
		ts, often increases wait nfamiliar with the residents.					
		happens, "Call light wait					
	times increase, and	residents get upset." NA-F					
	said there were 6 or	7 baths to give yesterday, " and the result was that "it					
	was nine-thirty where	we finally had everyone up					
	and going. We're su	pposed to have people up by					
	eight for breakfast."	NA-F also said residents					
	were not toileted as	they should be, and that o use the lift, and you only					
	have one staff; I thir	k there is a staffing issue."					
	In an interview on 9/	/18/2014 at 1:50 p.m., NA-I					
	stated R68 "complai	ns all the time" about wanting					
		λ-I continued, "Today, we did ) or so, and lunch was					
		A-I added, "We just don't have					
	time to get him up w						
		/18/2014 at 11:19 a.m.,					
		-A, said "The aides do the					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 South Highway 169 Grand Rapids, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
	HA-A said that if the replacement for the "it can be difficult for unit where many of	hat they have to work with."	F 353		
F 356 SS=C	director of nursing (I in the nursing home and acuity," and add good right now." Th staffing level is aded residents." The DO were "quite a few re care," and that they short." The DON sa call lights answered any wait times over said all staff [empha lights, and determin of the resident are. [emphasize all] nurs transfers, or whatev nursing can and mu said she felt the star and also said the cu with all tasks." 483.30(e) POSTED INFORMATION	18/2014 at 1:57 p.m., the DON) stated the staffing level was determined by "census ded "we're looking pretty e DON said "The current quate to meet the needs of the N said she realized there sidents who required a lot of "are the first to know if we are id the facility goal is to have in "five minutes," and that that "is excessive." The DON usize all] can answer the e what the immediate needs Further, the DON said, all sing staff can assist with er the need, and "all of st participate." The DON also if was "more stable," of late, irrent staff "are willing to help NURSE STAFFING st the following information on	F 356		)

ATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
AME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EN TERRACE			01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLE
E 250			F 356		
F 356	Continued From page		F 300		
		nd the actual hours worked gories of licensed and			
		aff directly responsible for		F356	
	resident care per shif			1550	
	<ul> <li>Registered nurs</li> </ul>			Immediate corrective action	n:
	-	al nurses or licensed			
	- Certified nurses	defined under State law). aides.		The actual hours worked we	
	o Resident census.			added to the facility Direct (	Care
				Staff Posting when the	
	specified above on a	t the nurse staffing data daily basis at the beginning		discrepancy was identified.	
	o Clear and readable			Action as it applies to othe	rs:
	o In a prominent place residents and visitors	e readily accessible to		The policy and procedure for	or
		·		posting of direct care hours	was
	The facility must, upo make nurse staffing of	on oral or written request, data available to the public		located and was current.	
	for review at a cost n	ot to exceed the community		The tool was updated to inc	lude
	standard.			actual hours worked.	
	The facility must mai	ntain the posted daily nurse			
	staffing data for a min	nimum of 18 months, or as		Staff responsible for the pos	
	required by State law	, whichever is greater.		of the direct care staff hour	'S
				were In serviced on the nev	N I
	This REQUIREMEN	Γ is not met as evidenced		format.	
	Based on observation review, the facility fail	on, interview, and document led to ensure the required		Date of completion: 10/27	/14
	actual hours worked	formation included the by each category of nursing			
	residents currently re	otential to affect all 82 esiding in the facility, as well			
	may wish to review t	or the general public who			

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

Facility ID: 00299

If continuation sheet Page 89 of 106

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-	-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014	4
AME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VERGRE	EN TERRACE			01 SOUTH HIGHWAY 169		
			G	RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLI	ETIO
F 356	Continued From pag	a 80	F 356			
1 000	Findings include:			Recurrence will be prevented	ed	
	-			by:		
		on 9/16/13, at 1:00 p.m. the		Visual audits of the Direct C	are	
		sting was observed on a d by the main entrance to the			are	
	building. The posting	g consisted of the facility		Staff Posting will occur 5 x		
		census, and the total number censed and unlicensed staff.		weekly x90days to assure th actual hours worked have b		
		nclude the actual hours		included. The results of the		
	•	e not included on the				
	posting.			audits will be shared with C		
	A subsequent observ	vation of the Direct Care		for input on the need to		
		at 12:40 p.m., identified the		increase, decrease or discontinue the audits.		
	same format being u hours being worked	sed, again lacking the actual by each discipline of staff.				
	When interviewed or	9/17/14, at 11:31 a.m., the		The correction will be		
	director of nursing (D	OON) stated the facility had		monitored by:		
	used the current forn and will changed the hours being worked	nat for the posting for awhile form to reflect the actual by each discipline.		Scheduler/Designee		
		9/17/14, at 2:05 p.m., the the facility did not have a				
	policy regarding the	staff posting.		F428		
		GIMEN REVIEW, REPORT	F 428			
SS=D	IRREGULAR, ACT C	, nc		Immediate corrective action:	:	
		each resident must be		Resident #6 was seen by		
	ſ	ce a month by a licensed		Psychiatry on 9/29/14 for		
	pharmacist.			review of medication regime		
		t report any irregularities to		and recommended doses.		
		an, and the director of eports must be acted upon.		Target Behaviors to be		
	nursing, and mese it			monitored were added to he	r l	
				Care Plan.		

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: 10/08/2014 FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245495	B. WING	<u></u>	09/18/2014
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	
				2801 SOUTH HIGHWAY 169	
EVERGRE	EN TERRACE			GRAND RAPIDS, MN 55744	
04010	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	10N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE DATE
	1				
F 428	Continued From page	e 90	F4	28	
1					
l					
l					
	This REQUIREMENT	is not met as evidenced			
	by:			Action as it applies to othe	irc:
		and document review, the		Action as it applies to othe	101
		e irregularities identified in 1		All residents receiving	
		edication regimen were pon by the consulting			
	pharmacist.	pon by the consulary		psychopharmacological	
	phanndolot			medications will be review	
				the Consultant pharmacist	by
	Findings Include:			10/27/14 to assure	
				recommendations for requ	ired
		m Data Cat (MDC) datad		GDR's or documentation to	1
		um Data Set (MDS), dated 3 was cognitively intact, had			
		sion, manic depression, and		support dose as well as Tar	
		er, the MDS indicated R6		Behaviors needed and refe	rrals
		ations, delusions, or other rs during the review period.		to psychiatry if indicated.	
· ·	documented benavio	is during the review period.		Date of completion:	
	R6's Psychopharmac	cological Drug Assessment,		10/27/2014	
		ted R6 took the following		10/2//2014	
	psychotropic medicat				
	Escitalopram Oxalate				1
		aily for depressive disorder			
	and;	anviatu modioations) 1 mg			
	daily at HS (hour of s	anxiety medications) 1 mg			
	schizophrenia and;				
	Lorazepam 0.5 mg di	aily at 10 a.m. and;			
	Lorazepam 1 mg twic	ce a day as needed and;			
		otic medication) 5 mg daily			
	in the morning and;				
		HS for a diagnosis of			
	paranoid schizophrer				
		cated R6 to be a new			
L	1	ity, and have a long history			
FORM CMS-256	67(02-99) Previous Versions Obs	solete Event ID: EYE	5V11	Facility ID: 00299 If con	ntinuation sheet Page 91 of 106

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03	
ATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE			I SOUTH HIGHWAY 169 AND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
		e 91 renia, however did not	F 428	Recurrence will be prevented		
	indicate if a psychiat	ry referral or gradual dose uld be completed for R6.		<b>by:</b> All residents on		
	Assessment, dated a continued to take Es Lorazepam, and Hal time(s) as when asse further indicated an medications, Latuda medication), was ad regimen, but did not been added. In add indicated R6 was a r address if or when a a psychiatry referral identified R6 as a ne still. R6's care plan, date bipolar schizophreni daily for treatment.	citalopram Oxalate, dol at the same doses and essed on 5/14/14. The form additional antipsychotic (an anti-psychotic ded to R6's medication indicate a reason why it had tion, the assessment new admission and did not GDR would be attempted, or would be made for R6, as it ev admission to the facility d 6/23/14, indicated R6 had a and received medication The care plan did not indicate aving psychiatry input for R6,		All residents on psychopharmacological medications will be grouped together in the report from the Consulting Pharmacist and results reviewed by the DON assure recommendation for GDR or documentation needed to support current dosing, Target Behaviors needed, and suggested psychiatry referral are included in the Report if indicated. This will be an ongoing practice and the resu will be shared with the QA Committee monthly.	to ed d a	
	dated 5/22/14, 6/20/ 9/17/14, indicated no by the consulting ph psychotropic medica aside from obtaining Latuda medication. During interview on assistant director of	ation Regimen Review's, 14, 7/22/14, 8/18/14, and b irregularities were identified armacist with R6's ation regimen or care plan, consent for the use of R6's 9/18/14, at 9:16 a.m., the nursing (ADON) stated she R6's care until recently. The		The correction will be monitored by: Consultant Pharmacist ar DON	nd	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 428 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 Facility ID: 00299

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

Event ID: EY5V11

If continuation sheet Page 93 of 106

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		1	EET ADDRESS, CITY, STATE, ZIP CODE	
VERGRE	EN TERRACE			1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO
F 428	should be indicated ir individualized interver DON stated the const reviewing the medicar resident and making s listed in the residents psychotropic medicat stated the lack of psy behaviors in the care identified by the cons	ON) stated target behaviors n R6's care plan and contain ntions to reduce them. The ulting pharmacist should be tion regimen of each sure target behaviors are care plan when they are on ion. Further, the DON chiatry referral and target plan should have been	F 428		
F 441 SS=F	requested, but none v 483.65 INFECTION C SPREAD, LINENS The facility must esta Infection Control Prog safe, sanitary and con		F 441	F441	
	of disease and infecti (a) Infection Control F The facility must esta Program under which (1) Investigates, cont in the facility; (2) Decides what pro- should be applied to	on. Program blish an Infection Control i it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective		Immediate corrective action Counseling and retraining we completed for LPN –E and l who did not wear gloves of wash hands when administ insulin injections for resider #52 and #145.	was RN-C r tering

		ID HUMAN SERVICES			×	FOF	ED: 10/08/2014 RM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES = CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) DAT	IO. 0938-0391 TE SURVEY MPLETED
		245495	B. WING			0	9/18/2014
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
EVEDADE				2801 SOUTH F	IGHWAY 169		
EVERGRE	EEN TERRACE			GRAND RAP	IDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF ACH CORRECTIVE ACTION S DSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG F 441	Continued From page (2) The facility must p communicable diseas from direct contact wi direct contact will trar (3) The facility must r hands after each dire hand washing is indic professional practice. (c) Linens Personnel must hand transport linens so as infection. This REQUIREMENT by: Based on interview a facility's infection con surveillance program infections that occurr trends and analysis of interventions to preve which had the potent residents who resided the facility failed to us injections for 3 of the observed who receive Findings include: During review of the program 9/17/14, at 2 nursing (DON), who	<ul> <li>94</li> <li>brohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease.</li> <li>equire staff to wash their ct resident contact for which eated by accepted</li> <li>Ile, store, process and so to prevent the spread of</li> <li>T is not met as evidenced</li> <li>and document review, the trol program lacked a and investigation of ed in the facility for tracking of data to determine ent the spread of infections ial to affect 83 of the 83 d in the facility. In addition se gloves while administering 4 resident (R52 and R145) ed injections.</li> <li>facility's infection control 2:05 p.m. with the director of was identified as the</li> </ul>		441 Actic		others: ontrol es and re ing has birector or Welcov hand use prior ing an histration ( ractice ude on- ing for ong personnel nt n of coccur as s of the rts to the	
	components of the in missing. The DON e	entions nurse, there were fection control program xplained she has been ne infection control program,					
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: EYS	5V11	Facility ID: 00299	9	If continuation she	et Page 95 of 106

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		D HUMAN SERVICES		~	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
EVERGRE	EN TERRACE			1 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 441	had recently started a months. She stated to one with the Line List which indicates the ro- treatment and if it is h infection or communi- stated she fills out a l lists the resident/wing and if the had on infe- facility. She reports a assurance committee Review of the last 4 r June 2014 to Septern Listing of Resident In identify residents roo what type of infection had. The June 2014 Line I log identified a total of facility, four had uring one clostridium diffici resistent step aurus ( The log did not consi symptoms the reside location, cultures, tre heath care acquired The July 2014 Line L log identified a total of facility, two YTI's, on- unidentified infection identify specific symp having and cultures. The August 2014 Line Infection log identifie There were three res	at the facility in the past few wo forms are being used ing of Resident Infections bom, symptoms, cultures, realthcare associated by acquired infection. She infection Control Log that g, date, infection, action plan ction on admission or in ny trends to there quality the second second second second the second second second second facility forms from aber 2014 indicated the Line fections. The logs did not m or the units they were on, or what symptoms they Listing of Resident Infection of seven infections in the ary tract infections (UTI)'s; le (c-diff) ; one methcillian MRSA) and one pneumonia. stently identify specific ints were having, room/unit atment, and community or infection. isting of Resident Infection of four infections in the e pneumonia, and one . The log did not consistently otoms the residents were e Listing of Resident d a total of eight infections. ipiratory infections, identified	F 441	<ol> <li>All staff will be to on the Infection Program by 10/ to include the u practices that we being followed. nurses will be inserviced and preturn demonst on hand washing use when adminingections.</li> <li>Additional assist a second nurse her been instituted to the DON with the management of Infection Controp Program.</li> </ol>	Control 27/2014 pdated vere not All perform trations g/glove istering ance by has to assist e the l
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: EYS	5V11 Faci	lity ID: 00299	continuation sheet Page 96 of 106

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES		~	PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/18/2014
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	
				2801 SOUTH HIGHWAY 169	
EVERGRE	EN TERRACE			GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
· <u> </u>	<u> </u>				
F 441	these infections occu frame, or if any cross determined among th The September 2014 Infection log identified infections occurred w During interview 9/17 stated the forms shou the facility the infection symptoms they had, she was unable to tra- infections to determin cross contamination. DON stated the facility streptococcus (strep) eight employees, who	here was no indication if rred during the same time contamination had been lese residents. Line Listing of Resident d two infections, the date the ere missing. /14, at 2:15 p.m. the DON uld have indicated where in ons were, and what She stated without this data ack trends or analyze the ne a potential patter or any During the interview the	F 44	Date of completion: 10/27/2014 Recurrence will be prevented by: The Infection Prevention Committee will meet month to review all infections and analysis of surveillance monitoring and report their findings and action plans to QA Committee. This will be ongoing practice. All nurses will have random	nly the an
	strep symptoms. The facility provided Restrictions forms wh from 8/4/14 to 9/7/14 reported to have Wor	Work/School Excuse and hich indicated the following:		visual audits x 90 days of ha washing and glove use with injection administration and results will be shared with t QA Committee for input on	and d the the the
	stated it was strange employees that work develop strep sympto determine, how these transmitted from one the one month period			need to increase, decrease discontinue these audits. The correction will be monitored by: DON or Designee	or
FORM CMS-25	computer key boards but was unable to de	or the mouse's they all used termine how the infection e had not completed any		Facility ID: 00299 If conti	nuation sheet Page 97 of 106

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	OMB I	<u>VO. 0938-0391</u>
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING				9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	, <u>, , , , , , , , , , , , , , , , , , </u>		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				SOUTH HIGHWAY 169 ND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		······					
F 441	Continued From pag	e 97	F	441			
	handwashing audits	and increased there					
		the staff were on there					
	antibiotics for 24 hrs.	(hours) before returning to					
	work. She also post	ed a memo which indicated,					
		d illness among the staff. We					
		aff wear a mask when					
	entering resident roc						
4	[ventilators] or have	trach's [tracheotomy]. the carts with disinfecting					
	Nurses need to wipe	and mouse for the computers.					
	All staff make sure v	ou are using the alcohol					
	hand sanitizer and V	VASH YOUR HANDS, WASH					
	YOUR HANDS OFT	EN" The DON stated other					
		adding extra cleaning no					
	other tracking or tren	nding was conducted to					
	determine how the s	trep was being transmitted.					
	Although the facility	had not consistently track					
	and trended residen	t infections, they had a		1			
	pattern of employee	strep symptoms in a one					
	month period on the	300 unit form 8/5 to 9/7/14.					
		determined how these					
	employees were be	coming ill nor how the					
	infection was transn	nitted during the one month					
	period of strep symp	otoms. The facility did not					
	completed any audi	ts or handwashing education					
1	or starr, out complet	ed extra cleaning of the unit h their hands and wear a					
	mask when entering	resident rooms that have					
	traches and ventilat						
	The feature - Barris	faction Drovention Program					
	The facility policy Infection Prevention Pr Overview revised May 2014 indicated the			· [			
	activities of the proc	gram are surveillance of					
	infections with imple	ementation of prevention of					
	infections and contr	ol measures. The policy					
	further indicated the	ere is on-going monitoring for					
	infections among re	sidents and personnel and					
	subsequent docum	entation of infections that					
FORM CMS-2	567(02-99) Previous Versions (		Y5V11	Facili	ty ID: 00299	If continuation s	heet Page 98 of 10

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER	CLIA	(X2) MULT	PLE CONSTR	RUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUME			3			MPLETED
		245495		B. WING			0	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP COD	E	
					2801 SOU	ITH HIGHWAY 169		
EVERGRE	EN TERRACE	· · ·			GRAND	RAPIDS, MN 55744		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CO		(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY F	ULL	PREFIX	ĺ	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMAT		TAG		DEFICIENCY)		
						·····		
F 441	Continued From pag	e 98		F 4-	41			
		ta is done on-going an	ч					
		npleted and reported to						
	Infection Prevention	•						
		num data set (MDS) da						
	8/14/14, included no	cognitive impairment,						
	diagnoses of diabete	es mellitus.						
	During an et a second	n of modioation						
	During an observation	17/14 at 7:55 a.m. lice	nsed					
		)-E prepared the insuli						
	injection to be given	to R52. LPN-E prepar	ed the					
	insulin, the first was	Lantus 54 units and a	second					
	a pre-filled syringe o	f Novolog 18 unit. L	PN-E					
	entered R52's room,	explained what she w	as					
	going to do and lifted	d R52's shirt and gave	one					
	injection. She placed	d the syringe down and						
	picked up the other	syringe and gave that lower right quadrant o	f the					
	abdomen I PN-E d	id not wear gloves whil	e					
	administering the inst	sulin or wash her hand	S		{			
	before or after the in							
1	During an interview	on 9/17/14 at 8:05 a.m	•					
		n't wear gloves to give	nsulin					
	shots. I have never	wore gloves"						
	R145's admission m	ninimum data set (MDS	) dated					
	8/21/14, included a	diagnosis of diabetes a	and					
	required total assist	ance from staff for all						
	activities of daily livi							
		on on 9/18/14 at 8:35 a						
	registered nurse (R	N)-C prepared an insul						
	Injection to be given	to R145 which consist N-C entered R145's roc	eu or m and					
		was going to do. R145						
		injected the insulin into						
L			Event ID: EY5V11		Facility ID:	00299	If continuation st	neet Page 99 of 106
FORM CMS-2	567(02-99) Previous Versions C	Jusulete	LAGIUD'EIOAH		i coary io.			•

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 245495 09/18/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 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 465 F 465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL SS=E F465 E ENVIRON Immediate corrective action: The facility must provide a safe, functional, sanitary, and comfortable environment for The construction was stopped residents, staff and the public. and a plan put into place as soon as the issue was This REQUIREMENT is not met as evidenced identified. Resident # 154, 43, bv: 144, 96, 93, 143, and 19 were Based on observation, interview, and document review, the facility failed to ensure environmental assessed for respiratory status factors did not contribute to acute respiratory per facility policy. distress for 7 of 12 residents (R154, R43, R144,

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Facility ID: 00299

If continuation sheet Page 100 of 106

		ID HUMAN SERVICES			~	FORM	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY
		245495	B. WING			09/	18/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	801 SOUTH HIGHWAY 169		
EVERGRE				G	GRAND RAPIDS, MN 55744	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	all 20 residents who I Findings include: During observation of approximately 9:30 a using jack hammers a removing ceramic tile rooms on the 300's w The construction area double doors in the s dining room, was 6 at in length. The south intersected the nursif split into two hallway 300's unit. On the 30 residents with trached utilized ventilators. In residents had various 300's unit was also a unit. Removal of the floor noise in the facility, a dust wafted from the adjacent dining room the 300's wing and no the rooms of resident ventilators. Neither t construction area nea	R19) identified with nt, and potentially affecting ived on the 300's unit. n 9/16/2014 from .m. to 11:15 a.m., workers, and other tools, were from a floor, near resident ring of the nursing home. a, located just beyond outhwest corner of the main nd 1/2 feet wide, by 41 feet end of the construction area ng station, where the unit wings, which formed the	F	465		e 300 ity or nd	
	nursing station, were to contain dust and d the floor tile. At abou doors to the dining an	fitted with any kind of barrier ebris during the removal of at 10:15 a.m., the double ea were observed to be tiles were being removed. ea, there was a			scility ID: 00299 If contin		Page 101 of 106

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SUR	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	· · · · · · · · · · · · · · · · · · ·	COMPLETE	ED
		245495	B, WING		09/18/2	2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2801 SOUTH HIGHWAY 169		
EVERGRE				GRAND RAPIDS, MN 55744		
(X4) ID		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) OMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AF		DATE
	1	·		DEFICIENCY)		
F 465	Continued From page		F 46	5		
		ine, with an intake tube, and				
		ling to a window and outside.				
		foot prints, from walkers,				
		bes, were observed both in		A policy was put into pl	ace to	
	<b>.</b> .	near the 300's wing nursing		assure the Administrate		
		staff and visitors walked tion area. Dust was also				
		the 300's unit, on various		Maintenance Director	would	
		ient: a mailbox, chair rails on		meet with any construct	tion	
		s, shadow boxes, a number		workers during any fac	ility	
		nd the nursing station desk.				
		3		projects to assure a pla	li was ili	
	During interview on §	9/16/2014 at 10:23 a.m.,		place to create a safe		
		I)-D (the nurse manager for		environment for any re	sidents	
		vas aware there had been		in close proximity and	funable	
		ed over the past weekend, as		to do so, a plan to mov		
		going on right now. RN-D				
		n "no barriers put up," since		residents to another ar	ea of the	
		the tile floor. When asked if		facility during these tin	nes as	
	she had any concerr	ns for the residents on the ostomies and ventilators, in		well as barriers to cont	ain dust.	
		ion, RN-D stated "I have a		Well us bulliers to com		
		e dust." RN-D said she had		Staff will be re-educate	ed on the	
	not talked to anyone	about the construction dust,		Construction policy and	the Pre	
	and did nothing furth	er to address those concerns				
		nts on the 300's wing. RN-D		and Post Construction	FORCY DY	
		currently 4 residents with		10/27/2014.		
	ventilators, and 7 res	sidents with tracheostomies.				
				Date of completion:		
		16/2014 at 11:00 a.m.,		10/27/2014.		
		(MW)-A agreed there was the removal of the tile floor			-	
		stated there was work on				
		some in the past two weeks."				
		s to the dining area were				
	closed, and "the filtra	ation system was on."				
	During intensions on t	9/16/14 at 12:30 p.m. MW-B				
	stated, they were no	ariori-ariz.ou p.m. www-b	1			

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169		
				GRAND RAPIDS, MN 55744	DEOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 465	Continued From pag	e 102	F 465	5		
1 400		d to be set up or not prior to	1 400			
	removal of the tile flo	• •				
				Recurrence will be pre-	vented	
	Review of the reside	nt records on the 300 unit		by:		
	identified the following					
•		-		All future construction	projects	
	D1Edle diagnopoo fr	om the Minimum Data Sot		will have a plan identifi	ed prior	
		om the Minimum Data Set 014, included respiratory		to the start of the work	that	
		nce on a ventilator, aphonia		would ensure a safe, fu	inctional,	
		voice], and quadriplegia		sanitary and comfortab	ble	
		proximately 50 feet from the		environment for reside		
	wing.	the end of the southwest		and public.		
		ed 9/14/2014, indicated that		The correction will be		
	ribcage and chest ar			monitored by:	•	
		shortness of breath, which suctioning or repositioning,		Administrator or Desig	nee	
		s had rhonchi [course,				
		ounds]. On 9/14/2014 at				
	evaluation.	as sent to the hospital for				
		gency room (ER) notes,				
		icated R154 presented with				
		of breath, coarse lungs requested pain medication.				
		R, R154 received respiratory				
		turned to the nursing home				
	on 9/15/2014 at 3:40					
	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 respirato his ventilator status,	ry complications because of				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES							<u> DMB NO. 0938-039</u>	<u>11</u>
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245495	B, WING		·	09/18/2014		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
EVERGRE	EN TERRACE				2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
					PROVIDER'S PLAN OF CORREC	TION	(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	٦X	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION	1
F 465	When asked if the co been the reason for F MD stated "I can't sa the reason why [R15 evaluation." The MD the dust "could ma and have contributed admission. The MD home would do "ali much dust as possib and indicated agreer put up barriers during dust and debris in the R144's diagnoses, fr dated 7/16/2014, inci failure, and congesti nursing progress not 9/16/2014, indicated treatments twice ead for complaints of sho resided on the 300's R93's diagnoses, from indicated no remark. R93 resided on the 3 R43's diagnosis, from 8/14/2014, included dependence on resp nursing progress no 9/16/2014 indicated distress or occurren 300's wing.	Instruction dust could have R154's visit the the ER, the y the inhalation of dust was 4] was admitted to the ER for also said the breathing in of ke [R154] short of breath, "' to his recent ER said, he hoped the nursing I it could" to minimize as le with ventilated residents, nent that it would be best to g construction to reduce the e area. "Om the admission MDS luded chronic respiratory ve heart failure. A review of tes from 9/6/2014 to R144 requested nebulizer ch day on 9/6 and 9/7/2014, ortness of breath. R144 wing. "Om the annual MDS dated chronic airway obstruction, atus. A review of nursing 9/2/2014 to 9/16/2014 able respiratory occurrences. 300's wing. "It the admission MDS, dated respiratory failure, and biratory status. A review of	F	<sup>2</sup> 46	55			
L	i tao a ulagnoaca, int						tion about Dago, 104 of :	4.00

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Event ID: EY5V11

Facility ID: 00299

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>D. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING	<u> </u>		09	/18/2014
NAME OF P	ROVIDER OR SUPPLIER	h <u>a an an</u>			REET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE				801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 465	9/2/2014, included re airway obstruction. / notes from 9/2/2014 remarkable respirato R19 diagnoses, from 5/13/2014, included a dependence on resp nursing progress not 9/16/2014 indicated in concerns. R143's diagnoses, fr chronic airway obstru- respirator status, and review of progress n	spiratory failure and chronic A review of nursing progress to 9/16/2014 indicated no ry concerns. the annual MDS dated acute respiratory failure, and irator status. A review of	F	465			
	the facility administra started on September worked on that week construction compar- cabinets were remov- and the construction studs up and steel of administrator stated during theses times. facility was going for construction and dua "We have no plan at administrator acknow- tile, and maintained the air and mainly administrator said no	st, the administrator stated this point." The wledged the removal of the "there was minimal dust in					

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Event ID: EY5V11

Facility ID: 00299

If continuation sheet Page 105 of 106

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

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STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		245495	B. WING	······	09/18/2014
	ROVIDER OR SUPPLIER		280	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 465	doing construction in the nursing facility, st a plastic, poly barrier and seal off both end CW-A also said a bar along with a hepa-filte "Taken care of the du During an interview o the environmental se the facility "does have construction being pe the facility housekeep dining room and othe needed. She further s that dust barriers wer staff were removing t During interview with	6/2014 at 1:55 p.m., (CW)-A and B, who were the facility, not employees of ated they would have put up before starting, "To enclose s of the construction." riter to contain the dust, ered air purifier, would have est." In 9/18/2014 at 10:30 a.m. rvices director (ESD) stated as some dust from the erformed." The ESD stated bing staff were mopping the er floor areas after meals as stated she was "unaware re needed when the facility he floor tile." the administrator about the nit stated, on 9/16/14 at 1:30	F 465		
FORM CMS-25	67(02-99) Previous Versions Ob:	solete Event ID: EY5	V11 Facilit	iy ID: 00299 If continua	ion sheet Page 106 of 106

ATEMENT C	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	O. 0938-039 E SURVEY PLETED
D PLAN OF	CORRECTION		2	NG 01 - MAIN BUILDING 01		
		245495	B. WING	STREET ADDRESS, CITY, STATE, ZIP		/16/2014
IAME OF PF	ROVIDER OR SUPPLIER			2801 SOUTH HIGHWAY 169	0000	
EVERGRE	EN TERRACE			GRAND RAPIDS, MN 55744	i	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN C		(X5) COMPLETIO
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	CROSS-REFERENCED TO	) THE APPROPRIATE	DATE
170				DEFICIE	NCY)	
14 000		<b>N</b>	K	000		
K 000	INITIAL COMMENTS			poc ok		
	FIRE SAFETY			DUCAN		
				1 1	-19	
		urvey was conducted by the ent of Public Safety. At the		\$ 10-0		
$\sim$		vergreen Terrace 01 Main		$(\chi)$		
9	Building was found n	ot in substantial compliance		1		
50	with the requirement					
1-88-01	Medicare/Medicaid a 483,70(a). Life Safet	y from Fire, and the 2000				
0	edition of National Fi	re Protection Association				
		1, Life Safety Code (LSC),				
	Chapter 19 Existing	Health Care.				
61	PLEASE RETURN T					
X						
1	DEFICIENCIES (K-T	AG5) TO.				
	Health Care Fire Ins		i.			1
	State Fire Marshal D 445 Minnesota Stree					1
	St. Paul, MN 55101					
~				BECE	IVED	
1×	Or by e-mail to: Marian.Whitney@sta	ate mn us			TAL D	
χ.	Manan. Winning @ou					
2				0CT 2	1 2014	
A	THE PLAN OF COR	RECTION FOR EACH				
0-		INCLUDE ALL OF THE		MN DEPT. OF PU	BLIC SAFETY	
	FOLLOWING INFO	RMATION:		STATE FIRE MARS	SHAL DIVISION	
Y,	1. A description of w	hat has been, or will be, done				
1	to correct the deficie					
D	2 The actual or pro	posed, completion date.				
32	2. The actual, or pro	pood, completion date.	1			
	3. The name and/or	title of the person				
BORATORY	DIRECTOR'S OR PROVIDER	TOUPPLIER REPRESENTATIVES SIGNATI	JRE	TITLE		(X6) DATE
	nically Signed	TX 1/1		Ma 1	11	1-16-

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.

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

PRINTED: 10/08/2014 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245495	B. WING		09/16/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGA DEFERRINGED TO T	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
К 000	responsible for correct prevent a reoccurrent Evergreen Terrace is partial basement and different times. The of constructed in 1963, basement, and was of II(111) construction. If without a basement, west of the original b to be of Type II (111) story addition was co- original building, was (111) construction, ar fire barrier. This build residents and is staff story additions were wing (a chapel) and (special cares unit) w Type II (111) constru 2-hour fire barriers. T smoke zones by 30-1 barriers. The facility is fully sp accordance with NFF Installation of Sprink The facility has a fire detection in the corri sleeping rooms insta NFPA 72 "The Nation edition. The fire alarn automatic fire depart areas have automatit the fire alarm system Minnesota State Fire	ction and monitoring to ce of the deficiency a 1-story building with a was constructed at 4 original building was is 1 story with a partial determined to be of Type n 1968 a one story addition, was constructed south and uilding, and was determined constructed to the north of the e determined to be a type V and is separated with a 2-hour ding is no longer used by fonly. In 2001 two other one built, one north of the west one south of the west wing which were determined to be ction and separated with fhe building is divided into 8 minute and 2-hour fire	K		If continuation sheet Page 2 of 7

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:		I - MAIN BUILDING 01	COMP	LETED
		245495	B. WING		09/	16/2014
NAME OF PR	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
			28	801 SOUTH HIGHWAY 169		
EVERGRE			G	RAND RAPIDS, MN 55744		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETIC
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO		DATE
IAG	1			DEFICIENCY)		
K 000	Continued From page		K 000			
	census of 81 at the ti	me of the survey.				
	The facility was surve	eyed as a single building.				
		-				
	The requirement at 4 not MET:	2 CFR, Subpart 483.70(a) is				
K 050		ETY CODE STANDARD	K 050			
K 050 SS=F	NEPA IUI LIFE SAFI	ETT CODE STANDARD	11000			
33-r	Fire drills are held at	unexpected times under				
		t least quarterly on each shift.		KOEO	. //	27-1
		ith procedures and is aware		КО5О	10-	1
	that drills are part of			Facility Environmental Servi		
		nning and conducting drills is		Director will establish a year		
	assigned only to com	npetent persons who are leadership.  Where drills are				
		PM and 6 AM a coded		drill schedule with varying t	imes	
		be used instead of audible	1.2	monthly.		
	alarms. 19.7.1.2			The fire drills will be docum	ontod in	
			1	accordance with NFPA 101	Life	
	This STANDARD is	not met as evidenced by:		Safety Code		
		of fire drill records, it was				
	determined that the f			Environmental Services Dire		
	conducted fire exit di	rills in accordance with		Administrator or designee	will	
	National Fire Protect	ion Association (NFPA) 101		monitor for compliance.		
	"The Life Safety Cod	le" (LSC) 2000 edition				
	section 19.7.1.2. Not	conducting fire exit drills				
	response which wo	n and delay in the staff Jld negatively impact all 81 of				
		y visitors in a fire emergency.				
	Findings include:					
	At the conclusion of	the facility tour on 9-16-14 at				
		ation revealed that fire exit				
		onducted at varying times				
	and situations. The f	acility is conducting more				

		D HUMAN SERVICES MEDICAID SERVICES		-	FORM	: 10/08/2014 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245495	B. WING		09/1	6/2014
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH HIGHWAY 169		
EVERGRE	EN TERRACE			RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050 K 052 SS=F	majority of the drills of documented as being This deficient practice (DC) and the Adminis exit. NFPA 101 LIFE SAFI A fire alarm system re installed, tested, and with NFPA 70 Nation 72. The system has a and testing program requirements of NFP. This STANDARD is Based on document the facility's fire alarr conformance with 9.6.1.4. This deficient building occupants. Findings include: At the conclusion of	nber of drills. However, the n the 2nd shift are g conducted at 1509. e was confirmed by the staff strator (KH) at the time of ETY CODE STANDARD equired for life safety is maintained in accordance al Electrical Code and NFPA an approved maintenance complying with applicable A 70 and 72. 9.6.1.4	K 050	K052 The fire alarm will be scheduled be tested monthly in accordance with NFPA 72 Life Safety Code. The fire alarm system will be te and documented within 24 hou after a silent drill test is conduce on the night shift. Environmental Services Director Administrator or designee will monitor for compliance.	l to e ested urs cted	27-14
	testing the fire alarm	ated that the facility is not system at least one time per can be tested in conjunction				

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

Facility ID: 00299

If continuation sheet Page 4 of 7

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/08/2014 FORM APPROVED OMB NO 0938-0391

in.

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ONIE NO. 0930-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		09/16/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
K 052 K 061 SS=F	conducts a "silent" dr 6:00AM, the system s documented within 24 This deficient practice staff (DC) and the ad of exit. NFPA 101 LIFE SAFI Required automatic s valves supervised so will sound when the v 72, 9.7.2.1 This STANDARD is Based on observatio valve has been recer the complete automat tamper function of the into the fire alarm sys NFPA72(99) Section Section 903.4. This c a negative impact on building. Findings include: During the facility tou approximately 9:30A newly install 4" butte been recently installe automatic fire sprinkl	drills. However, if the facility ill between 10:00PM and shall be tested and 4 hours of the silent drill. e was verified by the facility ministrator (KH) at the time ETY CODE STANDARD sprinkler systems have that at least a local alarm valves are closed. NFPA not met as evidenced by: on, a new 4" butterfly control ntly installed on the riser of tic fire sprinkler system. The is valve has not been wired stem as required by 2-9.1.1 and MSFC(07) deficient practice could have all occupants of the arr on 9-16-14 at M,observation reveled that a rfly water control valve has	K 05	K061 The Temper Function of a new butterfly control valve has bee wired into the fire alarm syste Work has been completed wir verified documentation. Environmental Services Direct Administrator or designee wir monitor for compliance.	en em. th tor, Il	
FORM CMS-256	57(02-99) Previous Versions Ob	solete Event ID: EY5	V21	Facility ID: 00299 If co	ontinuation sheet Page 5 of	

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

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245495	B. WING		09/16	6/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 061	tampered with. The r basement. This deficient condition	al if the valve were to be	K 06	1		
K 144 SS=F	Generators are inspe under load for 30 mir	PA 101 LIFE SAFETY CODE STANDARD enerators are inspected weekly and exercised der load for 30 minutes per month in cordance with NFPA 99. 3.4.4.1.		4 K144	10-2-	7-14
				A weekly and or monthly g inspection will be conduct 30% load testing in accord NFPA 110 Life Safety Code	ed under ance with	
	Based on a review of could not be verified generator is being p weekly and monthly This deficient practic staff and visitors.	not met as evidenced by: of available documentation, it that the emergency roperly inspected and tested as required by NFPA 110. es could affect all residents		This inspection will be doe on forms provided at time Environmental Services, Administrator or designed monitor for compliance.	e of exit.	
	10:30 AM, based on documentation, with Director, it could no emergency generato and or monthly in ac	the facility tour on 9-16-14 at interview, and review of the the Facility Maintenance t be determined, if the or is being inspected weekly cordance with the line in NFPA 110. It could not			*	

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

Facility ID: 00299

If continuation sheet Page 6 of 7

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OND NO. 0950-0591
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED
		245495	B. WING			09/16/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	
K 144	be determined if all the inspection are being monthly 30% load tes KW, fueled by diesel. facility at the time of e	the parameters of required met. This would include the sting. The generator is a 40 Forms were provided to the exit. e was confirmed by the staff(DC) and (KH)	K			
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: EY	′5V21	Facility ID: 00299	If cont	tinuation sheet Page 7 of 7



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

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

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

Evergreen Terrace October 6, 2014 Page 2

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

Minnesot	a Department of Healtl	า				
-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		00299	B. WING		09/1	8/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
EVERGRE	EN TERRACE		TH HIGHWAY 1 APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fin- the Minnesota Depart Determination of whe corrected requires co- requirements of the ru- number and MN Rule When a rule contains comply with any of th lack of compliance. L re-inspection with any result in the assessm	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
Minnesota Da	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are				
		SUPPLIER REPRESENTATIVE'S SIGNATURE	E	TITLE		(X6) DATE

6899

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
					-	
		00299	B. WING	710 0005	09	9/18/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
EVERGRE	EEN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	e 1	2 000			
	you electronically. Al is necessary for State enter the word "corre- text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Department On September 15-18 Department's staff, vi the following correction Please indicate in you correction that you ha and identify the date Minnesota Department the State Licensing C federal software. Tag	artment of Health orders being submitted to electronically. Although no plan of correction cessary for State Statutes/Rules, please the word "corrected" in the box available for You must then indicate in the electronic licensure process, under the heading oletion date, the date your orders will be cted prior to electronically submitting to the esota Department of Health. eptember 15-18, 2014 surveyors of this urtment's staff, visited the above provider and ollowing correction orders are issued. se indicate in your electronic plan of ction that you have reviewed these orders, dentify the date when they will be completed. esota Department of Health is documenting tate Licensing Correction Orders using al software. Tag numbers have been ined to Minnesota state statutes/rules for				
	column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested Me Time period for Corre PLEASE DISREGAR FOURTH COLUMN W "PROVIDER'S PLAN	npliance is listed in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute This Rule is not met as ng the surveyors findings ethod of Correction and ction.				

EY5V11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/18/2014		
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		[ 03	10/2014	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From page	e 2	2 000				
		JIREMENT TO SUBMIT A TON FOR VIOLATIONS OF STATUTES/RULES.					
2 435	MN Rule 4658.0210 S Assignments	Subp. 2 A.B. Room	2 435				
	must develop and improcedures for addresincluding complaints and roommates. At a procedures must inclu A. a mechanism resolution of room as complaints; and	omplaints. A nursing home plement written policies and essing resident complaints, regarding room assignments a minimum, the policies and ude the following: for informal dispute ssignment and roommate r documenting the complaint					
	by: Based on interview, a facility failed to provid	it is not met as evidenced and document review, the de adequate notice of a new esidents (R15) who received					
	Findings include:						
	alert and orientated, which providing reminders a	ed 5/4/14, indicated R15 was with an intervention of and cues to help R15 sh routine to promote good					
	During interview on 9	/16/14, at 9:00 a.m., R15					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00299	B. WING		00/49/2044		
IAME OF PI	ROVIDER OR SUPPLIER		B. WING         09/18/2014           ET ADDRESS, CITY, STATE, ZIP CODE				
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 435	Continued From page	23	2 435				
	(9/15/14). She was n and would have liked	new room-mate yesterday tot given notice beforehand, to have known she was ate with more notice than					
	licensed social worke receive a new roomm stated R15 was told s room-mate on the sau hours before the room stated she should have	/17/2014, at 9:14 a.m., r (LSW)-A stated R15 did hate on 9/15/14. LSW-A she would be getting a new me day (9/15/14) a few nmate arrived. LSW-A we been given more notice of ate but, "It an be difficult to r hours notice."					
	-	gress notes, dated 9/5/14 to ify that R15 was notified or her new roommate.					
	indicated all residents notified of room chan Further, the policy sta notified of the room c	ge policy, dated 4/13/12, s and family members are ges prior to them occurring. ated roommate(s) would be hange prior to receiving a t specify a length of time to					
	director of nursing an facility process for roo	OD OF CORRECTION: The d/or designee could review ommate changes to ensure dequate notice of a change.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565				

EY5V11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	)/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		10/2014
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 4	2 565			
	•	nprehensive plan of care ersonnel involved in the				
	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:					
	7/17/14, indicated he disease, Alzheimer's further indicated seve	num data set (MDS) dated had peripheral vascular s and dementia. The MDS ere cognitive impairment room once or twice in his assist of two.				
	cannot ambulate inde amputation and declin plan also indicated hi unsteady and he part maintenance program supervision when abl	d 2/12/14, indicated he ependently due to recent toe ne in cognition. The care s balance while standing is icipates in a functional m (FMP) for ambulation and e. Staff assist with FMP mbulate 75-100 feet (ft.) up y x2.				
	The facilities nursing undated indicated R2 partment of Health	assistant care sheet 0 to ambulate 75-100 ft. with				

STATE FORM

EY5V11

				(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		
			B. WING			
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE,		09	0/18/2014
			OUTH HIGHWAY 169			
EVERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 5	2 565			
	daily. Review of the progree and facility assessme September 18, 2014 being ambulated 75- walker (FWW), and g directed by the Walki Guidelines Restorativ Maintenance Recommended for R2 During interview 9/18 stated R20 has stopp ago and that he has 1 with cares. R27's annual minimu 6/12/14, indicated he and transfers with su and was moderately plan dated 6/2/14, indices the which includes ambut times daily with a from gait belt and assist of R27's nursing assistant	i/14, at 9:44 a.m. NA-D bed ambulating over a month becoming more combative m data set (MDS) dated ambulates with set up only pervision and assist of one cognitively intact. R27's care dicated he was on a FMP lating 90 to 100 feet (ft.) two ht wheeled walker (FWW), f one staff.				
	Maintenance Recommindicated he was to a daily and to increase	ve Nursing Functional mendations dated 10/15/13, imbulate 90 to 100 ft. twice as tolerated.				
	September 18th, 201 "ambulating 90 to 100 with a front wheeled assist of one staff," w	ey Report for July 2014 to 4, did not identify R27 0 feet (ft.) two times daily walker (FWW), gait belt and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		08	0/10/2014
			UTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	9 6	2 565			
	Walking/Ambulation F Functional Maintenan by PT.	Program Guidelines ace Recommendations sheet				
	had a diagnoses of an accident (CVA), was transferred and ambu	llated in his room with ssist of one and did not				
	on a FMP to ambulate walker. R48's nursing undated indicated he twice daily with a wall Walking/Ambulation F Restorative Nursing F Recommendations da	was to ambulate 100 ft. ker. R48's				
	he does not ambulate ambulate him. He fu	/14, at 8:20 am R48 stated e and the staff do not offer to rther stated if staff would him he would not refuse, noted in his room.				
	maintenance program September 8, 2014 d	id not identify R48 had been ce a day with a walker, as				
	had arthritis and oste indicated she was co	ated 7/1/14, indicated she oporosis. The MDS further gnitively intact, transferred endently in her room. She				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, Z	IP CODE		10/2014
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	with no set up or phys R22's care plan dated ambulate up to 100 ft chooses not to, and u (FWW). R22's Walkin Guidelines Restorativ Maintenance Recommindicated she uses a with stand by assistant Nursing assistant care ambulate up to 100 ft one and FWW. Review of the facility Documentation Surve September 18th, 2014 ambulating 100 ft. "V which was started on indication this has be recommend on the 6/ Program Guidelines F Recommendations sh R24's quarterly MDS had dementia, was co with transfers and new of one to ambulate in R24's care plan dated ambulate independer	<ul> <li>in the corridor once or twice sical assistance from staff.</li> <li>d 1/20/14, indicated she can a daily with a gait belt. but uses a front wheeled walker ug/Ambulation Program are Nursing Functional mendations dated 6/10/14 FWW and ambulates 100ft ince (SBA).</li> <li>e sheet undated indicated to a with gait belt and assist of</li> <li>Evergreen Terrace every Report for July 2014 to 4, did not identify he was vith FWW and SBA daily" 06/10/14. There was no en completed as '10/14, Walking/Ambulation Functional Maintenance neet by PT.</li> <li>dated 7/8/14, indicated he cognitively intact, independent eded supervision and assist his room and corridor.</li> <li>d 8/27/13, indicated he can antly in his room and he</li> </ul>	2 565	DEFICIENC		
	ambulate independer prefers to use his wal and uses a FWW and					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00200	B. WING		-	
NAME OF P	ROVIDER OR SUPPLIER	00299 STREET A	ADDRESS, CITY, STATE			0/18/2014
			UTH HIGHWAY 169			
EVENGRE		GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 8	2 565			
	Recommendations dato ambulate 400 ft. The	Functional Maintenance ated 9/17/14, indicated he is ne Nursing assistant care ted to ambulate 400 ft. twice				
	September 18th, 201 ambulating 400 ft. wit FWW and SBA which There was no indicati as recommend on the Walking/Ambulation F	ey Report for July 2014 to 4, did not identify he was th one seated rest with a was started on 8/27/13. Fon this has been completed e 8/27/13,				
	she was cognitively ir	S dated 6/26/14, indicated ntact, needed extensive n transfers and did not o or corridor.				
	on a FMP to ambulate belt and assist of one on her left tiptoe due	d 6/20/14, indicated she is e 200 ft. with a FWW, gait e staff and resident is to walk to heel wound on left heel ector off when walking.				
	Restorative Nursing F Recommendations da	undated indicated to				
	that she only walks to	/14, at 8:20 a.m. R53 stated the bathroom and back, need assistance from staff				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00000				
IAME OF PI	ROVIDER OR SUPPLIER	00299 STREET A	ADDRESS, CITY, STATE,		09	/18/2014
		2801 SC	UTH HIGHWAY 169			
EVERGRE		GRAND	RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pag	e 9	2 565			
		d they do not offer to walk I the staff are not offering to vell.				
	September 18th, 20 <sup>-</sup> "ambulation 200 ft w contact guard assist and p.m." which was was no indication thi a day as recommend Walking/Ambulation	ey Report for August 2014 to 14, did not identify ith FWW, gait belt and (CGA) twice per day a.m. s started on 8/27/14. There s has been completed twice d on the 8/27/14				
	physical therapy (PT	8/14, at 9:18 a.m. with )-A stated she had just P and she has had no				
	he was moderately of transferred with super ambulated in his roo assistance. R139's of indicated he was on					
	Restorative Nursing Recommendations d was to ambulate 200 The nursing assistant	oulation Program Guidelines Functional Maintenance lated 8/29/14, indicated he oft. with FWW and CGA. It care sheet undated also e 200 ft. with FWW and				
	Review of the facility					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00299	DDRESS, CITY, STATE,		09	/18/2014
			UTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 10	2 565			
	September 18th, 201 "ambulation 200 ft wir assist (CGA) twice pe 8/29/14. There was completed twice a da 8/29/14 Walking/Aml	ey Report for August 2014 to 4, did not identify th FWW and contact guard er day" which was started on a no indication this has been by as recommend on the bulation Program Guidelines nce Recommendations sheet				
	had dementia and a d (CVA), had severe conneeded extensive as ambulate. R14's care indicated she is on a	dated 5/28/14, indicated she cerebral vascular accident ognitive impairment, and sist of one to transfer and e plan dated 9/12/14, restorative nursing program address her functional				
	Restorative Nursing F Recommendations da ambulated 30 to 80 ft two by PT. Nursing a	lation Program Guidelines Functional Maintenance ated 5/28/14, indicated R14 t. with a FWW and assist of ssistant care sheet undated twice daily 30 to 80 ft. with ssist.				
	September 18th, 201 "ambulation 30 to 80 day" which was starte no indication this has day as recommend o Walking/Ambulation F	ey Report for July 2014 to 4, did not identify feet with FWW twice per ed on 5/28/14. There was been completed two times a n the 5/28/14				
		/14 at 8:00 a.m. with nursing NA-D both stated they were				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00200	B. WING			
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE		09	/18/2014
			UTH HIGHWAY 169			
EVERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 11	2 565			
	having enough time of task. During interview 9/17 director of nursing st with their FMP and re The staff members w program had left their August 2014 and the charge of the program program was not bein the care plan for thes Although R20, R27, F R14 all had a FMP of	R48, R22, R24, R53, R139, f ambulation on their care not implemented these				
	REHABILITATION					
	severe cognitive impa disturbances and nee	agnosis of dementia, with				
	Motion Guidelines sh occupational therapy nursing recommenda	een Terrace Range of leet, dated 7/5/14 from (OT) identified a restorative ltion which included mes] 15 min [minutes] 6 x/wk				
	a problem with falls p weakness. The staff	updated on 7/21/14 identified preventions due to increased were directed to use a a day 6 days per week."				

	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
FVFRGRF		2801 SC	OUTH HIGHWAY 169			
		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 12	2 565			
	11:00 a.m. and on 9/	n 9/17/ 14 at 7:20 a.m., 18/14 at 12:00 p.m. R18 was he "Nu-step 15 minutes a ."				
	August 2014 did not i "Nu-Step level 1 x [tir [week]," were being in	ey Report for July 2014 and identify the use of the nes] 15 min [minutes] 6 x/wk				
	Occupational Therap the facility has a func- which was to be com aides. But, at this tim that are implementing and have not had any longer. COTA-A state	/17/14 at 2:13 p.m. Certified y Assistant (COTA)-A stated tional maintenance program pleted by their restorative e they do not have any staff g the restorative program, y for at least three weeks or ed if we don't have any staff he program does not get the residents.				
	practical nurse (LPN) not receive any exerc	/18/14 at 2:30 p.m. licensed -P stated the resident does cise with the Nu-Step, due to o implement the residents ce program.				
	PRESSURE ULCER	INTERVENTIONS				
	dated 8/1/2014, inclu kidney disease with h scapula and multiple Minimum Data Set (M indicated R36 was co	IDS), dated 7/23/2014, gnitively impaired, and hysical assistance for				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00299			09	/18/2014
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
EVERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 13	2 565			
	ambulation. R36's Cl and included various intact skin, among wh turned and reposition lacked any direction of when R36 refused rep During observation or to 1:19 p.m. (2 hours seated in his wheel cl repositioning. R36 wh the noon meal at 10:3 to his usual table at 1 R36 was served, ther time he continued to chair. At 12:57 p.m., (LPN)-B approached chair, and pushed him room. Inside the roor signs, continuing to b he was to attend a ca few minutes, then exit	positioned or off-loaded R36 then propelled				
	At 1:19 p.m., nursing approached R36, and and stretch. NA-A off and encouraged him NA-D also asked R36	assistant (NA)-A I said it was time to get up ered to assist R36 to stand, to ambulate and stretch. to use the toilet in his II of NA-A's offers to move,				
	NA-A stated R36 had "around 10:30 this mo therapy and they off lo	n 9/17/2014 at 1:22 p.m., been last repositioned orning. I know he had baded him there for sure." n "almost three hours" since				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	0/18/2014
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page	e 14	2 565			
	NA-A stated that of la more and more "to st things suggested, like said when R36 is her difficult" to get him to During an interview o registered nurse (RN our repos [repositioni hours." RN-D said th area had resolved, he pressure ulcers, and	n 9/18/2014 at 9:00 a.m., )-D stated "We usually do ng] at least every two at although [R36's] pressure e remained at risk for future further, that [R36] "should ed at 2 hours." RN-D said				
	the director of nursing	n 9/18/2014 at 11:48 a.m., g (DON) stated the plan of ved" for any resident who tioning.				
	8/22/14, indicated R7 impairment, had a sta thickness tissue loss)	num Data Set (MDS), dated 7 had moderate cognitive age III pressure ulcer (full , and required extensive te transfers, bed mobility, living.				
	indicated R77 had a s his right outer ankle. indicated an intervent (to reduce pressure of	are plan, dated 4/1/14, stage III pressure ulcer on Further, the care plan tion of floating R77's heels on them), and to wear oke Boots) while in bed.				
	a.m., revealed R77 ly closed. R77 had his	7, made on 9/17/14, at 7:05 ying in bed with his eyes blankets pulled up over his els laying directly on the bed.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING			)/18/2014
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		//10/2014
VERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page 15		2 565			
		protective boots on to on his heels or ankles.				
	nursing assistant (NA white protective boots however she was uns them now or not. NA protective boots in be room, however had n since he moved room During interview on 9 stated R77 has not us bed since moving roo When interviewed on registered nurse (RN) supposed to be weard while in bed to reduce and ankle.	d when he was in a different ot seen them used for R77 is a couple months prior. /17/14, at 2:38 p.m., NA-G sed the protective boots in ms a couple months prior. 9/18/14, at 9:41 a.m., )-A stated R77 was ng protective Rooke boots e the pressure to his heels				
	-	/18/14, at 10:59 a.m., the ON) stated the care plan for n followed.				
	4/13, indicated impler occurs when disciplin	ng Process policy, dated nentation of the care plan es read, understand, and ver the residents daily care.				
	director of nursing an care plans for accurate	OD OF CORRECTION: The d/or designee could review cy and audit care to ensure ablished plan of care for				
	TIME PERIOD FOR	CORRECTION: Twenty-one				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00299	B. WING		09	09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		10/2014	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169				
			RAPIDS, MN 5574				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From page	e 16	2 565				
	(21) days.						
2 800	MN Rule 4658.0510 Staffing requirements	Subp. 1 Nursing Personnel;	2 800				
	home must have on of number of qualified r registered nurses, lice nursing assistants to residents at all nurses in all buildings if more	es relief duty, weekends,					
	by: Based on observation review, the facility fail nursing staff to meet resident care needs a the 200, 300 and 400 facility, and other resi the quality indicator s R48, R2 and R68) an concerns. This had t residents who require	t is not met as evidenced n, interview and document led to provide sufficient the on-going, assessed and services for residents in wings' of the nursing idents, as identified during urvey, (R36, R6, R77, R50, nd reviewed for staffing he potential to affect all ed assistance of staff to meet Il residents within the facility.					
	Findings include:						
	LACK OF TIMELY CA REPORTED BY RES	ARE AND SERVICES DENTS AND FAMILIES:					
	7/23/2014 indicated s and that R36 required	mum Data Set (MDS) dated severe cognition impairment, d extensive, physical es of daily living (ADLs),					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
				B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE		09	/10/2014	
	EN TERRACE	2801 SO	OUTH HIGHWAY 169	)			
EVERGRE	ENTERRACE	GRAND	RAPIDS, MN 5574	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE	
2 800	Continued From pag	e 17	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.						
	indicated R77 require for bed mobility, tran dressing, toileting an an interview on 9/16/ stated "I find myself of	ed extensive staff assistance					
	intact cognition. R50 assistance from two transfers, dressing, t personal hygiene. W 9/16/2014 at 8:47 a.r	staff with bed mobility, oileting, and completing					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00200	00299 B. WING			
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	03	0/18/2014
			OUTH HIGHWAY 169			
VERGRE		GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page	e 18	2 800			
	she had intact cogniti assistance with dress but limited staff assist dressing. During an i 8:45 a.m., R48 stated 30 minutes for assista and that it "usually ha R48 said that becaus she frequently had 'ad waiting too long was doesn't help," R48 sta R2's quarterly MDS d intact cognition. The required extensive as and dressing, and red transferring and toilet 9/15/2014 at 7:48 p.m 200's wing, she would assistance, but said " minutes before staff of because they only ha to help." R68's quarterly MDS, intact cognition. R68 staff for all ADLs, incl transferring, dressing personal hygiene. In 11:35 a.m., while wait stated "I always have to take care of me. I	ated 6/10/2014, indicated MDS further indicated R2 sist staff for bed mobility quired two staff for ing. In an interview on n., R2 stated that on the d have to wait 20 minutes for on the 400's wing, I wait 45 come to help me. It's ve one on during the week dated 7/18/2014, indicated was totally dependent on uding bed mobility,				
	STAFFING CONCER FACILITY PRACTICE	NS AS IDENTIFIED BY ES				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299			09	9/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
EVERGRE	EN TERRACE		RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From page	e 19	2 800				
	and document review each resident was pr services when recom when ambulation abil residents (R20) revie This resulted in actual experienced a decline Refer to F311: Base and document review ambulation services in maintain residents' al residents (R27, R48, and R18) who require Refer to F314: Base and document review comprehensively ass repositioning for 1 of for pressure ulcers. I resident needed to be every two hours, and	ess and provide timely 3 residents (R36) reviewed R36's care plan indicated the e repositioned as assessed was at risk to develop as not repositioned after 2					
	and document review necessary grooming	d on observation, interview v, the facility failed to provide for 1 of 3 residents reviewed vere dependent upon staff for v living (ADLs).					
	and document review the plan of care to pro for 1 of 9 residents re	d on observation, interview v, the facility failed to follow ovide ambulation services eviewed, (R20), who was not services as recommended					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00299 STREET A	DDRESS, CITY, STATE,		09	/18/2014
		2801 SO	UTH HIGHWAY 169			
			RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From page	e 20	2 800			
	R20 In addition, the fa plan of care and prov 8 of 9 residents (R27, R14 and R18) in order improve ambulation. follow the plan of care for 1 of 3 residents (R	resulted in actual harm for acility failed to follow the ide ambulation services for , R48, R22, R24, R53, R139, er to prevent a decline or Also, the facility failed to e to prevent pressure ulcers R36) reviewed who had a r, but remained at risk to ers.				
	LACK OF SERVICES REPORTED BY STAI					
	nursing assistant (NA to walk her residents	n 9/17/2014 at 8:00 a.m., .)-E stated she was unable because she "did not have hift." NA-D said, "I don't e my residents."				
	director of nursing (Di issue with the "function and restorative nursing staff member, who was	0/17/14 at 11:30 a.m., the ON) stated there was an onal maintenance program ng." The DON indicated the as in charge of the program, he last week of august. The ras in charge of the				
	staffing typically cons trained medication aid assistants. LPN-D st work, rarely is there a	se (LPN)-D stated the night ists of two nurses, one				

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE	1 00	
	EN TERRACE	2801 SC	UTH HIGHWAY 169	1		
EVENGNE		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page	e 21	2 800			
	<ul> <li><sup>2 800</sup> Continued From page 21</li> <li>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.</li> <li>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</li> </ul>					
t ר נ נ י י י י י י י י י י י י י י י י י	not right." In an interview on 9/1 registered nurse (RN are short [staffed]la the unit, and had to s unit." RN-F said that	<ul> <li>ks. LPN-C said "That is just</li> <li>8/2014 at 10:39 a.m.,</li> <li>)-F stated "We really often ast night we were short on hare an aide with another "yesterday" was shorted placement was only able to</li> </ul>				
	here, "get the basic c to visit, well there jus	t." RN-F said residents are, but if a resident wants t not time for that. I don't like ving sufficient staff to do				
	'consistently' short of completing resident r residents require two when using a [mecha aide cannot do it alor	A)-G said "I feel we are staff. We often run late in epositionings. Many of the staff, NA-G stated, and unical] lift to transfer, and one ne. "What can you do?" bsequent interview at 2:38				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
		00299			09	)/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE,	ZIP CODE		
	EN TERRACE	2801 SC	OUTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	l .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETI DATE
2 800	Continued From page	22	2 800			
passed late in the "because staff is NA-G also reside		rning and afternoon available to complete it." grooming and bathing" f 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 and going. We're sup eight for breakfast." I were not toileted as th "When it takes two to	we finally had everyone up oposed to have people up by NA-F also said residents ney should be, and that use the lift, and you only there is a staffing issue."				
	stated R68 "complain to get up earlier. NA- have time until 11:40	I added, "We just don't have				
	hospitality aide (HA)-, best they can with wh HA-A said that if there replacement for the s "it can be difficult for t unit where many of th	8/2014 at 11:19 a.m., A, said "The aides do the lat they have to work with." e a call in and no taff, and on the weekends, the aides, particularly on the residents require use of A-A said, "I see the aides				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE		09	/18/2014
			OUTH HIGHWAY 169			
VERGRE		GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page	e 23	2 800			
	director of nursing (D in the nursing home v and acuity," and add good right now." The staffing level is adequ residents." The DON were "quite a few res care," and that they " short." The DON sai call lights answered i any wait times over th said all staff [emphas lights, and determine of the resident are. F [emphasize all] nursi transfers, or whateven nursing can and mus said she felt the staff	18/2014 at 1:57 p.m., the PON) stated the staffing level was determined by "census ed "we're looking pretty e DON said "The current uate to meet the needs of the N said she realized there idents who required a lot of are the first to know if we are d the facility goal is to have n "five minutes," and that hat "is excessive." The DON size all] can answer the e what the immediate needs Further, the DON said, all ng staff can assist with er the need, and "all of t participate." The DON also was "more stable," of late, rent staff "are willing to help				
	director of nursing an current and ongoing if addition or relocation ensure all resident ca	IOD OF CORRECTION: The ad/or designee could review staffing patterns to evaluate on of staff is needed to ares needs are met. CORRECTION: Twenty-one				
	(21) days.					
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and	2 830			

STATE FORM

D PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
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ENTERRACE	GRAND	RAPIDS, MN 5574	4		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	24	2 830			
receive nursing care a custodial care, and su individual needs and p the comprehensive re plan of care as descr 4658.0405. A nursing of bed as much as po written order from the resident must remain	and treatment, personal and upervision based on preferences as identified in sident assessment and ibed in parts 4658.0400 and home resident must be out ssible unless there is a attending physician that the in bed or the resident				
by: Based on observation review, the facility fail factors did not contrib distress for 7 of 12 res R96, R93, R143 and I	i, interview, and document ed to ensure environmental ute to acute respiratory sidents (R154, R43, R144, R19) identified with				
Findings include:					
approximately 9:30 a. using jack hammers a removing ceramic tile rooms on the 300's wi The construction area double doors in the so dining room, was 6 ar in length. The south e intersected the nursin	m. to 11:15 a.m., workers, and other tools, were from a floor, near resident ing of the nursing home. a, located just beyond buthwest corner of the main and 1/2 feet wide, by 41 feet end of the construction area g station, where the unit				
	(EACH DEFICIENCY REGULATORY OR L Subpart 1. Care in ge receive nursing care a custodial care, and su individual needs and p the comprehensive re plan of care as descr 4658.0405. A nursing of bed as much as po written order from the resident must remain prefers to remain in b This MN Requirement by: Based on observation review, the facility fail factors did not contrib distress for 7 of 12 ret R96, R93, R143 and respiratory impairment Findings include: During observation or approximately 9:30 a. using jack hammers a removing ceramic tile rooms on the 300's w The construction area double doors in the so dining room, was 6 ar in length. The south of intersected the nursin split into two hallway 300's unit.	ENTERRACE SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 intensected the nursing station, where the unit split into two hallway wings, which formed the Jou's unit. Removal of the floor tiles resulted in intermittent	ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         EN TERRACE       2801 SOUTH HIGHWAY 168 GRAND RAPIDS, MN 5574         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 24       2 830         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.         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Removal of the floor tiles resulted in intermittent	CONDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         EN TERRACE       2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCEM UNST BE PRECEDED BY FULL REGULTIONY OR LSC IDENTIFYING INFORMATION)       ID PREFEX TAG       PROVIDERS PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO UENCIES         Continued From page 24       2 830         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 pars 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.         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ONDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE         EN TERRACE       2801 SOUTH HIGHWAY 169 GRAND RAPIOS, MN 5574         ISUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 24       2 830         Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual neces and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4563.0400 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.         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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING		09	9/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 5574				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From page	e 25	2 830				
	dust. The dust wafted into the adjacent dinin hallways of the 300's including into the root tracheostomies and w gateway at the end of nearest the dining root the construction area fitted with any kind of and debris during the about 10:15 a.m., the area were observed to tiles were being remo- area, there was a dus an intake tube, and a window and outside. prints, from walkers, w were observed both i the 300's wing nursin and visitors walked th Dust was also observ- unit, on various surfa- mailbox, chair rails or	ventilators. Neither the f the construction area om, nor the opposite end of , by the nursing station, were dust barrier to contain dust removal of the floor tile. At e double doors to the dining to be closed while the floor oved. In the construction st-abetment machine, with n exhaust tube leading to a Tracking marks and foot wheel chairs and shoes, n the dining area, and near g station, as residents, staff prough the construction area. wed throughout the 300's ces and equipment: a n the wall, light fixtures, nber of mechanical lifts, and					
	maintenance worker dust created during th this morning. MW-A the floor "today and s	6/2014 at 11:00 a.m., (MW)-A agreed there was ne removal of the tile floor stated there was work on some in the past two weeks." to the dining area were tion system was on."					
nesota De	There were not dust I the residents who live 300's unit had seven tracheostomies, four	barriers observed to protect ed on 300 unit. Presently the residents with					

STATE FORM

STATEMEN	ta Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	/18/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	, ZIP CODE	1 00	
		2801 SO	UTH HIGHWAY 169	)		
EVERGRE		GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 26	2 830			
	had various respirato was also a short-term	ry diagnoses. The 300's unit n rehabilitation unit.				
	interviewed on the 30 construction dust, and difficulties as a result interviewed stated the respiratory problem, I dust on the unit. Review of the resider following:	d if they had any respiratory of the dust. The residents				
	failure, with depender (inability to produce v MDS further indicated dependent upon staff (ADLs). The care are ADLs, dated 8/31/20 use of a mechanical l transfers due to inabi related to tracheostor room was approxima	f for activities of daily living ea assessment (CAA) for 14, indicated R154 required lift, with three staff, for all lity to stand, and for safety my and ventilator. R154's				
	at 8:00 p.m., R154 cc ribcage and chest are breath, which at that suctioning or reposition "rhonchi" throughout. that staff attempted v completed assessme send R154 to the em declined by the reside	d 9/14/2014, indicated that omplained of pain in the ea, and had shortness of time was not relieved by oning. R154's lungs had The note further indicated various interventions, ents, and that initial offers to ergency room which were ent. At 10:15 p.m., R154 e suctioned; following				

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	ROVIDER OR SUPPLIER	00299	DDRESS, CITY, STATE		09	/18/2014	
			UTH HIGHWAY 169				
VERGRE	EN TERRACE		RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From page	e 27	2 830				
	additional interventions, and requested to be sent to the hospital for evaluation.						
	notes, dated 9/14/20 presented with increa (SOB), coarse lungs requested pain medic included blood work, x-ray, suctioning, and including two differen R154 returned to the at 3:40 a.m. In a telephone intervi p.m., R154's medical review the 9/14/14 EI equalizer treatments, of adelectasis (a colla Further, the MD-A sta and had been improv construction dust cou R154's visit the the E say the inhalation of a [R154] was admitted MD-A also said the b make [R154] short of contributed" to his rea was at a high risk for because of his ventila medical issues and w MD-A further stated,	asing shortness of breath sounds, and that he cation. The ER treatment vital sign monitoring, a chest a various medications t nebulizer treatments. nursing home on 9/15/2014 ew on 9/16/2014 at 4:48 doctor (MD)-A said in a R visit, stated R154 had and was given a diagnoses apse of lung tissue). ated R154 had a chest x-ray, ing. When asked if the lid have been the reason for R, the MD-A stated "I can't dust was the reason why to the ER for evaluation." reathing in of the dust "could breath, and have cent ER admission. R154 respiratory complications					
	up barriers during con and debris in the area	that it would be best to put nstruction to reduce the dust a. om the admission MDS					
	-	uded chronic respiratory					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		08	9/18/2014
			UTH HIGHWAY 169			
VERGRE		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 28	2 830			
	<ul> <li><sup>2 830</sup> Continued From page 28</li> <li>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.</li> <li>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.</li> <li>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 respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status. A review of nursing progress notes from 9/1/2014 to 9/16/2014 indicated no respiratory status.</li> </ul>					
	9/2/2014, included re airway obstruction. A notes from 9/2/2014 t	wing. n he admission MDS dated spiratory failure and chronic a review of nursing progress o 9/16/2014 indicated no ry concerns. R96 resided on				
	5/13/2014, included a dependence on respi nursing progress note	o respiratory concerns were				
		om the MDS dated, included ction, dependence on				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		COMPLE	
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IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		0:	9/10/2014
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	29	2 830			
	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 METH					

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	director of nursing an to ensure facility proje care in a negative wa	d/or designee could monitor ects do not imapct resident	2 830			
2 900	Ulcers Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that: A. a resident who without pressure sore pressure sores unless condition demonstrate authenticates, that the B. a resident who receives necessary t	ent assessment, the director ust coordinate the sing care plan which enters the nursing home es does not develop s the individual's clinical es, and a physician ey were unavoidable; and o has pressure sores reatment and services to vent infection, and prevent	2 900			
	by: Based on observatior review, the facility fail accordance with an e physician orders, to p infection for 2 of 3 res current pressure ulce	stablished care plan and romote healing and prevent sidents (R77, R36) with r(s). This resulted in actual sed by worsening pressure				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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2 900	Continued From page	9 31	2 900			
	Findings include:					
	8/22/14, indicated R7 impairment, had a dia (a metabolic disease sugars over a long pe extensive assistance mobility and activities stage III pressure ulco slough may be presen depth of tissue loss) v (centimeter) X (by) 1. granulation tissue (pin moist, granular appea R77's care plan, revis had a stage III pressu ankle. The care plan be free of skin breakd interventions of, "Treat	nk or red tissue with shiny,				
	indicated R77 should wound (pressure ulce saline, dressed with o used for wounds with covered with Optifoar absorb wound draina Report, signed by the	y Report, dated 9/4/14, have his right outer ankle er) cleansed with normal calcium alginate (a dressing significant drainage), and m (a dressing used to ge). The Order Summary e medical doctor on 9/4/14, have this dressing changed				
	was lying in bed with blankets pulled up ov	n 9/17/14, at 7:05 a.m. R77 his eyes closed and had er his face, with his heels ed. R77 did not have any				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	)/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		2801 SO	UTH HIGHWAY 169	)		
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 5574	4		
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2 900	Continued From page	e 32	2 900			
		oke boots) on to reduce the or ankles as identified in				
	nursing assistant (NA white boots when he she was unsure if he or not. NA-F stated t protective boots in be	ed when he was in a different not seen them used since				
	stated R77 has not us	/17/14, at 2:38 p.m., NA-G sed the protective boots in a different room a few				
	registered nurse (RN supposed to be wear	9/18/14, at 9:41 a.m., )-A stated R77 was ing protective Rooke boots e the pressure to his heels				
	9/18/14 at 10:05 a.m. treatment for R77's ri was to cleanse it with calcium alginate, and Optifoam everyday. sock from his foot rev his right ankle. There dressing which read, Further, the dressing written underneath th resident's room at 10	f pressure ulcer care on RN-C stated the current ght ankle pressure ulcer normal saline, dress with cover the ulcer with RN-C removed R77's cotton vealing a foam dressing to e was writing on the foam "9-19" (the following day). had an illegible name e date. RN-D came into the :15 a.m. to observe the ulcer ted it appeared as if the				
	dressing had been pla prior, and the date on	aced on the ankle days the dressing had been tated it appeared the actual				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION ( ILDING:		E SURVEY PLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	03	0/10/2014	
	EN TERRACE	2801 SO	UTH HIGHWAY 169				
EVERGRE		GRAND	RAPIDS, MN 55744	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From page	9 33	2 900				
	dressing on R77's an RN-D stated the writin to be 9/15 versus 9/11 to observe the pressu RN-C, and RN-D. RN wound earlier that sat appeared the dressin since 9/15 according RN-A stated the ulcer dressing changed eve foam dressing from R wound was observed RN-A measured the p 1.0 cm X 0.1 cm, how had purulent drainage and the wound bed no granulation tissue, bu slough (non-viable tis debridement [remova wound appeared to h around the wound ed previously viewed ear completed the pressu applied a new Optifoa 9/18/14. When interviewed imm wound care observati a.m., RN-C stated the had not been consisted basis, as the physicia stated the ulcer seem previously had seen.	kle had not been changed. Ing on the dressing appeared 9. RN-A came into the room ire ulcer at 10:19 a.m. with V-A stated she had seen the me week, and it that it g had not been changed to writing on the dressing. The should be viewed, and the eryday. RN-C removed the 7.7, and the pressure ulcer by RN-A and the surveyor. The survey of the ulcer now the (primarily pus), foul odor, to longer had 100% t now contained some sue that requires I]). RN-A further stated the ave increased redness ges from when she had the rise ulcer treatment, and am dressing and dated it mediately following the on, at approximately 10:45 to pressure ulcer dressing ently changed on a daily n ordered. RN-C further is to be larger than she					
	Review of R77 record	l identified the following:					
	identified R77 develo	to the physician on 8/13/14, ped a "fluid filled blister on Area measures 1.4 X 2.5					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00299	B. WING		09	9/18/2014
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
EVERGRE	EN TERRACE		RAPIDS, MN 5574			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 34	2 900			
	dated 8/27/14, indicat pressure ulcer on his indicated the ulcer to cm in size, have 1009 wound base, moderat no odor or pain associ addition, the form ind was stable in conditio current treatment of c applying calcium algin foam dressing. R77's Weekly Wound dated 9/2/14, indicate pressure ulcer on his indicated the ulcer to cm in size, have 1009 wound base, scant se odor or pain associate the form indicated the improved in overall co continue the current to	ondition with a plan to reatment.				
	Documentation Form R77 had a stage III producer ankle. The form 1.0 cm X 1.0 cm X 0.3 granulation tissue in t serosanguinous drain and serous fluid), no associated with the pro- form indicated the pre-	completed Weekly Wound , dated 9/9/14, indicated ressure ulcer on his right n indicated the wound to be 2 cm in size, have 100% the wound base, scant hage (containing both blood odor, and no pain ressure ulcer. Further, the essure ulcer was stable in in was to continue the				
		or Predicting Pressure Sore ndicated R77 had no				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING			09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	EN TERRACE	2801 SO	UTH HIGHWAY 169	)			
EVERGRE		GRAND	RAPIDS, MN 5574	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETI DATE	
2 900	Continued From page	e 35	2 900				
	sensory perception in occasionally exposed occasionally, had ver nutrition, and was pol and shear. Further, t had an open area (pr and a history of skin l R77's Care Area Asse note, dated 9/18/14, i pressure ulcer on his remained at risk for fu related to R77's impa- incontinent of urine, a Further, the note indi- healing of stage 3 ulc dressing changes and During interview on 9 director of nursing (D orders and care plan followed. The DON s changes should be co orders, documented a plan interventions sho R77 had a current sta assessed at risk for fu development, and ha dressing changes of f facility did not implem as ordered by the phy pressure ulcer. The fa pressure ulcer. As a re- ulcer on his right ankl	npairments, was I to moisture, walked y limited mobility, excellent tentially exposed to friction he document indicated R77 essure ulcer) on his ankle, breakdown. essment (CAA) progress indicated R77 had a stage III right outer ankle, and urther skin breakdown ired mobility, being and cognitive impairments. cated, "staff are monitoring ter on right ankle daily with d documenting weekly." /18/14, at 10:59 a.m. the ON) stated the physician interventions need to be stated R77's dressing ompleted per the physician accordingly, and the care ould have been followed. age III pressure ulcer, was urther pressure ulcer. The nent daily dressing changes ysician for R77's stage III acility also did not implement ots while in bed to prevent opment or worsening of the sult, R77's stage III pressure					
		present, developed a foul					
	odor when none had partment of Health	been present before, and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SUR COMPLET	
		00299	B. WING	B. WING		2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	03/10/	2014
EVERGRE	EEN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	Continued From page developed purulent d infection on 9/18/14.		2 900			
	dated 2/2014, indicate serious skin condition facility should have a assure assessments for changes in conditi evaluated, and report indicated the date and should be recorded in R36's diagnoses, as if (CP), dated 8/1/2014, kidney disease with the scapula and multiple dated 7/23/2014, indi- impaired, and require assistance for ADLs, with bed mobility, tran Braden Pressure Son 8/18/2014, indicated development of press R36 repositioned him ulcers, dated 5/29/20 risk to develop press kidney disease, and r assistance with bed rn nursing progress note R36 had an open are measured 3 centimet than 0.2 cm in depth. During observation on seated in his wheel cl p.m., a total of 2 hour any off-loading (remo- perfusion) or repositioned and the second to the second second second second perfusion) or repositioned the second second second second second second perfusion) or repositioned second second second second second second second second second second second perfusion) or repositioned second se	ed. Further, the policy d time skin care was given the medical record. dentified on the care plan included dementia, chronic emodialysis, and fracture of ribs. The admission MDS, cated R36 was cognitively d extensive, physical including two-person assist hasfers and ambulation. A e risk assessment, dated R36 was at low risk for sure sores, and further, that self. The CAA for pressure the includicated R36 was at are ulcers related to chronic needing extensive nobility and weakness. A e dated 7/31/2014, indicated a on left buttocks, which ers (cm) by 2 cm by less				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		2801 SC	OUTH HIGHWAY 169	)		
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC		DF CORRECTION CTION SHOULD BE D THE APPROPRIATE NCY)	(X5) COMPLET DATE
2 900	Continued From page	e 37	2 900			
	other residents. At 1 by staff, and relocated dining area, and subs At 12:57 p.m., license removed R36, still se the dining area, and p Inside the room, LPN and continued to rem he was to attend a ca few minutes, and a st to the meeting room. L repositioned or off-loa At 1:09 p.m., R36, sti propelled himself from day room, positioning At 1:19 p.m., NA-A er approached R36, and up and stretch. NA-A stand, and encourage stretch. NA-D also as his room but R36 refu move, reposition, or of During an interview o NA-A stated R36 had 10:30 this morning," i hours" since R36 had wheel chair. NA-A ac been seated in his w repositioning or off-lo 50 minutes. NA-A sta been refusing more a repo, or do other thing teeth." NA-A also sai	d told him it was time to get A offered R36 to assist him to ed him to ambulate and sked R36 to use the toilet in used all of NA-A offers to off load. In 9/17/2014, at 1:22 p.m. been last repositioned "at t had been "almost three d been repositioned out of his cknowledged that R36 had				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE,	ZIP CODE		
		2801 SO	UTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	l .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 38	2 900			
	progress noted on 8/ of a stage 2 pressure measuring 0.8 cm x 0 cm. The ulcer was 10 scant, serous drainage with no signs or symp also indicated R36 ex- treatment. A review of from 8/13/2014, to 9/ pressure ulcer was he had resolved. During observation of LPN-A had assisted F buttocks was slightly LPN-A applied a barr previously open area denied any sensation During an interview of RN-D stated, "We us [repositioning] at leas said that although [R3 resolved, he remaine sores, and further, that repositioned at 2 hou be more aggressive i subsequent interview she did not know if R repositioned or off load dialysis, and noted th three hours." RN-D a was refusing to follow the days he does not said R36's refusal to the wheel chair "shou and care plan." RN-D	, during which time R36 of pain. on 9/18/2014, at 9:00 a.m. ually do our repos st every two hours." RN-D 36's] pressure area had d at risk for future pressure at [R36] "should have been rs." RN-D said, "We need to n follow through." In a y at 11:10 a.m., RN-D said				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
VERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 39	2 900			
	risk to develop press did not identify R36's repositioning or off lo not identify if R36 wa dialysis, even though hours three days a w pressure ulcers, and interventions to main required [R36] " to every 2 hours." The or action, staff were to off-site, such as when R36 refused reposition regardless of location During an interview of the DON stated the p followed" for any resi repositioning. The D refusals of care also	tain intact skin, among which be turned and repositioned CP lacked further direction, to take either, when R36 was n attending dialysis, or when oning or off-loading,				
	director of nursing an inservice staff and m	OD OF CORRECTION: The ad/or designee could onitor for compliance with cerning pressure ulcer care				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 910	MN Rule 4658.0525 Incontinence	Subp. 5 A.B Rehab -	2 910			

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		00299	B. WING		09/18/2014			
NAME OF PR	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE					
		2801 SC	OUTH HIGHWAY 169					
EVERGRE		GRAND	RAPIDS, MN 55744					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 910	Continued From page	e 40	2 910					
	have a continuous primanagement to reduce unnecessary use of comprehensive reside home must ensure the A. a resident who without an indwelling unless the resident's that catheterization w B. a resident who receives appropriate prevent urinary tract	o enters a nursing home catheter is not catheterized clinical condition indicates						
	by: Based on observation review, the facility fail received timely assist residents (R77) who I addition, the facility fa justification of use for							
	Findings include:							
	R77's care plan, date							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	03	10/2014
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
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2 910	Continued From page	e 41	2 910			
	<ul> <li>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.</li> <li>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.</li> </ul>					
	8/21/14, indicated R7 and had several risk f incontinence including being dependent on s assessment indicated incontinence resulted and, "Lack of ability to substitute". Further staff were to assist wi	g impaired mobility, and taff for transfers.The I R77 had functional from mobility impairments				
	stated this was their r (observation that mor a.m.) for delivering ca resident should have	/17/14, at 2:20 p.m., NA-F normal routine procedure ning on 9/17/14 at 7:08 are to R77. NA-F stated the been offered the use of the anged at the bedside. Also,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	00	/10/2014
	EN TERRACE	2801 SO	UTH HIGHWAY 169			
		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From page	e 42	2 910			
	-	used wound cleanser on his to provide perineal care.				
	<ul> <li>coccyx and buttocks to provide perineal care.</li> <li>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."</li> <li>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.</li> <li>During interview on 9/18/14, at 12:43 p.m., the</li> </ul>					
	been helped to the to cares as directed by t plan. The DON furthe	ON) stated R77 should have ilet by staff during morning the assessment and care er stated not assisting R77 R77's risk of further bladder s of function.				
	dated 4/13, indicated	Bladder Retraining policy, the facility will ensure each s incontinent, is given the e continence when				
	8/12/14, included a di accident (CVA), had s an indwelling Foley ca	nimum data set (MDS) dated agnosis of cerebral vascular severe cognitive impairment, atheter, extensive g, transferring and hygiene.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	00299 STREET A	DDRESS, CITY, STATE,		09	/18/2014
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_		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From page	e 43	2 910			
	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.					
	catheter and than liste diagnosis:urinary rete	d, 8/20/14 indicates urinary ed under problem list is "my ention" there was no ed why R150 had urinary				
	licensed practical nur is because he has uri unsure if he just had t hospital, was unsure R150 experienced, o	n 9/18/14 at 10:29 a.m. with se (LPN)-B said the catheter nary retention. She was the catheter when in the of how many cc of retension r how frequently did R150 and if it still was a problem.				
		14 11 a.m. the DON said cal from the hospital does as urinary retention.				
		nary catheter and/or urinary sted from the facility but not				
	SUGGESTED METH	OD OF CORRECTION: The				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00299	00299 B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	1	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 5574			
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2 910	Continued From page	e 44	2 910			
	-	ing medical justification for e of toileting programs to				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
2 915	MN Rule 4658.0525	Subp. 6 A Rehab - ADLs	2 915			
	comprehensive reside home must ensure th A. a resident is g treatments and servic abilities in activities o deterioration is a norr the resident's conditio part, activities of daily resident's ability to: (1) bathe, dress (2) transfer and (3) use the toilet (4) eat; and	iven the appropriate ces to maintain or improve f daily living unless mal or characteristic part of on. For purposes of this / living includes the , and groom; ambulate; ;; language, or other				
	by: Based on observatior review, the facility fail services to prevent lo residents (R20 and R assistance with ambu	t is not met as evidenced n, interview, and document led to provide ambulation iss of function for 2 of 9 (48) who required physical ulation, and were not ecline in ambulation. The				

Minnesota Department of Health STATE FORM

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STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	1 00	
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EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	ļ		
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2 915	Continued From page	e 45	2 915			
	harm for R20 and R44 Findings include: R20's quarterly Minim 7/17/14, indicated he disease, Alzheimer's, impairment, ambulate or corridor with assist pain medication and H R20's quarterly MDS had severe cognitive his room or corridor, r medication and had n Care Area Assessment indicated R20 triggere (ADLs) due to needin hygiene, bathing, not wheelchair or walker. During interview 9/17 nursing assistant (NA they have not been al other residents due to assignments for the p During observation 9/ sitting in his room in a not observed in his ro ambulation. During interview 9/18 assistant (NA)-D who has stopped ambulati that he has becoming She also stated, "We our residents," which past several months. Review of a Hospital 1/5/14, indicated R20 sepsis likely seconda amputation of the righ completed on 1/3/14	hum Data Set (MDS) dated had peripheral vascular dementia, severe cognitive ed once or twice in his room is of two, received scheduled had no presence of pain. dated 4/30/14, indicated he impairment, did not walk in received scheduled pain to presence of pain. The nt (CAA) dated 1/24/14, ed for activities of daily living g supervision with dressing, being steady and needs a /14, at 8:00 a.m. with b)-E and NA-D both stated ble to ambulate R20 and their work load to their work load to their work load to their work load to their distance of the stated ble to ambulate R20 and to their work load to t				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
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		00299	B. WING		09	/18/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744	L		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From page	9 46	2 915			
	amputation and declin plan indicated R20's H unsteady and that R2 functional maintenand ambulate with superv down the hallway time Review of R20's Pain updated on 6/20/14, i had no pain presence assessment for pain to 00-10 (00 being no pa pain experienced) R2 "1" mild discomfort. T R20 received Tylenol (analgesic) three time Assessment 3.0 date no pain presence, rar numeric rating was 00 identified R20 denied mg three times a day effective for pain relie dated 8/21/14, and 9/ from the 7/3/14, asse denied pain and Tyler effective for pain relie Review of R20's prog 9/22/14, did not indic pain or discomfort fro January 2014. The facility's nursing a undated, directed star with a front wheeled w two times daily. A Wa Guidelines Restorativ	ision 75-100 feet (ft.) up and es two, when able. Assessment 3.0 which was indicated when asked he e, rarely has pain and staff using numeric scale from ain to 10 being the worst 0 identified their pain as a The assessment identified 500 milligrams (mg) es a day. The Pain d 7/3/14, indicated R20 had ely has pain and his 0. The assessment pain, and the Tylenol 500 on 6/20/14, and seems f. The Pain Assessment 3.0 21/14, remained unchanged ssment indicating resident nol extra strength seems f. ress notes from 7/1/14 thru ate R20 was having any m his toe amputation in assistant care sheet ff to ambulate R20 75-100 ft. valker (FWW) and gait belt lking/Ambulation Program				
	physical therapy (PT) walked with a FWW a two self-performance	dated 4/9/14, indicated R20 and a gait belt 75-100 ft. with				

Minnesota Department of STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		00299 B. WING					
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2		09	/18/2014	
	NOWIDER OR SOLT LIER		UTH HIGHWAY 169				
EVERGRE	EN TERRACE		RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From page	e 47	2 915				
	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 state that R20 was not amb he had not been seer 4/9/14, when he'd sta walking/ambulation p	ed she hadn't been informed oulating, and confirmed that n by physical therapy since					
	of nursing (DON) stat facility started docum computer system and find any documentation R20 with his FMP that DON further stated the who left in March 201	/14, at 9:20 a.m. the director red in November 2013, the enting the FMP's in a new d stated she was unable to on that staff were providing it started on 4/9/14. The staff development nurse 4, was supposed to be y on his progress with his completed this.					
	occupational therapy the facility has a func- which was to be com- aides. But, at this time that are implementing and have not had any longer. COTA-A state	/17/14 at 2:13 p.m. certified assistant (COTA)-A stated tional maintenance program pleted by their restorative e they do not have any staff g the restorative program, / for at least three weeks or id, "If we don't have any staff he programs have not been of the residents."					

Ainnesota Department of Heal TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
	00200	00299 B. WING				
IAME OF PROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE,		09	0/18/2014	
AWE OF PROVIDER OR SUPPLIER		OUTH HIGHWAY 169				
VERGREEN TERRACE		RAPIDS, MN 55744				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915 Continued From pag	e 48	2 915				
"[functional decline] who presents with a ambulation due to pa current FMP for amb bilateral ankle ROM resulted in the patien more assistance for and ambulation." The initial assessment th walked 100 ft. with h current level of his a needs "moderate ass requires 50 % physic transfer]." The refer indicated his prior let current level is "0 fee indicated "Therapy is bilateral ankle ROM, along with updating of appropriate for the p with behavior disturb patient is at risk for f The referral indicated acetaminophen for p was currently having During interview 9/18 stated that R20 start that he was able to a front wheeled walker attempted to ambula and R20 would not a spoken to the staff a [R20] was no longer staff are supposed to declining or is no lon FMP, but stated she	ain but did not indicate R20					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		09	/18/2014
			OUTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From page	e 49	2 915			
	<ul> <li><sup>2</sup> 915 Continued From page 49</li> <li>During a phone interview 9/22/14, at 11:40 a.m.</li> <li>PT-A stated that if a resident was observed during her evaluation to have pain she would document that on the evaluation.</li> <li>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.</li> </ul>					
	had a diagnosis of ar accident (CVA), was transferred with limite	ed assist of one. He n with extensive assist of				
	5/23/13 he was place					
	indicated under comr identified "[R48] to an with walker and assis demonstrate benefits	tation dated May 2013 nents section of the FMP nbulation 100 ft. twice a day t of one staff. he will from his program by his sfer with assist of one staff."				
	and NA-D both stated ambulate R48 or their	/14, at 8:00 a.m. with NA-E I they have not been able to r other residents due to their ts for the past several				
	8:20 a.m. R48 stated the staff do not offer t	observation on 9/17/14, at he does not ambulate and o ambulate him. He further ffer to ambulate with him he				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		/10/2014
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 915	would not refuse. The in his room. During interview on 9 stated the facility has completed by their re time they do not have implementing the res not had any for at lea COTA-A stated, "If we the programs, the pro- implemented for any Review of the progree June 2014 to Septem R48 had been ambul a walker, as identified During interview 9/18 stated she would be nambul ated she would be nambul ate	ere was no walker observed /17/14 at 2:13 p.m. COTA-A a FMP which was to be storative aides. But, at this e any staff that are torative program, and have st three weeks or longer. e don't have any staff to do ograms have not been of the residents." as notes, and FMPs from ber 8, 2014, did not identify ated 100 ft. twice a day with d by the 5/23/13 FMP. /14, at 9:01 a.m. PT-A reassessing R48's ability to al Therapy Plan of Care 8/14 (during survey), evaluated for ambulation to The evaluation indicated he 100 ft and now was only t, but wanted to continue his ew 9/25/14, at 10:30 a.m. n she had evaluated R48 for y able to ambulate 20 feet,	2 915			
	a decline he was only and the program initia stated she had recom ambulate R48 up to 1 walker and assistance	v able to ambulate 20 feet, ally started May 2013. PT-A mend the facility to 00 feet with front wheeled e of two staff. to the facility for the May				

Vinnesota Department of Health			CTRUCTION		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
	00299	B. WING		09/18/2014	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZI	IP CODE		
		OUTH HIGHWAY 169			
EVERGREEN TERRACE	GRAND	RAPIDS, MN 55744			
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2 915 Continued From page	9 51	2 915			
During interview 9/17, stated they have an is restorative nursing an member who was in o walked off of the job t they currently have no program. Although R48 had a F ambulation, the facilit which resulted in a de was not reassessed, for R48. A Restorative Nursing March 2013, indicated "promote each resider attain his or her maxin promote each resider of physical, mental an The policy further indi- programs must be rev and need to address changes are made, w This needs to be dom- individualized and ad- maintaining or improv- motion (ROM), contin about how this is hap The policy also indica assess progress or la made, why programs discontinue in some o maintaining or restori residents activity of da	<ul> <li>/14, at 11:30 a.m. the DON ssue with their FMP and ad indicated the staff charge of the program had he last week of August and p one in charge of the</li> <li>FMP to assist with y failed to ambulate R48, ecline in ambulation which and resulted in actual harm</li> <li>g Program policy revised d the policy to, nts ability to adapt to or mum functional potential. To at shighest practicable level ad psychosocial functioning." icated all restorative nursing viewed by a registered nurse how they are working and if thy the changes were made. e quarterly. They must be dress how they are fing ambulation, range of ence etc. and be specific pening for each resident. Ited the notes need to ck of progress, changes needed to continue (or cases), and why program is ng a function that affects the aily living skills (ADL'S).</li> </ul>				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	00299 B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		10/2014
EVERGRE	EN TERRACE		OUTH HIGHWAY 169			
			RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From page	e 52	2 915			
	rehabilitation services	S.				
	Findings include:					
	6/12/14, indicated he depression. The MD ambulates with set up supervision and assis cognitively intact. R2 indicated he was on a ambulating 90 to 100	m Data Set (MDS) dated had diabetes mellitus and S further indicated he o only and transfers with at of one and is moderately 7's care plan dated 6/2/14, a FMP which includes feet (ft.) two times daily with er (FWW), gait belt and				
	indicated he was to a daily. R27's Walking/ Guidelines Restorativ Maintenance Recomm	re Nursing Functional mendations dated 10/15/13, pulate 90 to 100 ft. twice				
	9/17/14, indicated the re-evaluation for appr ambulation in order to decline. The referral Assessment his prior transfer and that he a contact guard, and hi	Plan of Care Evaluation dated e reason for referral for ropriateness of FMP for o check for any possible indicated for Initial level was stand by assist for imbulated 100 ft. needing s current level indicated he '5 ft. with contact guard				
nnesota De	September 18th, 201 "ambulating 90 to 100 with a front wheeled v	ey Report for July 2014 to				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		10/2014	
EVERGRE	EEN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744	Ļ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 915	There was no indicati as recommend on the Walking/Ambulation F Functional Maintenan by PT. During interview 9/18 therapist (PT)-A state now ambulates 175 ft R22's annual MDS da had arthritis and oster indicated she transfer ambulated independe ambulated independe ambulated in the corr set up or physical ass cognitively intact. R22's care plan dated ambulate although sh a FWW. The care pla ambulate up to 100 ft R22's Walking/Ambul Restorative Nursing F Recommendations da uses a FWW and am assistance (SBA). Nursing assistant care ambulate up to 100 ft one and FWW.	ion this has been completed e 10/15/13 Program Guidelines ace Recommendations sheet /14, at 9:05 a.m. physical ed she evaluated R27 and he t. ated 7/1/14, indicated she oporosis. The MDS further rred independently and ently in her room and idor once or twice with no sist from staff and is d 1/20/14, indicated she can the chooses not to, and uses an further indicated she can t. daily with a gait belt. ation Program Guidelines Functional Maintenance ated 6/10/14 indicated she bulates 100ft with stand by e sheet undated indicated to the sheet undated indicated to the sheet undated indicated to the sheet undated indicated to the sheet of the sheet of	2 915	DEFICIE	ENCY)		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
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IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	1 00	
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
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2 915	Continued From page	2 54	2 915			
	ambulating 100 ft. wi which was started on indication this has bee recommend on the 6/ Program Guidelines F Recommendations sh During interview 9/18 stated R22 has remai ambulation and has n R24's quarterly MDS had dementia and wa	10/14, Walking/Ambulation Functional Maintenance neet by PT. /14, at 9:10 a.m. with PT-A ned the same with her ot had a decline. dated 7/8/14, indicated he s independent with transfers on and assist of one to				
	ambulate independen prefers to use his wal and he uses a FWW a	8/27/13, indicated he can tty in his room and he ker while going on outings and transfer belt. The care ambulate twice daily for				
	Restorative Nursing F Recommendations da	ation Program Guidelines Functional Maintenance ated 9/17/14, indicated he is th a seated rest and FWW SBA).				
	Nursing assistant care ambulate 400 ft. twice	e sheet undated indicated to e a day.				
	9/17/14, indicated he	lan of Care Evaluation dated is currently able to ambulate d rest and supervision stand				
	Review of the facility	Evergreen Terrace				

	OF DEFICIENCIES OF CORRECTION	N (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING			09/18/2014	
IAME OF PI	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
VERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
2 915	<ul> <li><sup>15</sup> Continued From page 55</li> <li>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.</li> <li>During interview 9/18/14, at 9:12 a.m. with PT-A</li> </ul>		2 915				
	she had a thyroid dise	S dated 6/26/14, indicated order and needed extensive nsfers and did not ambulate or. The MDS further					
	on a FMP to ambulate belt and assist of one on her left tiptoe due	d 6/20/14, indicated she is e 200 ft. with a FWW, gait e staff and resident is to walk to heel wound on left heel ector off when walking.					
	Restorative Nursing F Recommendations da	ation Program Guidelines Functional Maintenance ated 8/27/14, indicated she n a FWW , gait belt and (CGA).					
	Nursing assistant car ambulate 200 ft. with	e sheet undated indicated to FWW twice a day.					
	dated dated 9/17/14,	apy Plan of Care Evaluation indicated she was able to now can ambulate 250 ft.					
	Review of the facility	Evergreen Terrace					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
				B. WING		
	ROVIDER OR SUPPLIER	00299	DDRESS, CITY, STATE,		09	/18/2014
			UTH HIGHWAY 169			
EVERGRE	EEN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From page	e 56	2 915			
	September 18th, 201 "ambulation 200 ft wir contact guard assist ( and p.m." which was was no indication this a day as recommend Walking/Ambulation F	th FWW, gait belt and (CGA) twice per day a.m. started on 8/27/14. There has been completed twice on the 8/27/14				
	that she only walks to she stated she would to walk in the hall and	/14, at 8:20 a.m. R53 stated b the bathroom and back, need assistance from staff d they do not offer to walk the staff are not offering to d R139.				
		/14, at 9:18 a.m. with PT-A arted her on FMP and she				
	he transferred with su	DS dated 6/27/14, indicated upervision and set up and n independently with no help gnitively impaired.				
		ed 9/17/14, indicated he is ates 200 ft. with FWW and				
	Restorative Nursing F Recommendations da	ulation Program Guidelines Functional Maintenance ated 8/29/14, indicated he ft. with FWW and CGA.				
	September 18th, 201	ey Report for August 2014 to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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IAME OF PE	ROVIDER OR SUPPLIER	00299	B. WING 09/18/201 ADDRESS, CITY, STATE, ZIP CODE				
	EN TERRACE	2801 SO	UTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From page	9 57	2 915				
	<ul> <li>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.</li> <li>Nursing assistant care sheet undated indicated to ambulate 200 ft. with FWW and CGA.</li> </ul>						
	stated he had just sta	/14, at 9:18 a.m. PT-A rted him on a FMP and he nd she did not re-evaluate					
	had dementia and a c (CVA) the MDS furthe	dated 5/28/14, indicated she cerebral vascular accident er indicated she needed le to transfer and ambulate ely impaired.					
	on a restorative nursi	1 9/12/14, indicated she is ng program the care plan unctional status with mobility.					
	Restorative Nursing F Recommendations da	ation Program Guidelines Functional Maintenance ated 5/28/14, indicated R14 . with a FWW and assist of					
	•	e sheet undated indicated to 30 to 80 ft. with FWW and					
	dated 9/17/14, indica	py Plan of Care Evaluation ted she was able to ow can ambulate 40 ft.					
	Review of the facility	Evergreen Terrace					

STATEMENT OF DEFICIENCIES (X1 NND PLAN OF CORRECTION						) DATE SURVEY COMPLETED	
		00299	299 B. WING		09/18/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	IP CODE			
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 915	Documentation Surve September 18th, 2017 "ambulation 30 to 80 day" which was starten no indication this has day as recommend o Walking/Ambulation F Functional Maintenar by PT. During interview 9/18 stated R14 has had m During interview 9/17 nursing assistant (NA ambulate her residen time on her shift. NA to ambulate her residen time of hursing (D issue with there funct and restorative nursir member who was und walked off of the job t they currently have no program and realized documentation that the completed. SUGGESTED METH director of nursing an all restorative ambula their completion as on	ey Report for July 2014 to 4, did not identify feet with FWW twice per ed on 5/28/14. There was been completed two times a in the 5/28/14 Program Guidelines are Recommendations sheet /14, at 9:20 a.m. with PT-A to decline in her mobility. /14, at 8:00 a.m. with 0)-E stated she is unable to ts due to not having enough -D also stated she is unable ents. /14, at 11:30 a.m. the ON) stated they had an ional maintenance (FMP) ing she indicated the staff charged of the program had he last week of august and to one in charge of the there has been no he programs are being OD OF CORRECTION: The d/or designee could review tion programs to ensure	2 915				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
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2 920	Continued From page	e 59	2 920				
s c t a s	MN Rule 4658.0525 \$	Subp. 6 B Rehab - ADLs	2 920				
	<ul><li>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:</li><li>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.</li></ul>						
	by: Based on observatior review, the facility fail grooming (nail care) f whom was dependen	t is not met as evidenced n, interview, and document ed to provide routine for 1 of 3 residents (R77) t on staff for care, whom vities of daily living and					
	Findings Include:						
	8/22/14, indicated R7 diabetes mellitus, req	num Data Set (MDS), dated 7 had an active diagnosis of uired extensive assistance onal hygiene, and had npairment.					
	required assistance w	d 9/8/14, indicated R77 vith dressing, grooming, and care plan indicated R77 care.					
	was seated in his whe had long, un-trimmed	n 9/16/14, at 9:22 a.m., R77 eelchair in his room. R77 fingernails on both hands, e underneath several of the					

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE	1 00	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From page	9 60	2 920			
	7:08 a.m., and 9/18/1	tions of R77 on 9/17/14 at 4 at 8:19 a.m., were made have un-trimmed, dirty				
	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.					
	assistant (NA)-D state trimmed on the reside	/17/14, at 9:04 a.m., nursing ed fingernails should be ent's bath day. Further, ngernails should have been				
	from staff to complete cares. RN-A stated F preference to have lo	)-A stated R77 required help grooming and personal				
	director of nursing (D expected to trim and Further, the DON sta	9/18/14, at 10:59 a.m., the ON) stated nursing staff are clean fingernails routinely. ted R77's fingernails should ccording to his preference.				
	8/09, indicated stand resident is provided t	e Standards policy, dated ards to follow to ensure each he highest practicable level policy indicated, "Fingernails clean and trimmed."				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	03	// 10/2014
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From page	e 61	2 920			
	director of nursing an inservice staff regard completion of activitie whom are dependent	ing timely and consistent as of daily living for residents				
21045	Mn Rule 4658.0620 S Dining Room	Subp. 4 Frequency of Meals;	21045			
	Subp. 4. Dining roor a specified dining are resident's choice and					
	by: Based on observatior review, the facility fail given the choice of m residents (R102, 92, 51, 117, 86 and 157)	t is not met as evidenced n, interview, and document ed to ensure resident were eal preferences for 13 of 16 85,18,150,107, 67, 64, 105, in the secured dementia ed as being capable of eal entrees.				
	Findings include:					
	9/15/2014 at 5:30 p.n wing, secured dement tables, awaiting the el loaded with resident in the unit. Licensed pro- individual trays off the resident, and in turn, and placed the food effects.	removed the plate covers, entree in front of the seated pleted this for all residents in				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00300	00299 B. WING				
AME OF PI	ROVIDER OR SUPPLIER		B. WING         09/18/201           ET ADDRESS, CITY, STATE, ZIP CODE				
			OUTH HIGHWAY 169				
VERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21045	Continued From page	e 62	21045				
	residents any questions related to the food entree, nor offer any choice to the residents regarding food choice.						
	9/17/14 at 8:00 a.m., wheeled a metal rack dementia unit where it dining room. The rack residents in the unit, a with a plastic insulate (NA)-I and licensed p removed the cover fro consisted of a cheese toast, and served all t dementia unit their pla not ask the residents a food choice or prefet that was already prov Also, there was no inc	e omelet, fried potatoes and the resident in the secured ates. NA-I and LPN-P did prior to being served about erence but served the food vided on each of the plates. dication in the secured list of meal alternatives or					
	room of the facility, nu and G were observed residents. Staff were wanted to eat, either vegetable, or country and gravy. The entre written on a white boa dining room. Staff too	p.m. in the main dining ursing assistants (NA)-D, F d collecting menu slips from a asking residents what they lasagne with garlic toast and fried steak, with potatoes ee choices were noted to be ard on the south side of the ok the slips into the kitchen, elivered the chosen meal to					
	R102's undated facilit diagnosis of altered n quarterly Minimum Da partment of Health						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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		00299			09	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21045	Continued From page	e 63	21045			
	also indicated R102 w herself understood to others. The care plan identified a choice of admission, with the in [R102] to locate radio programming of choid R92's undated facility diagnoses of dement The quarterly MDS, of cognitive impairment. R92 sometimes made others, sometimes un responded adequatel communication. The 9/18/14 identified a p facility activities which and escort to particip included, "Staff assist activities of choice as	life activities prior to htervention of, "Staff assist /TV/video/music ce upon request." y diagnosis sheet identified ia and Alzheimer's disease. lated 8/26/2014, indicated The MDS also indicated herself understood to hderstood others, and y to simple, direct care plan print date of reference about attending n needs reminders, invites bate. The interventions t to transport to these a scheduled, encourage nal visits,, 3m's discussion				
	diagnoses of Alzheim dementia. The quarter indicated cognitive im indicated R85 somet understood to others, others, and responder direct communication 9/18/14 identified, I w activities," with the int [R85] with setting up programming for him.	sometimes understood d adequately to simple, . The care plan print date of ant to attend some facility tervention of, "Staff assist				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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		00299			09	/18/2014
NAIVIE OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
EVERGRE	EEN TERRACE		RAPIDS, MN 5574			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21045	Continued From page	e 64	21045			
	requested."					
	The admission MDS, cognitive impairment. R18 usually made hir usually understood of communicating some but was able, if prom plan print date of 9/18 attend some facility a independent activities need assistance of in	Attified diagnosis of dementia. dated 6/5/2014, indicated . The MDS also indicated mself understood to others, thers, and had difficulty e words or finishing thoughts, pted or given time. The care B/14 identified wanting to ctivities but also have s. Staff were to assist with "I				
	diagnosis of depressi The admission MDS, cognitive impairment. R150: usually made h usually understood of communicating some but was able, if prom plan print date of 9/18 communicate my nee effectively communic plan also identified "I decisions", with a goa	ty diagnosis sheet identified on and cerebellar ataxis. dated 8/12/2014, indicated . The MDS also indicated himself understood to others, thers, and had difficulty e words or finishing thoughts, pted or given time. The care 8/14 identified, "I am able to eds", with a goal of, " I will ate needs daily." The care am able to make my own al of, "I want to remain in cisions", and "staff to fully cal status."				
	diagnosis of dementia disease. The admissi	ty diagnosis sheet identified a and cerebrovascular on MDS, dated 7/22/2014, ognitive impairment. The				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING		00/48/2044		
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE				
	EN TERRACE		UTH HIGHWAY 169				
EVERGRE		GRAND	RAPIDS, MN 55744	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21045	Continued From page	e 65	21045				
	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."						
	diagnosis of depressi MDS, dated 8/13/201 impairment. The MD herself understood to understood others. T 9/18/14 identified a c	he care plan print date of hoice of life activities prior to ntervention of, "Staff assist TV/video/music					
	diagnosis of confusio quarterly MDS, dated moderate cognitive in	ty diagnosis sheet identified n of unspecific site. The l 6/25/2014, indicated npairment. The MDS also ly made himself understood					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			9/18/2014
			UTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21045	Continued From page	9 66	21045			
	difficulty communicati thoughts, but was abl The care plan print da choice of life activities intervention of, "Staff radio/TV/video/music upon request." R51's undated facility diagnosis of senile de dated 8/6/2014, indica The MDS also indicat himself understood to understood others, ar communicating some but was able, if promp plan print date of 9/18 activities prior to adm of, "Staff assist [R51]	nd had difficulty words or finishing thoughts, oted or given time. The care 8/14 identified a choice of life ission, with the intervention				
	diagnosis of dementia disturbances. The qua 6/4/2014, indicated in also indicated R117 of others, and usually un plan print date of 9/18 of attending facility ac of, "Staff invite/remind activities of choice" R86's admission MDS cognitive impairment.	arterly MDS, dated tact cognition. The MDS made her self understood to nderstood others. The care 8/14 identified a preferences stivities, with the intervention d/assist to transport to S, dated 8/1/2014, indicated The MDS also indicated e herself understood to iderstood others, and				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
EVERGRE	EN TERRACE		UTH HIGHWAY 169			
			RAPIDS, MN 55744		05 00005071011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
21045	Continued From page	e 67	21045			
	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 10:49 the dietary manager (DM) stated menu sl printed for each meal for every resident. explained the slips list each resident's preferences, "like cranberry versus apple and each resident's dietary needs, "like n thick liquids, a diabetic diet, and adaptive and spoon." The DM said the resident m were printed with the day's main entree, t "the residents can choose to have an alte entree." The DM said the main daily entr the alternate entree were usually written of board in the dining room. The DM said re in main dining room would fill out their ow and were "asked by the aides what the eat," and had a choice of different food ite	(DM) stated menu slips are for every resident. The DM st each resident's nberry versus apple juice;" lietary needs, "like nectar ic diet, and adaptive plate said the resident menu slip day's main entree, but that oose to have an alternate d the main daily entree and vere usually written on the om. The DM said residents vould fill out their own slips, y the aides what they want to				
	secured dementia, ". system" in regard to t residents. The DM si residents on the secu- the residents' choices "what staff have lea resident likes and dis resident's preference	ew, the DM said on the they follow a different the entree meal choices for aid the daily menu slips for ured dementia unit reflected s and preferences, based on arned about what each likes." The DM said that s on the secured unit, "it was				
	further stated, "ofte to preferences." The up and put it on the tr locked unit] are not a want to eat." The DM	but from the residents," and n we had no family input as DM said, "When we dish it ray; they [the residents in the sked that day what they I further added that if the what was on the tray, the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	03	// 10/2014
			UTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21045	Continued From page	e 68	21045			
	<ul> <li>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.</li> <li>During interview on 9/17/2014 at 11:03 a.m., cook (C)-A stated she didn't know the residents on the</li> </ul>					
	those residents' entre what was is on their t can come back to the	it "had a choice." C-A said tes were dished up "as to icket." C-A said the aides kitchen and pick up a the secured unit, "About				
	in the secured demen choice of entrees, and main entree unless th though there was no found in the secured continued to state, the secured dementia un (R102, R92, R85, R1 R67, R64, R105, R51 making a choice betw entrees, but were not residents were in the	se (LPN)-B stated residents tia unit were not given a d were always given the ney told us differently, even listing of these meal choice				
	director of nursing (D "dining options" on th matter where the resi "each should have the	/18/2014 at 2:24 p.m., the ON) said she had discussed e locked unit, and stated, no dent is in the nursing home, e choices afforded all other also said, we should allow				

STATEMEN	a Department of Health T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE	1 00	
EVERGRE	EEN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21045	pg-	e 69 ake their dining choices, if	21045			
	were identified as bei choice of entrees, the	4, 105, 51, 117, 86 and 157) ing capable of making a ey were not provided that cility due to being in the				
	dietary manager and/	OD OF CORRECTION: The /or designee could review (s) to ensure resident and respected.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
21390	Subp. 4. Policies an control program must procedures which pro A. surveillance by collection to identify r residents; B. a system for d control of outbreaks of C. isolation and p reduce risk of transm D. in-service edu prevention and contro E. a resident hea immunization program defined in part 4658.	ovide for the following: ased on systematic data nosocomial infections in letection, investigation, and of infectious diseases; precautions systems to ission of infectious agents; ucation in infection	21390			

Minnesota Department of Health STATE FORM

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If continuation sheet 70 of 100

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00299			09	/18/2014
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE		
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	O THE APPROPRIATE	COMPLETI DATE
21390	Continued From page	e 70	21390			
	the prevention and treatment of infections;					
		ent and implementation of				
		cies and infection control				
		tuberculosis program as				
	defined in part 4658.0					
	<ul><li>G. a system for reviewing antibiotic use;</li><li>H. a system for review and evaluation of</li></ul>					
	-	infection control, such as				
	disinfectants, antisep					
	incontinence products					
		aintaining awareness of				
	current standards of p	practice in infection control.				
	This MN Requirement is not met as evidenced					
	by:					
		nd document review, the				
	facility's infection con					
	surveillance program					
	trends and analysis o	ed in the facility for tracking				
		ent the spread of infections				
	-	al to affect 83 of the 83				
		d in the facility. In addition				
		e gloves while administering				
		4 resident (R52 and R145)				
	observed who receive	ed injections.				
	Findings include:					
	During review of the f	acility's infection control				
		2:05 p.m. with the director of				
	nursing (DON), who w	vas identified as the				
		entions nurse, there were				
	-	fection control program				
		xplained she has been				
		e infection control program, at the facility in the past few				
		wo forms are being used				
	one with the Line List		1			

Minnesota Department of Health STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE		09	/18/2014
			OUTH HIGHWAY 169			
VERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21390	Continued From pag	e 71	21390			
	treatment and if it is infection or commun stated she fills out a lists the resident/win and if the had on infe facility. She reports a assurance committee Review of the last 4 June 2014 to Septen Listing of Resident Ir identify residents roc	oom, symptoms, cultures, healthcare associated ity acquired infection. She Infection Control Log that g, date, infection, action plan ection on admission or in any trends to there quality e. months of facility forms from nber 2014 indicated the Line nfections. The logs did not om or the units they were on, n or what symptoms they				
	log identified a total of facility, four had uring one clostridium diffic resistent step aurus The log did not cons symptoms the reside	Listing of Resident Infection of seven infections in the ary tract infections (UTI)'s; ile (c-diff); one methcillian (MRSA) and one pneumonia. istently identify specific ents were having, room/unit eatment, and community or infection.				
	log identified a total of facility, two YTI's, on unidentified infection	isting of Resident Infection of four infections in the e pneumonia, and one . The log did not consistently ptoms the residents were				
	Infection log identifie There were three res on the 300 unit, but t these infections occu	the Listing of Resident and a total of eight infections. spiratory infections, identified there was no indication if urred during the same time is contamination had been these residents.				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		10/2014
			OUTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	e 72	21390			
	Infection log identified	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.					
	Restrictions forms wh from 8/4/14 to 9/7/14 reported to have Wor	Work/School Excuse and hich indicated the following: eight employees had k/School Excuse and le to step symptom illnesses.				
	stated it was strange employees that work develop strep sympto determine, how these transmitted from one the one month period thought they were ge computer key boards but was unable to de was transmitted. She handwashing audits a cleaning, made sure	ed on the same wing oms. They were unable to e infections were being employee to another during d from 8/4/14 to 9/7/14. She itting the infections from the or the mouse's they all used termine how the infection e had not completed any and increased there the staff were on there				
	cleaning, made sure antibiotics for 24 hrs. work. She also poste					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	 B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	03	0/10/2014
			UTH HIGHWAY 169			
VERGRE		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	273	21390			
	wipes, key boards, ar All staff make sure yo hand sanitizer and W. YOUR HANDS OFTE than the memo and a other tracking or trend determine how the str Although the facility h and trended resident pattern of employees month period on the 3 The facility had not de employees were becc infection was transmit period of strep symptic completed any audits of staff, but completed and told staff to wash mask when entering retraches and ventilator The facility policy Infe Overview revised Mar activities of the progra- infections and control further indicated there infections among resi- subsequent documen occur. analysis of dat	ns that are on vent rach's [tracheotomy]. the carts with disinfecting ad mouse for the computers. u are using the alcohol ASH YOUR HANDS, WASH N" The DON stated other dding extra cleaning no ding was conducted to rep was being transmitted. ad not consistently track infections, they had a strep symptoms in a one 800 unit form 8/5 to 9/7/14. etermined how these oming ill nor how the tted during the one month or handwashing education d extra cleaning of the unit their hands and wear a resident rooms that have rs. ection Prevention Program y 2014 indicated the major am are surveillance of nentation of prevention of measures. The policy e is on-going monitoring for dents and personnel and tation of infections that a is done on-going and				
	-	pleted and reported to the				
		OD OF CORRECTION: The d/or designee could review				

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00200	B. WING		20/10/2014	
	ROVIDER OR SUPPLIER	00299 STREET A	ADDRESS, CITY, STATE	, ZIP CODE	09	/18/2014
EVERGRE	EEN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page	Continued From page 74				
	include ongoing surve trending of collected of education completed spread of infection.					
	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control		21426			
	maintain a comprehen infection control progression current tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortalit This program must in infection control plan unpaid employees, cor residents, and volunte Health shall provide to regarding implementa	ram according to the most infection control guidelines States Centers for Disease on (CDC), Division of ion, as published in CDC's ty Weekly Report (MMWR). clude a tuberculosis that covers all paid and ontractors, students, eers. The Department of echnical assistance ation of the guidelines. ce with this subdivision must				
	by: Based on interview a	t is not met as evidenced nd document review, the e a facility tuberculosis (TB) completed for 3 of 5				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00000	B. WING		09/18/2014	
	ROVIDER OR SUPPLIER	00299 STREET A	DDRESS, CITY, STATE		09	9/18/2014
			UTH HIGHWAY 169			
		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 75	21426			
	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:					
	received a chest x-ray	A)-B was hired 6/12/14, and y 6/24/14 which indicated he B did not have a symptom ring record review.				
	and had been working	(MA)-A washired 8/28/14 g at the facility,and did not rST or symptom screen until				
	had been working at	A)-A was hired 8/6/14 and the facility, and did not TST or symptom screen ecord review.				
	administrator verified receive there sympton	/14, at 1:00 p.m. the facility the employees did not m screening and that they ng the TST test upon hire for es.				
	lacked evidence that factors and physical s symptoms of TB had record also indicated	28/13, R77's medical record a assessment for risk screening for active been completed. R77's that his TST test that was 6/12/14 was documented as				
		/02/12, R90's medical ce that a assessment for risk screening for active				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299		B. WING		/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		09	//18/2014
			UTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	2 76	21426			
lac fac syr TS	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.					
	lacked evidence that factors and physical s symptoms of TB had	been completed.R93's d on 4/12/13 and 4/26/13				
	lacked evidence that factors and physical s symptoms of TB had	been completed.R62's d on 1/04/12 and 9/19/12				
	medical records indic measure the TST tes	/14, at 12:20 p.m. with ated the facility did not t results as they should have e documented as negative.				
	Program revised July risk assessments will infection prevention n indicated all staff and	osis Prevention and Control 2014, indicated Annual TB be completed by the urse. The policy further volunteers of the facility will ployment or volunteering.				
		OD OF CORRECTION: The d/or designee could review				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		10/2014
EVERGRE	EEN TERRACE	2801 SO	UTH HIGHWAY 169	)		
		GRAND	RAPIDS, MN 5574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 77	21426			
	<u> </u>	es for tuberculosis control ilities and complete ongoing missions to ensure				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			
	reviewed at least mor currently licensed by This review must be Appendix N of the Sta Surveyor Procedures Requirements in Lon the Department of He Health Care Financin This standard is inco available through the system. It is not subj B. The pharmaci irregularities to the di and the attending phy must be acted upon the physician visit, or soo pharmacist. For purp upon" means the accor report and the signing of nursing services an C. If the attendin with the pharmacist's not provide adequate pharmacist believes to being adversely affect refer the matter to the if the medical director	the resident's quality of life is sted, the pharmacist must e medical director for review				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE,		09	/18/2014
			OUTH HIGHWAY 169			
EVERGRE		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	e 78	21530			
	justification for the oru physician does not ch must be referred for r assessment and assu by part 4658.0070. If	the attending physician is the consulting pharmacist directly to the quality				
	by: Based on interview, a facility failed to ensur of 5 residents (R6) m	t is not met as evidenced and document review, the e irregularities identified in 1 edication regimen were pon by the consulting				
	Findings Include:					
	8/19/14, indicated R6 diagnoses of depress schizophrenia. Furth displayed no hallucin	um Data Set (MDS), dated was cognitively intact, had ion, manic depression, and er, the MDS indicated R6 ations, delusions, or other rs during the review period.				
	dated 5/14/14, indica psychotropic medicat Escitalopram Oxalate					
	Lorazepam ( an anti- daily at HS (hour of s schizophrenia and; Lorazepam 0.5 mg da partment of Health					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00000	B. WING			
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE,	09	/18/2014	
			OUTH HIGHWAY 169			
VERGRE		GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	e 79	21530			
	Haldol (an anti-psych in the morning and; Haldol 10 mg daily at paranoid schizophren The assessment indic admission to the facili of paranoid schizophr indicate if a psychiatry reduction (GDR) shou A subsequent Psycho Assessment, dated 7, continued to take Esc Lorazepam, and Hald time(s) as when asse further indicated an a medications, Latuda ( medication), was add regimen, but did not in been added. In addit indicated R6 was a no address if or when a 0 a psychiatry referral w	cated R6 to be a new ity, and have a long history renia, however did not y referral or gradual dose ald be completed for R6. opharmacological Drug /2/14, indicated R6 bitalopram Oxalate, lol at the same doses and ssed on 5/14/14. The form dditional antipsychotic (an anti-psychotic ed to R6's medication indicate a reason why it had				
	bipolar schizophrenia daily for treatment. T	6/23/14, indicated R6 had and received medication he care plan did not indicate wing psychiatry input for R6, target behaviors R6				
	dated 5/22/14, 6/20/1 9/17/14, indicated no by the consulting pha psychotropic medicat	ion Regimen Review's, 4, 7/22/14, 8/18/14, and irregularities were identified rmacist with R6's ion regimen or care plan, consent for the use of R6's				

Minnesota Department STATE FORM

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING		00/40/0044	
	ROVIDER OR SUPPLIER	00299	ADDRESS, CITY, STATE	09	9/18/2014	
	ROVIDER OR SUFFLIER		UTH HIGHWAY 169			
EVERGRE	EEN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	e 80	21530			
	Latuda medication.					
	assistant director of n was responsible for R ADON stated nothing R6's psychopharmac reduction or monitorir felt R6 to be stable (m psyche) and s/he was R6's medication regin significant psychopha use. The ADON state time any referral to ps	/18/14, at 9:16 a.m., the survive of the state of the st				
	registered nurse (RN) been referred to a psy extensive history of s stated R6 should hav GDR's for R6's psych medications as it wou subsequent interview 9/18/14, at 10:45 a.m psychotropic medicat R6's care plan does r behaviors for R6. RN felt to be stable in cor monitored for behavio might not require all c	chizophrenia. Further, RN-A e a plan in place to address iopharmacological ild be to her benefit. A was held with RN-A on . regarding R6's ion regimen. RN-A stated not address specific target I-A stated because R6 was ndition, she was not or. Further, RN-A stated R6 of her psychotropic r staff are not sure because				
	consulting pharmacis surprised R6 was not given R6's personal h psychotropic medicat	/18/14, at 10:50 a.m., the t (CP)-A stated s/he was being followed by psychiatry history of schizophrenia, and ion use. CP-A stated s/he R6's medication regimen				

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00299	B. WING	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE	• • • •		
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21530	<ul> <li>21530 Continued From page 81</li> <li>was of concern. Further, CP-A stated to behaviors should be listed on a resident plan and monitored accordingly.</li> <li>During interview on 9/18/14, at 12:45 p. director of nursing (DON) stated target</li> </ul>		21530				
	should be indicated in individualized interve DON stated the cons reviewing the medica resident and making listed in the residents psychotropic medicat stated the lack of psy	n R6's care plan and contain ntions to reduce them. The ulting pharmacist should be tion regimen of each sure target behaviors are care plan when they are on ion. Further, the DON chiatry referral and target plan should have been					
	requested, but none of SUGGESTED METH director of nursing an complete ongoing mo ensure pharmacy invo	OD OF CORRECTION: The					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
21540	MN Rule 4658.1315 Usage; Monitoring	Subp. 2 Unnecessary Drug	21540				
	monitor each residen unnecessary drug us home's policies and p pharmacist must repo	age, based on the nursing					

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		03	5/16/2014
EVERGRE	EN TERRACE	2801 SO	UTH HIGHWAY 169			
		GRAND	RAPIDS, MN 55744	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	982	21540			
	adequate justification believes the resident' adversely affected, the matter to the medical medical director is no the medical director of physician does not have the order and if the at change the order, the review to the Quality (QAA) committee req the attending physici	tion, or does not provide				
	by: Based on interview, a facility failed to provid referral, and complete 5 residents (R6) who psychotropic medicat Findings include: R6's admission Minim 5/21/14, indicated R6 May 2014. R6's quart (MDS), dated 8/19/14 cognitively intact, had manic depression, an the MDS indicated R6	num Data Set (MDS), dated admitted to the facility in erly Minimum Data Set , indicated R6 was I diagnoses of depression, d schizophrenia. Further, 6 displayed no ons, or other documented				
	R6's care plan, dated	6/23/14, indicated R6 had and received medication				

STATE FORM

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1 00	
		2801 SO	UTH HIGHWAY 169			
EVERGRE	EN TERRACE	GRAND	RAPIDS, MN 55744	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	e 83	21540			
		he care plan did not indicate ors, nor intervention(s) of ut 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;					
	in the morning and; Haldol 10 mg daily at paranoid schizophrer The assessment indic					
	did not identity if a ps	hia, however the assessment ychiatry referral was needed ction (GDR) should be				
	Assessment, dated 7 continued to take Esc Lorazepam, and Halo time(s) as when asse					
	medications, Latuda ( medication), was add	(an anti-psychotic led to R6's medication ndicate a reason why it had				
	address if or when a a psychiatry referral w	ew admission and did not GDR would be attempted, or would be made for R6, as it w admission to the facility				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09	0/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2	ZIP CODE		
EVERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	e 84	21540			
	still.					
	assistant director of n was responsible for R ADON stated nothing R6's psychopharmacc reduction or monitorin R6 was stable (regard psyche) and she was R6's medication regin significant psychopha use. The ADON state time any referral to ps "I'm thinking we have When interviewed on registered nurse (RN) been referred to a ps extensive history of s	ng. Further, the ADON felt ding her cognition and not in a hurry to address nen as a result despite her armacological medication ed she was unsure the last sychiatry was made for R6, to work on this stuff." 9/18/14, at 9:27 a.m., )-A stated R6 should have ychiatrist given her chizophrenia. Further, RN-A e a plan in place to address iopharmacological				
	During interview on 9 stated no formal beha completed for R6. RI charting should be co psychotropic medicat should be completed indicating a resident's regimen. RN-C state not contain any progr medication regimen a monitoring, or reducti A subsequent intervie 9/18/14, at 10:45 a.m	/18/14, at 10:41 a.m., RN-C avior monitoring was N-C further stated daily mpleted for someone taking ions, and a progress note at least every third week s psychotropic medication d R6's medical record did ess notes regarding her and/or plan for behavior on.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00299	B. WING		09	/18/2014
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
VERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744	L		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	85	21540			
	felt to be stable in cor monitored for behavio might not require all o medications, howeve they are not monitorin During interview on 9 director of nursing (D should be indicated in individualized interven Further, the DON stat referred to psychiatry and oversight given F and psychotropic med	br. Further, RN-A stated R6 of her psychotropic r staff are not sure because ing her regimen. (18/14, at 12:45 p.m., the ON) stated target behaviors in R6's care plan and contain intions to reduce them. ted R6 should have been to provide additional care 26's history of schizophrenia dication use.				
21685	director of nursing an staff regarding approp medication monitoring involvement to ensure and corrected prompt TIME PERIOD FOR 0 (21) days. MN Rule 4658.1415 S Housekeeping, Opera Subp. 2. Physical pla	g and monitor for pharmacy e irregularities are identified ly. CORRECTION: Twenty-one Subp. 2 Plant	21685			
	systems, and equipm continuous state of go					

Minnesota Department of STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	03	// 10/2014
EVERGRE	EEN TERRACE		UTH HIGHWAY 169			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	RAPIDS, MN 55744	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	COMPLET DATE
21685	Continued From page	86	21685			
	well-being of the resi routine maintenance	dents according to a written and repair program.				
	by: Based on observation review, the facility fail factors did not contrib distress for 7 of 12 re R96, R93, R143 and respiratory impairmen	t is not met as evidenced n, interview, and document ed to ensure environmental oute to acute respiratory sidents (R154, R43, R144, R19) identified with nt, and potentially affecting ived on the 300's unit.				
	Findings include:					
	using jack hammers a removing ceramic tile rooms on the 300's w The construction area double doors in the s dining room, was 6 at in length. The south intersected the nursin split into two hallway 300's unit. On the 30 residents with trached utilized ventilators. In residents had various	m. to 11:15 a.m., workers, and other tools, were from a floor, near resident ing of the nursing home. a, located just beyond outhwest corner of the main nd 1/2 feet wide, by 41 feet end of the construction area og station, where the unit wings, which formed the				
	noise in the facility, a dust wafted from the adjacent dining room the 300's wing and nu	tiles resulted in intermittent nd created visible dust. The construction area, into the , and down the hallways of ursing station, including into s with tracheostomies and				

STATE FORM

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00299	B. WING		09/18/2014	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 87	21685			
	Continued From page 87 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.					
	registered nurse (RN) the unit) stated she w remodeling completed well as construction g said there have been beginning to remove she had any concerns unit who had tracheos light of the construction little concern, with the not talked to anyone a and did nothing further regarding the residen identified there were overtilators, and 7 residen	/16/2014 at 10:23 a.m., )-D (the nurse manager for vas aware there had been d over the past weekend, as going on right now. RN-D "no barriers put up," since the tile floor. When asked if s for the residents on the stomies and ventilators, in on, RN-D stated "I have a e dust." RN-D said she had about the construction dust, er to address those concerns ts on the 300's wing. RN-D currently 4 residents with idents with tracheostomies.				
		6/2014 at 11:00 a.m., (MW)-A agreed there was				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09/18/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		10/2014
VERGRE	EEN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21685	21685       Continued From page 88         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.		21685			
	identified the following R154's diagnoses, fro (MDS) dated 8/25/20 failure, with depender [inability to produce v	at records on the 300 unit g: om the Minimum Data Set 14, included respiratory nce on a ventilator, aphonia oice], and quadriplegia proximately 50 feet from the				
	construction area, at wing. A progress note, date at 8:00 p.m., R154 co ribcage and chest are indicated R154 had s was not relieved by se and that R154's lungs rattling respiratory so	the end of the southwest ed 9/14/2014, indicated that mplained of pain the the				
	dated 9/14/2014, indi increasing shortness sounds, and that he r	gency room (ER) notes, cated R154 presented with of breath, coarse lungs equested pain medication. R154 received respiratory				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00299			09	9/18/2014
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
EVERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21685	Continued From page	e 89	21685			
	treatments. R154 ret on 9/15/2014 at 3:40	turned to the nursing home a.m.				
	medical director (MD) risk" for for respirator his ventilator status, a When asked if the co been the reason for F MD stated "I can't say the reason why [R154 evaluation." The MD the dust "could mak and have contributed admission. The MD s home would do "all much dust as possibl and indicated agreem put up barriers during dust and debris in the	said, he hoped the nursing it could" to minimize as e with ventilated residents, nent that it would be best to g construction to reduce the e area.				
	dated 7/16/2014, incl failure, and congestiv nursing progress note 9/16/2014, indicated treatments twice each	R144 requested nebulizer h day on 9/6 and 9/7/2014, rtness of breath. R144				
	4/18/2014, included of and tracheostomy sta progress notes from 9	m the annual MDS dated chronic airway obstruction, atus. A review of nursing 9/2/2014 to 9/16/2014 ble respiratory occurrences. 00's wing.				
	8/14/2014, included r	n the admission MDS, dated respiratory failure, and ratory status. A review of				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	9/18/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		2801 SC	OUTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 90	21685			
		es from 9/1/2014 to no remarkable respiratory es. R43 resided on the				
	9/2/2014, included re airway obstruction. A	m he admission MDS dated spiratory failure and chronic A review of nursing progress to 9/16/2014 indicated no ry concerns.				
	5/13/2014, included a dependence on resping progress note	the annual MDS dated acute respiratory failure, and irator status. A review of es from 9/2/2014 to no remarkable respiratory				
	chronic airway obstru respirator status, and review of progress no	om the MDS dated, included action, dependence on I tracheostomy status. A otes from 9/1/2014 to no remarkable respiratory				
	the facility administra started on Septembe worked on that week construction company cabinets were remove and the construction studs up and steel or					
	during theses times. facility was going forv construction and dust "We have no plan at	t, the administrator stated				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         IDENTIFICATION NUMBER:       A. BUILDING:			COMPLETE	
		00299	B. WING		00	0/18/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, Z	IP CODE		10/2014
EVERGRI	EEN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	tile, and maintained " the air and mainly o administrator said nu assessments" on the construction. In an interview on 9/1 construction workers doing construction in the nursing facility, st a plastic, poly barrier and seal off both end CW-A also said a bar along with a hepa-filte "Taken care of the du During an interview o the environmental se the facility "does have construction being pet the facility housekeep dining room and othe needed. She further se that dust barriers wer staff were removing to During interview with dust down the 300 ur p.m., "I did not have a SUGGESTED METH director of nursing an to ensure facility projecare in a negative wa	there was minimal dust in In the floor." The rsing was doing "respiratory residents in light of the 6/2014 at 1:55 p.m., (CW)-A and B, who were the facility, not employees of ated they would have put up before starting, "To enclose s of the construction." rier to contain the dust, ered air purifier, would have st." In 9/18/2014 at 10:30 a.m. rvices director (ESD) stated e some dust from the erformed." The ESD stated bing staff were mopping the r floor areas after meals as stated she was "unaware the administrator about the hit stated, on 9/16/14 at 1:30 any knowledge." OD OF CORRECTION: The d/or designee could monitor ects do not imapct resident	21685			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	/18/2014
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE	1 00	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 92	21805			
21805	MN St. Statute 144.6 Residents of HC Fac	51 Subd. 5 Patients & .Bill of Rights	21805			
	residents have the rig courtesy and respect	a treatment. Patients and ght to be treated with for their individuality by ons providing service in a				
	by: Based on observation review, the facility fai grooming to promote	n, interview, and document led to complete timely dignity for 1 of 3 residents riewed for activities of daily				
	Findings include:					
	8/22/14, indicated R7 assistance from staff and had moderate co R77's care plan, date	for his personal hygiene, gnitive impairment. ed 9/8/14, indicated R77				
	required assistance w bathing and weekly n	vith dressing, grooming, ail care.				
	was seated in his wh long, un-trimmed fing There was a dark sub of the nails. Subsequ 9/17/14 at 7:08 a.m.,	n 9/16/14, at 9:22 a.m., R77 eelchair in his room. with ernails on both hands. ostance underneath several ent observations of R77 on and 9/18/14 at 8:19 a.m., ued to have un-trimmed,				

STATEMENT	a Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING			)/18/2014
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	09	/18/2014
VERGRE	EN TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page		21805			
	stated he would like h and kept shorter and was embarrassing for with. During interview on 9 assistant (NA)-D who	9/18/14, at 8:19 a.m., R77 his fingernails to be trimmed that long, dirty fingernails r him to be seen by others /17/14, at 9:04 a.m., nursing cared for R77 stated his trimmed on the resident's				
		ninistration Record, dated not indicate R77 should d by the staff.				
	should have been trin	)-A stated R77 fingernails nmed by a nurse as he was I-A stated R77's long, dirty				
	director of nursing (D expected to trim and	9/18/14, at 10:59 a.m., the ON) stated nursing staff are clean fingernails routinely should have been trimmed erence.				
	purpose of ensuring a dignity and respect. I examples of appropri	gnity policy indicated a all residents are treated with Further, the policy indicated ate actions to promote oviding grooming according ividual wishes."				
	director of nursing an	OD OF CORRECTION: The d/or designee could ing provision of care with				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	9/18/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	• • • •	
EVERGRE	EN TERRACE		UTH HIGHWAY 169			
			RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21855	Residents of HC Fac. Subd. 15. Treatme residents shall have t and privacy as it relat personal care prograt consultation, examina confidential and shall Privacy shall be respo bathing, and other ac except as needed for assistance. This MN Requirement by: Based on observation review, the facility fail	ent privacy. Patients and the right to respectfulness tes to their medical and m. Case discussion, ation, and treatment are be conducted discreetly.	21855			
	who were dependent privacy.	ts (R68, R145) observed upon staff to provide				
	7/18/14, indicated R6 quadriplegia. The MI cognitive impairment, indwelling supra-pubi	DS identified R68 had no				
	was lying in bed, his of from the hallway whe staff could see the re- abdomen was expose	n 9/15/14, at 4:30 p.m., R68 door was wide open, visible ere residents,visitors and sident exposed. R68's ed along with their colostomy at collects stool, typically a				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299			00	9/18/2014
NAME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		/10/2014
EVERGREE	N TERRACE		UTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
	pad used to absorb flincontinence). R68 w due to limited use of fl His abdomen and low and could be viewed residents, visitors and When interviewed on stated he did not like exposed to other residental hallway, but he was u without staff assistand R145's admission Mindated 8/21/14, indicated mellitus, was cognitiv boxygen, and required for all their daily need During an observation administration, on 9/1 nurse (RN)-C entered shirt to provide a med the residents door op his insulin. R145 coul hallway where visitors administration of the in the door or curtain in visual privacy. When interviewed on stated they would typ providing medical treat	stool. R68's had an with blue chux (disposable uids typically used for vas unable to cover himself his upper body extremities. ver body remained exposed, from the hallway by other d staff. 9/15/14, at 4:30 p.m., R68 the door open, and being dents, and visitors from the unable to close the door ce. himum Data Set (MDS), ted R145 had diabetes ely intact, dependant on total assistance from staff is.	21855			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	9/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
EVERGRE	EN TERRACE	2801 SO	UTH HIGHWAY 169			
		GRAND	RAPIDS, MN 55744	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
21855	Continued From page	96	21855			
	director of nursing an inservice pertinent sta cares including perso	OD OF CORRECTION: The d/or designee could aff to provide privacy for all nal cares and injections. CORRECTION: Twenty-one				
21990	MN St. Statute 626.5 Maltreatment of Vulne	57 Subd. 4 Reporting - erable Adults	21990			
	immediately make an entry point. Use of a for the deaf or other s considered an oral re point may not require extent possible, the re content to identify the caregiver, the nature maltreatment, any ev maltreatment, the native reporter, the time, dat incident, and any othe reporter believes mig the suspected maltree reporter may disclose in section 13.02, and	me and address of the te, and location of the er information that the ht be helpful in investigating atment. A mandated e not public data, as defined medical records under ne extent necessary to				
	by: Based on interview, a facility failed to ensur abuse, neglect, injurie misappropriation of re were immediately rep	t is not met as evidenced and document review the e alleged allegations of es of unknown origin and esident property incidents ported to the administrator, re thoroughly investigated for				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00299	B. WING		09	)/18/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE,	ZIP CODE	1	
EVERGRE	EN TERRACE		OUTH HIGHWAY 169 RAPIDS, MN 55744			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLET
21990	Continued From page	e 97	21990			
	1 of 4 residents (R15	1) allegations reviewed.				
	Findings include:					
	dated 8/20/14, indicat cognitive impairment, behaviors or wanderi 8/13/14, indicated R1 status and dementiat home due to memory home and becomes a going home which sta agitated. The care pl aware of his surround but not always to time The facility's Elopeme 8/20/14, indicated R1 elopement, or history	however displayed no ng. R151's care plan, dated 51 had an altered mental with barriers to him going closs and inability to find angry when he asks about aff are to redirect him when an further stated he was dings and people around him e and place. ent Risk Assessment dated 51 had no history of				
	staying in the same rendered at Elop					
		/14, at 12:30 p.m. R151 nderstand why he is at the go home.				
	9/5/14, at 12:59 p.m. staff to be outside wa parking lot when I can cooperative and plea					
	to the main entrance to walk over their and					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00299	B. WING			148/2044
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		09	/18/2014
			OUTH HIGHWAY 169			
EVERGRE	EEN TERRACE	GRAND	RAPIDS, MN 55744	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	98	21990			
	immediately notified r thoroughly investigate	nor was the elopement ed.				
	director of nursing (D report the incident on he was attempting to R151 had left the buil lot unattended, and the clear if the staff knew just found him out the The facilities Elopeme indicated nursing mus reports of missing res indicated, "Any elope not seen leaving, or here	/14, at 9:21 a.m. with the ON) stated they did not 9/5/14 since she didn't feel elope. The DON verified ding went into the parking he progress note was not where he was or if they had ere. The policy revised July 2013, st report and investigate all sidents. The policy further ment where the resident is has unusual circumstances table incident under the				
	necessary to avoid pl anguish, or mental illr failure of a caregiver care or services, inclu clothing, shelter, heal is reasonable and ner the residents physica safety, considering th	een Terrace Abuse ed 5/21/12, indicated rovide goods and services hysical harm, mental hess. Neglect is defined as to supply a resident with the uding but not limited to food, th care or supervision which cessary to obtain or maintain I and mental health or e physical or mental ident which is not the result				
	had left the facility an wanted to go home. T the incident immediat	evere cognitive impaired, d made comments that he The facility did not reported ely to the administrator, upleted an investigation of				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY PLETED
		00299	DDRESS, CITY, STATE,	7/0.0005	09	/18/2014
			UTH HIGHWAY 169			
VERGRE	EN TERRACE		RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 99	21990			
	the incident.					
	director of nursing or	ing timely reporting and				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				