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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYXS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**

2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **HOMESTEAD REHABILITATION & LIVING CENTER**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/05/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria Thoma, HFE-NEII 04/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/06/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/19/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/08/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5428
Item 16 Continuation for CMS-1539

An extended NOTC survey was completed at this facility on January 9, 2012. Deficiencies were found, the most serious at a S/S level of H. Also at the time of the survey, conditions were found in the facility that constituted SQC to resident health or safety.

As a result, we imposed state monitoring effective February 5, 2012. In addition, we recommended to the CMS RO imposition of the following remedy:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00

On March 13, 2012 a health PCR conducted and one deficiency was found uncorrected at a S/S of D (no LSC deficiencies were cited at the time of the extended survey).

We therefore recommended the following to CMS:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00 remain in effect
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00 remain in effect
- Mandatory DOPNA, effective April 9, 2012

On April 5, 2012, a PCR was conducted and the remaining deficiency was found corrected. State monitoring is therefore discontinued effective March 27, 2012.

We are therefore recommending the following:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00 remain in effect
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00 remain in effect
- Mandatory DOPNA, effective April 9, 2012 be rescinded effective March 27, 2012

Please note the facility is subject to NATCEP loss effective January 9, 2012, due to the extended survey.

See attached is the CMS-2567b for the results of the April 5, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5428

April 6, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Dear Mr. Stampohar:

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 March 27, 2012 the above facility is recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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,

Nicole Steege

Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 6, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428021

Dear Mr. Stampohar:

On February 1, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 5, 2012. (42 CFR 488.422)

On February 29, 2012, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $1500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1500.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $2000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2000.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 9, 2012. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of February 29, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 9, 2012.

This was based on the deficiencies cited by this Department for an extended survey completed on January 9, 2012. The most serious deficiencies were found to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H) whereby corrections were required.

On March 13, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 9, 2012. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended

survey, completed on January 9, 2012. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On February 29, 2012, we notified the CMS Region V Office of the following actions:

- Per instance civil money penalty of $1500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1500.00 remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $2000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2000.00 remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 9, 2012. (42 CFR 488.417 (b))

On April 5, 2012, 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 March 13, 2012. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 13, 2012. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 27, 2012.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Per instance civil money penalty of $1500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1500.00 remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $2000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2000.00 remain in effect. (42 CFR 488.430 through 488.444)4)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 9, 2012 be rescinded effective March 27, 2012. (42 CFR 488.417 (b))

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

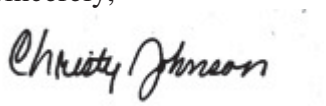
As we notified you in our letter of February 1, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 9, 2012.

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,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5428R12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245428	A. Building B. Wing	4/5/2012

Name of Facility	Street Address, City, State, Zip Code
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**03/27/2012**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CJ/NCS	4/6/12	28594	4/5/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/9/2012

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYXS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**

2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **HOMESTEAD REHABILITATION & LIVING CENTER**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/13/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sharron Williams, HFE-NEII 03/28/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/06/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/16/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/08/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5428
Item 16 Continuation for CMS-1539

At the time of the extended survey completed on January 9, 2012, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H) whereby corrections are required. Also at the time of the survey, conditions were found in the facility that constituted SQC to resident health or safety.

As a result, we imposed state monitoring effective February 5, 2012. In addition, we recommended to the CMS RO imposition of the following remedy:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00

On March 13, 2012 a health PCR conducted and one deficiency was found uncorrected at a S/S of D (no LSC deficiencies were cited at the time of the extended survey). State monitoring is therefore remaining in effect.

We are also recommending the following to CMS:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00 remain in effect
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00 remain in effect
- Mandatory DOPNA, effective April 9, 2012

Please note the facility is subject to NATCEP loss effective January 9, 2012, due to the extended survey.

See CMS-2567 and CMS-2567b for the results of the March 13, 2012 revisit. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4112

March 16, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428021

Dear Mr. Stampohar:

On February 1, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 5, 2012. (42 CFR 488.422)

On February 29, 2012, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1,500.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $2,000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2,000.00. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on January 9, 2012. The most serious deficiencies were found to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H) whereby corrections were required.

On March 13, 2012, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 9, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 27, 2012. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on January 9, 2012. The deficiency not corrected is as follows:

F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 29, 2012:

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $2,000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 9, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

As we notified you in our letter of February 1, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 9, 2012.

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.

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:

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114
Fax: (218) 308-2122

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 9, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

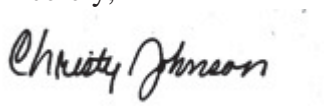
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5428R12.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245428	A. Building B. Wing	3/13/2012

Name of Facility	Street Address, City, State, Zip Code
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/13/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/13/2012**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/13/2012**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/13/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/13/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/13/2012**
ID Prefix **F0317** Reg. # **483.25(e)(1)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/13/2012**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CJ/NCS	3/16/12	19697	3/13/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245428	A. Building B. Wing	3/13/2012

Name of Facility	Street Address, City, State, Zip Code
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/13/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/13/2012**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **03/13/2012**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **03/13/2012**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CJ/NCS	3/16/12	19697	3/13/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/9/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	{F 000}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate interventions had been implemented related to falls from an electric height control bed to minimize the risk of further falls and accidents for 1 of 3 residents (R33) reviewed for falls. Findings include:	{F 323}	F 323 for 3/13/12 review The Plan of Care for Resident 33 was reviewed and updated on 3/14/12. The Plan of Care was subsequently updated on 3/22/12 after a Fall Prevention Committee recommendation. The electric control bed is unplugged and the cord is out of the reach of Resident 33 when he is in bed so he can not raise the bed, reducing the possibility of injury. Mats are placed next to bed to reduce injury, Hourly checks continue	3/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffry Stapleton — TITLE: CEO — (X6) DATE: 3-26-2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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{F 323}	Continued From page 1 R33's diagnoses included a recent below the knee amputation (BKA). The admission Minimum Data Set (MDS) dated 1/25/12, indicated R33 was severely impaired and was totally dependent on one or two staff for transfers and mobility. The MDS indicated R33 had sustained 2 or more falls since admission with no injury. The Falls Care Area Assessment (CAA) dated 1/25/12, indicated R33 was at risk for falls, had fallen from the wheelchair and had rolled out of his bed on to a mat. The 2/2/12, plan of care (POC) indicated R33 was unable to transfer independently, had a bed mobility deficit, and was at risk for falls. The POC also indicated R33 had a low bed, bed alarm, mat on the floor and staff were to complete a room check every 30 minutes when R33 was in bed. A review of the initial admission nursing documentation dated 1/18/12, indicated R33 was admitted from a hospital following a right BKA. The falls tracking form identified R33 had fallen/slipped from the bed unto the floor 10 times from 1/18/12 through 2/27/12. Review of the nurses progress notes from 2/27/12 to 3/12/12, included the following incidents: 2/27/12, 11:00 p.m. -- R33's alarm was sounding, R33 was found on the floor on the mat, bed in lowest position, no injury. 2/28/12, 5: 50 a.m. -- Alarm sounding, R33 was sitting on the mat leaning against the bed, call light with in reach, bed in lowest position, no injury.	{F 323}	from 7p.m. to 7 a.m. for Resident 33. Bed alarms remain in place for Resident 33. All residents have been audited for fall risk assessment. Individualized proactive preventative interventions are in place. Staff were educated on 3/15/12 regarding positioning of beds, positioning of residents, placement of personal need items to prevent falls. A root cause of falls during last 6 months was performed analyzing time of day, location, and activity. Residents continue to be assessed for risk and prevention measures implemented. Investigation of falls occurs immediately after the fall and the interdisciplinary fall prevention team reviews falls for additional recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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{F 323}	Continued From page 2 3/2/12, 9:15 p.m. -- R33's alarm sounding, resident on the floor on the matt, head on pillow and covered with blanket, no injury. 3/3/12, 1:30 a.m. -- Staff observed R33 using control at foot of bed to raise the bed up, staff talked to resident and left control alone. 3/4/12, 12:00 midnight -- Staff found R33 sitting on the edge of bed. R33 had raised the bed to highest position and had pushed the mats under the bed. At that time, bed was lowered and bed control was unplugged. 3/6/12, 5:00 a.m. -- Alarm sounding, R33 was found sitting on mat next to low bed, and had stated, "just slid out." No injury was noted. No further falls were identified. On 3/13/12, at 9:35 a.m. R33 was observed in his room, in a wheelchair with an alarm in place. There were mats in his room and the electric bed was plugged in. He was observed to have a splint on the right leg. He stated they had just removed the stitches from his leg and then asked when he would be getting a "wooden leg." On 3/13/12 at 9:40 a.m. nursing assistant (NA)-A stated R33 does not attempt to get out of the wheelchair anymore, but likes to get out of his bed at night. She was not aware R33 could raise the bed with the electric control, but added R33 likes to "fiddle" with things.	{F 323}	D. The DON/designee will review falls assessment and prevention for new admissions and all falls for appropriate investigation and interventions. Falls will be reviewed at weekly Fall Prevention Committee sessions ongoing. Variances will be reported to the Administrator and reviewed at QA at least quarterly. E. Date of Completion: March 27, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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{F 323}	Continued From page 3 On 3/12/12, at 3:15 p.m. the director of nursing (DON) stated she was unaware the resident had raised the electric bed up. She stated staff complete a post fall assessment after each fall, a post fall evaluation, and a supervisory report which included a root cause analysis and the actions implemented. At that time, the DON verified R33's bed should not be in the highest position, but because she had not been informed of R33's actions of raising the bed, no interventions had been implemented. The DON added the POC would be revised. On 3/13/12, at 1:15 p.m. the DON stated the unreported incidents involving R33 raising the bed up were concerning. She added the staff did the right thing at the time and unplugged the bed. She added there was a gap in communication and the POC should have been revised right away.	{F 323}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYXS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**
2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **HOMESTEAD REHABILITATION & LIVING CENTER**
(L4) **1002 COMSTOCK DRIVE**
(L5) **DEER RIVER, MN** (L6) **56636**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/09/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE-NEII 03/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 03/07/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/08/2012 GYXS CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5428
Item 16 Continuation for CMS-1539

At the time of the extended survey completed on January 9, 2012, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H) whereby corrections are required. Also at the time of the survey, conditions were found in the facility that constituted SQC to resident health or safety.

As a result, we imposed state monitoring effective February 5, 2012. In addition, we recommended to the CMS RO imposition of the following remedy:

- A PI CMP in the amount of $1500.00 for the deficiency cited at F317 (S/S= G) for a total amount of $1500.00
- A PI CMP in the amount of $2000.00 for the deficiency cited at F323 (S/S= H) for a total amount of $2000.00

Please note the facility is subject to NATCEP loss effective January 9, 2012, due to the extended survey.

See CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 2406

January 26, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
1002 Comstock Drive
Deer River, Minnesota 56636

RE: Project Number S5428021

Dear Mr. Stampohar:

On January 9, 2012, an extended 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 a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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:

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). The current survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 5, 2012. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F317, effective January 9, 2012, for a total penalty of $1,500.00. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of $2,000.00 for the deficiency cited at F323, effective January 9, 2012, for a total penalty of $2,000.00. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Homestead Rehabilitation & Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 9, 2012. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, 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: Oliver Potts, Chief
330 Independence Avenue, SE
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.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your 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 latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 9, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 9, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

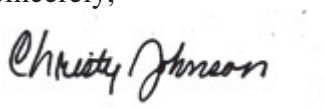
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5428S12.rtf

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

RECEIVED
FEB 14 2012
Minnesota Department of Health
Duluth

PRINTED: 01/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	01/09/2012 01/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	1602 COMSTOCK DRIVE DEER RIVER, MN 56636

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F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	all completion dates are 02/27/2012 See addendum	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post the most recent State survey results in a readily accessible location for 19 of the 26 residents identified as using chair or wheelchair all or most of the time.	F 167	F167 Element # 1 The most recent survey results binder was lowered to the recommended height accessible (3 feet) for all residents including those in wheel chairs. Element # 2 At Resident Council residents were notified of the location of most current survey results. A memo noting the change was posted with the monthly activity calendar mailed to families. Element # 3 The RN supervisors and Social Worker have been educated on location and requirements for posting survey results.	2/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Stanford CEO | TITLE | (X6) DATE: 2-13-12

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

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F 167	Continued From page 1 Findings include: On 1/5/11, at 2:30 p.m., a posting of the State survey results were noted on the wall across from the nurses desk. The holder with the survey results were at an approximate 5 foot height. On 1/6/12, at 10:00 a.m. licensed practical nurse (LPN)-A stated the State survey results were not accessible to residents utilizing wheelchairs without having to ask for assistance. At 2:45 p.m. the acting director of nursing stated the survey results should be accessible to residents in wheelchairs and that the State survey result container would be lowered.	F 167	Element # 4 The DON/Designee will check the availability of the book weekly x 4 weeks, monthly x 2 months and quarterly on going. Exceptions will be reported to the Administrator and reviewed at QA at least quarterly. Element # 5 Corrective action completion date: March 15, 2012.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	F225 (LPN)-E no longer works at the facility. Residents 47 and 22 no longer reside at HRLC. A baseline audit was performed of incident reports during the annual survey and this was determined to be an isolated incident without investigation, timely reporting and communication with the common entry point. The vulnerable adult policy has been updated to reflect reporting, investigation, and notification	2/27/12

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F 225	Continued From page 2 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential verbal abuse had been reported to the State agency in a timely manner for 1 of 2 residents (R47), and also failed to ensure that an incident of potential verbal abuse had been investigated for 1 of 2 residents (R22) who were reviewed with an incident of potential verbal abuse by a staff member. Findings include: An isolated incident of potential verbal abuse occurred during the night shift on 8/31/11, by licensed practical nurse (LPN)-E towards 2 residents (R47 and R22). Documentation regarding R47 indicated the common entry point (CEP) had not been informed of the incident, the	F 225	requirements. The incident report form has been updated to cue staff to follow and check off required procedures. All staff has been educated regarding notification, investigation, and reporting abuse. Incident reports will be reviewed daily by the DON/Designee ongoing. Variances will be immediately corrected, reported to the administrator and reviewed at QA at least quarterly. Corrective action completion date: March 15, 2012. 02/27/2012	

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F 225	Continued From page 3 initial report to the State agency had not been done immediately, nor had the investigative report been submitted to the State agency within 5 working days. The facility had no documentation regarding the incident of potential verbal abuse by LPN-E towards R22 to indicate that an investigation had been done or that the incident had been reported to the State agency. R47 was diagnosed with dementia and was no longer a resident of the facility at the time of the survey. The admission Minimum Data Set (MDS) dated 8/31/11, indicated the resident had moderate cognitive impairment. R22 was diagnosed with multiple sclerosis and respiratory failure and was no longer a resident of the facility at the time of the survey. The annual MDS dated 6/14/11, identified R22 had no memory impairments and had modified independence with daily decision making. The Shift Happening form completed by two nursing assistants (NA) NA-I and NA-K dated 8/30/11, (later verified by licensed social worker on 1/4/12, at 2:05 p.m. that the date on that form should have read 8/31/11) identified an incident of potential verbal abuse by LPN-E towards R47 had occurred on the night shift beginning 8/30 into 8/31/11. The form indicated after R47 had a fall, LPN-E began yelling and swearing at the resident. The form also indicated LPN-E yelled in anger at R22 sometime within the same shift. The Incident Report indicated the incident regarding R47 was first submitted to the State agency on 9/1/11, and the investigative report was submitted 9/7/11. The investigative report	F 225		

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F 225	Continued From page 4 indicated on 8/31/11, staff members were interviewed and the LPN was terminated 9/1/11. Documentation was lacking regarding the notification of the administrator. No documentation was included regarding notification of the incident to the CEP (per State rules). No incident report or further documentation was completed regarding R22. On 1/4/12, at 2:02 p.m. the licensed social worker (LSW) verified the time the incident involving R47 occurred was 12:40 a.m. on 8/31/11, and at the time the night shift consisted of 2 nursing assistants (NA-I and NA-K) and an LPN who worked until 6 a.m. The LSW stated the NAs filled out the Shift Happening form and gave it to the on-coming LPN that started at 6 a.m. on 8/31/11. The LSW stated she found out about the incident the morning of 8/31/11. The LSW stated the administrator was notified that morning. The LSW verified the common entry point had not been informed of the incident. The LSW stated they ensured that LPN-E was not on the schedule for the next night shift, started the interview process of the NAs involved, and stated the previous DON (director of nursing) helped with that process. (The DON was unavailable for interview as she no longer worked at the facility). The LSW stated they just wanted to get it submitted to the State agency, but verified that happened after the NAs had been interviewed the following day, 9/1, as they were on night shift and had been unavailable/sleeping during the day. The LSW stated it was still within 24 hours that she initially submitted it. The LSW also stated R47 was being observed through the day and once she knew LPN-E wasn't working that night	F 225		

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F 225	Continued From page 5 and knew the resident was out of harms way, then she reported the incident to the State agency. The LSW stated they do normally submit the final investigation within 5 days, that was common knowledge. When asked if an investigation was done regarding the alleged verbal abuse towards R22 that occurred the same night of the incident regarding R47, the LSW stated there was an investigation done, but was not sure where it was. On 1/5/12, at 8:54 a.m. the LSW stated in regards to the incident involving R22, she would call the DON to see if she had further documentation about the incident. At 9:40 a.m. the LSW stated she had called the previous DON and the DON had not documented anything in a permanent file or record, but had investigated that incident as well. The LSW stated the incident involving potential verbal abuse by LPN-E towards R22 should also have been reported to the State agency. On 1/4/12, at 3:43 p.m. the administrator stated he had been notified of the incident on 8/31/11, regarding LPN-E, R47 and R22. On 1/5/12, at 9:48 a.m. the administrator stated he was in Duluth the day of the incident. The administrator stated he was notified of the incident by phone but could not retrieve his phone record to indicate that. The administrator stated they had a different DON at that time, a different lead human resources person, and different Quality Manager who had all been involved in this incident, but none of them were employed with the facility at this time so he was unable to ask	F 225		

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F 225	Continued From page 6 them additional questions regarding the incident. The Vulnerable Adult Assessment, Reporting and Prevention policy dated 8/1/09, directed, "All mandated reporters are required to report orally or in writing any suspected or known cases of physical, emotional, sexual, or verbal abuse or neglect while the incident is occurring or within 24 hours to their supervisor or Department Manager... The CEO will be notified within 24 hours that an internal investigation is proceeding." The procedure indicated written information regarding incidents of abuse and neglect shall be communicated to the State agency (addresses and phone numbers were included). However, neither policy addressed when the State agency would be notified or that the investigation of the incident would be submitted to the State agency within 5 working days. The undated Vulnerable Adult Maltreatment Prevention Plan indicated, "Once it has been determined that the incident is reportable, an oral report will be made immediately by telephone to the CEP" (common entry point).	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies were developed	F 226	F226 (LPN)-E no longer works at the facility. Residents 47 and 22 no longer reside at HRLC. A baseline audit was performed of incident reports during the annual survey and this was determined to be an isolated incident without	2/27/12

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F 226	Continued From page 7 and implemented related to the required components of notification of the administrator and State agency as well as the investigation report to the State agency regarding allegations of potential abuse/neglect for 2 of 2 residents (R47 and R22) reviewed with incidents of potential verbal abuse by a staff member. Findings include: The facility's Vulnerable adult policy lacked inclusion of immediate notification of the administrator and State agency for any alleged of abuse/mistreatment, and also lacked that the investigation would be submitted to the State agency within 5 working days. An isolated incident of potential verbal abuse by licensed practical nurse (LPN)-E towards 2 residents (R47 and R22) was not reported timely to the State agency for R47 and not reported to the State agency at all for R22. In addition, the policy was not followed in regards to notification of the incident to the common entry point (CEP) per State rules. The Vulnerable Adult Assessment, Reporting and Prevention policy dated 8/1/09, and the undated Vulnerable Adult Maltreatment Prevention Plan were reviewed. The Vulnerable Adult Maltreatment Prevention Plan identified verbal abuse as "use of repeated or malicious oral, written, or gestured language toward a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening." The Vulnerable Adult Maltreatment Prevention Plan indicated, "once it has been determined that the incident is	F 226	investigation, timely reporting and communication with the common entry point. The vulnerable adult policy has been updated to reflect reporting, investigation, and notification requirements. The incident report form has been updated to cue staff to follow and check off required procedures. All staff has been educated regarding notification, investigation, and reporting abuse. Incident reports will be reviewed daily by the DON/Designee ongoing. Variances will be immediately corrected, reported to the administrator and reviewed at QA at least quarterly. Corrective action completion date: March 15, 2012. 02/27/2012	

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F 226	Continued From page 8 reportable, an oral report will be made immediately by telephone to the CEP" (common entry point). The Vulnerable Adult Assessment, Reporting and Prevention policy directed, "All mandated reporters are required to report orally or in writing any suspected or known cases of physical, emotional, sexual, or verbal abuse or neglect while the incident is occurring or within 24 hours to their supervisor or Department Manager and orally to the County... The CEO will be notified within 24 hours that an internal investigation is proceeding." The procedure indicated written information regarding incidents of abuse and neglect shall be communicated to State agency (addresses and phone numbers were included). However, neither policy addressed when the State agency would be notified or that the investigation of the incident would be submitted to the State agency within 5 working days. The Shift Happening form completed by two nursing assistants (NA) dated 8/30/11, (later verified by licensed social worker on 1/4/12, at 2:05 p.m. that the date on that form should have read 8/31/11) identified an incident of potential verbal abuse by LPN-E towards R47 had occurred on the night shift beginning 8/30 into 8/31/11. The form indicated after R47 had a fall, LPN-E began yelling and swearing at the resident. The form also indicated LPN-E yelled in anger at R22 sometime within the same shift. The Incident Report indicated the incident regarding R47 was first submitted to the State agency on 9/1/11, and the investigative report	F 226		

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F 226	Continued From page 9 was submitted 9/7/11. The investigative report indicated on 8/31/11, staff members were interviewed and the LPN was terminated 9/1/11. Documentation was lacking regarding the notification of the administrator. No documentation was included regarding notification of the incident to the CEP. No incident report or further documentation was completed regarding R22. On 1/4/12, at 2:02 p.m. the licensed social worker (LSW) verified the time the incident occurred was 12:40 a.m. on 8/31/11, and at the time the night shift consisted of 2 nursing assistants (NA-I and NA-K) and an LPN who worked until 6 a.m. The LSW stated the NAs filled out the Shift Happening form and gave it to the LPN that started at 6 a.m. The LSW stated she must have found out about it the morning of 8/31/11. The LSW stated the administrator was notified, although they had not documented that he had been. The LSW verified the common entry point had not been informed of the incident. The LSW stated they ensured that LPN-E was not on the schedule for the next night shift, started the interview process of the NAs involved and stated the DON (director of nursing) helped with that process. (The DON was unavailable for interview as she no longer worked at the facility). The LSW stated they just wanted to get it submitted to the State agency, but verified that happened after the NAs had been interviewed the following day, 9/1, as they were on night shift and had been unavailable/sleeping during the day. The LSW stated it was still within 24 hours that she initially submitted it. The LSW also stated R47 was being observed through the day and once she	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 10 knew LPN-E wasn't working that night and knew the resident was out of harms way then she reported the incident to the State agency. The LSW verified terminology in the policy did not include to immediately notify the administrator and verified the policy lacked immediate notification to State agency, and to submit the investigation to the State agency within 5 working days. The LSW stated they do normally submit the final investigation within 5 days, that was common knowledge. When asked if an investigation was done regarding the alleged verbal abuse towards R22 the same night of the incident regarding R47, the LSW stated there was an investigation done, but was not sure where it was. On 1/5/12, at 8:54 a.m. the LSW stated in regards to the incident involving R22, she would call the DON to see if she had further documentation about the incident. At 9:40 a.m. the LSW stated she had called the previous DON and the DON had not documented anything in a permanent file or record, but had investigated that incident as well. On 1/4/12, at 3:43 p.m. the administrator stated he had been notified of the incident 8/31/11, regarding LPN-E, R47 and R22. The administrator stated he has been getting notified by phone messages and that process changed "not too long ago" so now he gets notified by email either on his computer or through his phone and stated he should be notified ASAP and stated he had been getting notified immediately of	F 226		

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F 226	Continued From page 11 incidents. The administrator verified their current policy did not include notifying the administrator immediately, the State agency immediately, or submitting the investigation to the State agency within 5 working days. The administrator stated he would check to see if the previous DON or the LSW were gone that day to see if that is why the initial submission to the State agency was not done until the next day. On 1/5/12, at 9:48 a.m. the administrator stated they need to clean up their policy, but it is not the routine to do the investigation first, then notify the State agency. He stated staff know that even if the policy doesn't say it. He stated he was in Duluth the day of the incident, and was notified of the incident, but could not retrieve his phone record to indicate that however. The administrator stated they had a different DON at that time, a different lead human resources person, and different Quality Manager who also had been aware of this incident, but were no longer here for him to ask additional questions regarding the incident.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250	F 250 The discharge plan and plan of care for R15 has been updated. A baseline audit of discharge plans has been performed for all residents. Discharge plans and the plan of care have been updated. The LSW will document discharge	2/27/12

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F 250	Continued From page 12 Based interview and document review, the facility failed to provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 3 residents (R15) reviewed who required assistance with discharge planning. Findings include: R15 was diagnosed with diabetes mellitus and cerebral palsy. The admission Minimum Data Set (MDS) dated 10/3/11, indicated R15 was cognitively intact and required total assistance from staff with activities of daily living (ADLs.) The MDS indicated an active discharge plan was in place for the resident to return to the community and local agency contacts had been made for discharge planning. The plan of care dated 10/18/11, indicated R15's goal was to be discharged by Thanksgiving and referrals would be made as needed. On 10/18/11, the Initial Care Conference Notes indicated R15 had a goal of returning to her apartment with her significant other in the community by Thanksgiving. R15 continued to work with therapy and they did not recommend the resident return home due to assistance needed with ADLs. R15 was noted to become upset when discussing any long term stay and insisted on returning home. On 11/11/11, the Progress Notes indicated physical therapy would be working with the resident two more weeks in hopes that R15 would become stronger. Social services would be looking into home care, a standing lift at home and possible other options for going home. The notes indicated staff "will revisits this in another 2	F 250	planning on a timely basis in the social services progress notes. Timely basis has been defined as at admit and at the point in care where discussion or a change in resident status indicates a change. The DON will perform a review of progress notes and care plans on a weekly basis times 4, monthly times 4, and quarterly thereafter. Date of Correction: March 15, 2012 02/27/2012	

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F 250	Continued From page 13 weeks." No further notes related to discharge planning was in the clinical record. On 1/3/12, at 5:00 p.m. R15 stated she would like to go live with her boyfriend in the community. R15 stated this (the facility)was were she would want to live when she was older but did not want to stay here at this time. She stated she would like to leave in the spring. On 1/6/12, at 10:00 a.m. nursing assistant (NA)-A stated she was aware R15 would like to go home and sometimes cries because she wants to go home. She stated R15 still requires assistance from staff with ADLs and transferring. At 1:15 p.m. registered nurse (RN)-A stated the resident is in need of assistance from staff and did not improve even though she worked with therapy a long time. RN-A stated R15 needs staff assistance and can not see how she would be able to go home with the help of her significant other. At 2:15 p.m. licensed social worker (LSW)-A stated she has been working closely with and communicating with R15's public health nurse to work on discharge planning. LSW-A expressed that R15 requires assistance that is best met at the facility. The LSW stated they have contacted the county regarding assistive devices to use in a home setting and have been able to obtain a commode for the resident and were looking at a lift for the resident. The LSW stated she would like to see the resident stay in the facility due to past vulnerable adult issues. When asked where	F 250		

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F 250	Continued From page 14 the documentation was related to the change in discharge planning or the discussions with R15 related to a continued stay in the facility, the LSW pointed to her head. LSW-A stated no further documentation of discharge planning was in the clinical record and the plan of care had not been updated with discharge planning as well.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272	F 272 The comprehensive assessment for R12 has been reviewed and updated to indicate the number of falls/injuries sustained, reasons why R12 is at risk for falls/injuries, and interventions to reduce the risk of falls/injury. A baseline audit was performed on all residents who have sustained falls/injuries in the past six months. Care plans have been updated and individualized to identify risks for falls and interventions to prevent falls Education has been provided to clinical nursing staff. Fall/injury documentation is being evaluated for changes to	2/27/12

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F 272	Continued From page 15 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment of the resident's risk factors and conditions to ensure individualized interventions were in place to minimize the risk of falls for 1 of 3 residents (R12) in the sample who were identified as having falls. Findings include: R12 was diagnosed with Alzheimer's disease and diabetes mellitus. R12's annual Minimum Data Set (MDS) dated 10/20/11, indicated R12 was severely cognitively impaired, was independent with bed mobility and locomotion on the unit and required limited assistance with walking and activities of daily living (ADLs.) The MDS indicated R12 had sustained falls since the prior assessment period, but lacked indication of how many falls had occurred or if injuries were sustained. On the Fall Risk Assessment dated 10/17/11, indicated R12 at risk for falls due to factors such as confusion at all times, assistance required with elimination, a history of falling, assistive device required for ambulation, and an unsteady gait.	F 272	improve assessment. Falls/injuries are analyzed during the huddle. The charge nurse will assure that documentation of fall/injuries occurs. The DON/designee will audit the fall/injury report to assure that root cause analysis has been evaluated. The DON/designee will audit comprehensive assessments weekly times 4, monthly times 4 and quarterly thereafter. Exceptions will be reported to the administrator and reviewed at QA at least quarterly. Completion Date: March 30, 2012 02/27/2012	

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F 272	Continued From page 16 The Falls Care Area Assessment (CAA) dated 10/23/11, indicated R12 had a history of falls. R12 was noted to have bed and wheelchair alarms due to self transferring and had recent falls with no injury. Diagnosis reviewed included general muscle weakness, macular degeneration, and Alzheimer's disease. A review of R12's clinical record indicated: -On 2/1/11, at 12:30 a.m. the Patient/Resident Occurrence Report (PROR) indicated R12 was found sitting on the floor next to her bed with her pajama pants down. The bed alarm was not sounding. R12 stated she was trying to go to the bathroom. No injuries were sustained. No new interventions were identified. -On 9/18/11, at 4:00 p.m. the PROR indicated R12 was found sitting on the floor next to her bed. R12 stated she landed easy and no injuries were sustained. The Root Cause Analysis and Action Taken section of the assessment dated 9/1/11, indicated there were no contributing factors to the fall and to continue with bed and chair alarms. The PFA dated 9/18/11, indicated R12 had a history of self transferring, continued to have bed and chair alarms to alert staff, and no changes to the plan of care were recommended. No further assessment of causal factors were determined to implement further interventions was completed. -On 10/19/11, at 4:45 p.m. the PROR indicated R12 was heard calling for help and was found sitting on the floor next to her bed. R12 stated she was trying to get candy out of her drawer. The floor was noted to be wet with water and a water glass was found under the bed. No alarm	F 272		

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F 272	Continued From page 17 sounded when R12 fell. R12 had stockings on her feet and stated she just slid down. No injury was sustained. The Root Cause Analysis and Action Taken section of the assessment dated 10/21/11, indicated staff was to remind the resident to ask for help and that there were no contributing factors to the fall. The PFA dated 10/19/11, noted a history of falls and self transferring and no changes to the plan of care were recommended. No further assessment of causal factors were determined to implement further interventions was completed. The documentation did not address why the alarm did not sound. On 1/5/12, at 12:22 p.m. registered nurse (RN)-B stated R12 attempts to self transfer and gets very disoriented. RN-B stated she could not tell by reviewing the Patient/Resident Occurrence Reports and assessment of the falls all factors contributing to falls and why alarms did not always work. The RN stated she was unsure what else they could do for R12 besides providing alarms to alert staff of self transfers. RN-B added she thinks they need to change the forms they use to complete fall assessments because they are not getting the all the information they need to assess falls. At 1:03 p.m. the interim director of nursing (DON) stated they had identified a concern with assessments of falls and would like to enhance a form to apply more of a root cause analysis approach. The DON stated more data should be gathered to assess falls. She stated the forms are also lacking areas that should be assessed such as medications which could be a contributing factor to falls. The DON stated alarms just alert	F 272		

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F 272	Continued From page 18 the staff that a resident is making an attempt to self transfer but often resident have already gotten up and staff may not reach them in time. The DON stated these are all issues that will be a focus of more intensive training in the near future.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment of the resident's risk factors and conditions to ensure individualized interventions were in place to minimize the risk of further falls and accidents for 2 of 3 residents (R16, R25) in the sample identified as having falls. In addition, the facility failed to to comprehensively assess a decline in range of motion to determine causal factors in order to implement appropriate interventions for 1 of 3 residents (R24) in the sample reviewed for limitations in range of motion. Findings include: R16 was diagnosed with Alzheimer's disease, congestive heart failure, osteoporosis, anemia, malaise and fatigue, and a history of falls. The quarterly Minimum Data Set (MDS) dated 12/16/11, indicated R16 had severe cognitive impairment, was independent with bed mobility,	F 276	F 276 The comprehensive assessment for R12 has been reviewed and updated to indicate the number of falls/injuries sustained, reasons why R12 is at risk for falls/injuries, and interventions to reduce the risk of falls/injury. A baseline audit was performed on all residents who have sustained falls/injuries in the past six months. All care plans have been updated and individualized to identify risks for falls and interventions to prevent falls Education has been provided to clinical nursing staff. Fall/injury documentation is being evaluated for changes to improve assessment. Falls/injuries are analyzed during the huddle. The charge nurse will assure that documentation of fall/injuries occurs. The DON/designee will audit the fall/injury report to assure that root cause analysis has been	2/27/12

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F 276	Continued From page 19 required supervision with transfers, and limited assistance for ambulation, toileting, and personal hygiene. R16 was also identified with unsteady balance at times and as continent of bowel and bladder. The MDS indicated R16 had sustained no falls since admission or the prior assessment period. On 6/16/11, R16 had a physical therapy (PT) evaluation due to weakness and unsteady ambulation. At that time, the PT recommendation was to discontinue R16's bed and chair alarm. On 7/1/11, R16 was discharged from physical therapy. The PT indicated R16 required standby assist with ambulation and transfers. The incident reports identified falls over the last 6 months: -7/9/11, at 12:55 a.m., R16 was found by bed on her back with her pants halfway down. R16 had bumped the back of her head. R16 was identified to be confused and that it was the 1st time R16 had not pulled her pants up after toileting. Staff were to check on R16 when she went to the bathroom. - 7/25/11, at 7:55 a.m., R16 was found beside her bed sitting on buttocks and was very confused. No injury was noted. A new intervention of a bed alarm was added to be used at night. -10/24/11, at 2:15 p.m., R16 was in the bathroom by the nursing desk, she had told staff to leave, and then was heard yelling. Staff found R16 on her back on the floor. R16 had sustained no injuries.	F 276	evaluated. The DON/designee will audit comprehensive assessments weekly times 4, monthly times 4 and quarterly thereafter. Exceptions will be reported to the administrator and reviewed at QA at least quarterly. Completion Date: March 30, 2012 02/27/2012	

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F 276	Continued From page 20 -11/1/11, at 1:15 a.m., R16 was found in the bathroom sitting on the floor. No injuries were noted. R16 had gone to the bathroom by herself and was noted to not always ring for assist related to dementia. Staff noted "continue to monitor. " -11/11/11, at 6:00 p.m., R16 was found in her bathroom on the floor and yelling for help. R16 had stated she hit her head and neuro checks were completed. R16 had not pulled her pants up or down appropriately, continued to independently ambulate and slips. R16 was also noted to have dementia and did not use the call light. No new interventions were put in place. -11/12/11, at 7:50 a.m., R16 was in the bathroom and an alarm was sounding. R16 was identified to not have sustained injuries from the 11/11/11 and 11/12/11 falls. No new interventions were put in place. The Incident Report and nursing notes following the falls lacked a comprehensive assessment and investigation into the falls. Documentation failed to include potential causes of the falls including whether current interventions had been implemented, when the resident had last been toileted, or if any new interventions had been implemented. The 11/13/11, nurse progress note indicated R16 complained of left rib cage pain and was sent to the emergency room (ER) for x-rays. The x-rays at that time revealed no fracture, but R16 was noted to have sustained a left rib contusion. R16	F 276		

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F 276	Continued From page 21 was also noted to have a urinary tract infection (UTI) and received treatment. The 11/13/11, ER report indicated R16 had complaints of anterolateral chest pain after losing her balance and falling. The report indicated R16 was discharged from the ER with Vidocin (narcotic pain medication) and advised to ice and heat intermittently. The 11/17/11, physician visit note indicated R16 was seen for follow up of an ER visit. The report indicated R16 was seen in ER on 11/13/11, for a prior fall and diagnosed with a left rib contusion. Radiology had recommended a repeat x-ray in a week to recheck for occult fracture versus parenchymal disease on left rib cage. The report indicated R16 continued to have left chest wall discomfort. The findings at that time revealed R16 had fractures of the 6th, 7th, and 8th ribs. An additional incident reports identified: -11/26/11, at 2:30 a.m., R16 was found on the floor in the bathroom and had been independently ambulating. R16 had sustained no injury. The note indicated R16 had dementia, did not use call light, and forget to pull her pants up. R16 was to be checked on often, to be assisted every 2 hours with toileting, staff were to encourage R16 to wait for assistance, and continue the bed alarm. The Incident Report and nursing notes following the falls lacked a comprehensive assessment and investigation into the falls. Documentation failed to include potential causes of the falls including whether current interventions has been implemented, when the resident had last been toileted, or if any new interventions had been implemented.	F 276		

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HOMESTEAD REHABILITATION & LIVING CENTER	1002 COMSTOCK DRIVE DEER RIVER, MN 56636

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F 276	Continued From page 22 On 1/5/12, at 12:25 p.m. licensed practical nurse (LPN)-B stated R16 had been in the same room for over 6 months and could not recall any room changes. On 1/5/12, at 1:10 p.m. NA-A stated R16 had a bed alarm and no chair alarms. NA-A added toileting was offered every 2 hours on everybody. On 1/6/12, at 2:30 p.m. registered nurse (RN)-A stated they review falls during interdisciplinary team (IDT) meetings, but did not document any of what was discussed in R16's record. RN-A verified the 12/16/11, quarterly MDS lacked the accuracy related to falls. RN-A stated R16 lacked a comprehensive fall assessment. RN-A added about a year ago staff were advised to use new Fall forms that lacked information and made it hard for RNs to complete comprehensive fall assessments. RN-A stated the facility did not have a policy and procedure regarding Accidents/Falls. R25's diagnoses included a stroke with right sided hemiparesis, restless leg syndrome, and osteoarthritis. The quarterly MDS dated 10/7/11, indicated R25 had moderately impaired cognition, required total assist with toileting, set up assistance for walking in the hallway, and set up assist for transfers. In addition, the MDS indicated R25 was occasionally incontinent of urine. The Cognitive Loss CAA dated 1/29/11, identified	F 276		

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F 276	Continued From page 23 R25's belief she could ambulate independently. The Activities of Daily Living CAA dated 1/29/11, indicated R25 was unable to remember recent things and indicated R25 believed she could ambulate independently. The Falls CAA dated 1/29/11, identified a recent stroke with paralysis and impaired balance, and that R25 required assistance for mobility. It also indicated R25 had sustained two falls since admission related to self transfers. The Patient/Resident Occurrence Report (PROR) forms identified multiple falls without injury from 1/23/11 to 2/8/11: -1/23/11, R25 was found on the floor in bedroom at 4:30 a.m. R25 was re-educated to use the call light. R25 was identified to utilize a concave mattress and bed and chair alarms. -1/24/11, R25 was found kneeling on the floor at 6:50 a.m. R25 told staff she wanted to use the bathroom. R25 was directed to use the call light. An additional intervention of a mat on floor was identified. -1/27/11, R25 had fallen out of recliner and was found lying on back in living room at 11:10 p.m. R25 was reminded to call for help. -2/4/11, R25 was found kneeling on mat next to bed at 2:00 a.m. No interventions was identified. -2/4/11, R25 was found kneeling on mat next to bed at 8:30 p.m. R25 told staff she needed to use the toilet. No new intervention was identified. -2/4/11, R25 was found kneeling on mat next to bed at 10:45 p.m. R25 stated she needed to go to the bathroom. No new intervention was identified. -2/5/11, R25 was found on knees on mat next to bed at 1:00 a.m. No new intervention was	F 276		

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F 276	Continued From page 24 identified. An additional intervention of a low bed was identified. - 2/5/11, R25 was found on knees on mat next to bed with upper body on bed at 1:10 a.m. -2/5/11, R25 was found lying on back in living room by chair at 1:50 p.m. R25 was reminded to call for help and staff were to check frequently. -2/5/11, R25 was found on kneeling on mat next to bed at 11:15 p.m. R25 was reminded to call for assistance. -2/6/11, R25 was found kneeling on mat next to bed with upper body in bed at 3:00 a.m., and 4:00 a.m. R25 was reminded to call for assistance. No new interventions were identified. -2/6/11, R25 was found kneeling on mat next to bed with upper torso lying over bed at 11:30 p.m. No new interventions were identified. -2/8/11, R25 was found kneeling on mat next to bed at 5:30 a.m. No new interventions were identified. No further falls were identified until July 2011. The dated PROR forms identified further falls on: -7/20/11, R25 was found sitting in urine on floor at 4:15 a.m. R25 had slipped and fell landing on buttocks in own room and was barefoot. No injuries sustained. Plan was to monitor. The form indicated R25 had bladder urgency at night. Actions to be taken were to continue offer incontinence pad at night, however, the form also indicated R25 had refused use in past. R25's gait and balance was noted to be good with no problems noted. Night staff were to check R25 frequently and evening staff were to offer an incontinent pad. No referrals or changes were made in the plan of care.	F 276		

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F 276	Continued From page 25 The Nurse Progress Note, dated 8/29/11, indicated R25 toileted self, and dribbled urine on the floor on the way to the bathroom, in the bathroom, or on the floor by the bed and had many urinary incontinent episodes during the night. In addition, R25 would remove the incontinence product. R25 had a history of slipping in urine resulting in falls, however, R25 did not understand the importance of leaving the incontinence product on and using the call light to ask for help. The Nurse Progress Noted dated 9/15/11, at 6:30 p.m. indicated R25 was ambulating slowly while hanging onto nurses desk, stopped passing physician, and informed the doctor she had "terrible knee pain." The PRORs and nursing notes following the falls lacked comprehensive assessment and investigation into the falls to identify whether current interventions were adequate and to determine if additional appropriate interventions had been implemented related to potential causes of the falls. At 2:27 p.m. the DON reviewed R25's fall reports with the surveyor. The DON stated the fall report forms lacked accuracy, and comprehensive assessments related to causal factors as well as identification and implementation of new interventions were lacking. The DON also verified R25 was at risk for falls.	F 276		

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F 276	Continued From page 26 R24's diagnoses included Alzheimer's disease and osteoporosis. The quarterly Minimum Data Set (MDS) dated 12/29/11, identified R24's memory problems and severely impaired decision making skills. The MDS identified R24 did not walk and was dependent on staff for all activities of daily living (ADLs). The MDS indicated R24 had no functional limitations in range of motion (ROM) of upper or lower extremities and no restorative nursing minutes were coded to indicate ROM had been completed. The annual MDS dated 7/1/11, identified the same information. The Activities of Daily Living Care Area Assessment (CAA) at the time of the annual MDS dated 7/1/11, was not completed as this area did not trigger. The Mood State CAA dated 7/1/11, identified R24 had altered clothing to "ease her need for range of motion." No other documentation was included in R24's CAAs from 7/1/11, regarding limitations in range of motion, restorative nursing programs, or other preventative services or treatments. The last assessment areas that addressed ROM and restorative nursing were done at the time of the annual assessment under the Psychological Well Being and Mood State CAA sections dated 10/7/10. The CAAs identified R24 did not walk. The Mood State CAA identified restorative nursing had noted that due to R24's advancing dementia the resident "does not always understand most of what is stated to her and she becomes fearful after things are explained." The CAA also indicated R24 will often refuse restorative nursing but indicated the continuation	F 276		

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F 276	Continued From page 27 of restorative nursing for maintaining PROM (passive range of motion) and AROM (active range of motion). However, R24's corresponding MDS dated 10/4/10, did not indicate R24 received any restorative nursing services at that time. All previous restorative nursing documentation was requested and indicated the last time R24's ROM program was documented was 6/30/09, and the restorative program that was specifically for transferring was last documented 8/31/09. No further restorative notes or nursing notes regarding R24's restorative nursing program had been made after that date. The current plan of care (POC) dated 10/5/11, included "therapy deficit r/t (related to) decreased mobility, cognitive deficits from dementia dx (diagnosis)." The identified goal was, "No decline in ROM will be noted." The POC identified R24's restorative program was discontinued related to refusals. The interventions included to "monitor for any declines, therapy screens prn" (as needed). Restorative Services forms indicated R24 had received restorative nursing services until 2009. R24's medical records were reviewed from 2009-current. R24's medical record did not indicate contractures were present prior to 11/29/11. R24 had pain documented on 6/26/11, when a nursing note identified pain during transfers. A Memo To Physician form dated 8/29/11, identified signs and symptoms of pain during transfers. A nursing note dated 10/26/11, identified R24 complained of pain, saying "ouch" when right	F 276		

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F 276	Continued From page 28 knee and foot were manipulated or moved. Another nursing note dated 11/29/11, indicated R24's knee was stiff and sore and not bending at knees. A Physician's Telephone Order form dated 11/29/11, indicated physical therapy (PT) and occupational therapy (OT) to evaluate and treat for LE (lower extremity) joint contractures. PT documentation indicated R24 received skilled services twice a week for 1 month for bilateral hip and knee joint contractures. The PT evaluation dated 12/5/11, identified the medical diagnosis of LE (lower extremity) joint contractures with treatment diagnosis of bilateral hip and knee joint contractures. The assessment by PT indicated R24 had substantial hip and knee joint contractures making transfers difficult at that time. The PT discharge note dated 12/29/11, indicated R24 "continued to have contractures but with gentle stretching we were able to get her hip abduction to neutral on the right and 15-20 degrees on the left, and knee extension within 20-30 degrees bilaterally to approximately 90 degrees of flexion." R24 was then discharged from PT and restorative nursing was set up for further range of motion of the knee and hips. OT documentation indicated an evaluation was completed 12/13/11, which identified R24's bilateral hip and knee contractures. The evaluation indicated R24 required a custom w/c to ensure proper positioning of the pelvis given LE hip contractures, and to elevate leg rests to accommodate for LE knee contractures.	F 276		

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F 276	Continued From page 29 On 1/5/12, at 7:25 a.m. nursing assistant (NA)-A stated when R24 was first admitted no problems were noted. NA-A stated she did not know when the knee problems started and could not recall if it had been over a year or not. On 1/5/12, at approximately 8:00 a.m. the restorative aid (RA)-A stated R24 was not receiving ROM services and it had been well over a year since she had. She added it could be a couple years since she last had restorative services. RA-A stated R24 no longer received restorative nursing due to the degree of her dementia. On 1/5/12, at 9:30 a.m. NA-B and NA-C assisted with R24's transfer with the mechanical lift and both stated at that time R24's knees had gotten gradually worse. On 1/5/12, at 1:45 p.m. the physical therapist (PT)-A and the physical therapy assistant (PTA) -A were interviewed. PT-A stated R24's hips and knees had become arthritic. PT-A stated on 12/5/11, R24 was seen for hip and knee contractures, and the goal was for no further pain and complications, to ease the staff when helping to transfer and dress R24, and to help with ROM. PT-A stated R24 would continue with restorative nursing with hip and knee stretching which would start today. PT-A stated he did not know if a restorative program would have prevented the contractures and added it might have but could not say that for sure. PT-A stated their department last assessed R24 in '09 and that last screen indicated R24 was attempting to	F 276		

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F 276	Continued From page 30 participate with rehab nursing. When asked if ROM would irritate R24's arthritis, PT-A stated it would not if it was gentle. PT-A stated R24 did not demonstrate signs or symptoms of pain when he had been working with R24. PTA-A stated there was only one time when working with R24 during abduction of the hips that the resident had muscle guarding, but other than that had not expressed pain symptoms. On 1/5/12, at 2:33 p.m. RN-B stated the only time ROM assessments were done was if residents had a decline or if something was observed such as a change in positioning in the w/c. RN-B stated the NAs report if the residents aren't transferring the same, then they do a screen and then PT does an assessment. When RN-B was asked when the last time restorative/range of motion services were attempted she stated the last sheets in chart were from '09. RN-B verified documentation to indicate why restorative services had stopped was lacking. On 1/5/12, at 2:35 p.m. PTA-A stated he could not find anything in the electric record about R24 being assessed by PT since '09. On 1/6/12, at 9:04 a.m. PTA-A stated it looked like R24 had been semi-participating in the restorative program and with increased confusion that program stopped. PTA-A verified even though R24 could no longer participate in an active ROM program, R24 could have still had a passive program. On 1/6/12, at 1:45 p.m. RN-A stated there had been a loss of function in R24's legs. RN-A stated she just noticed the loss of function on	F 276		

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F 276	Continued From page 31 11/29/11, when staff told her they were having a hard time straightening R24's legs. RN-A stated she did a PT referral then and because R24 was recently sliding down in the wheelchair, OT saw her then too. RN-A verified she did not know of any prior documentation in R24's record about contractures. When RN-A was asked when the contractures developed, she stated she first noticed it was when R24 was not sitting in the w/c properly around 11/29/11. RN-A stated she did not know that R24's restorative program had stopped and could not recollect why it was stopped. RN-A verified there was no documentation as to why R24's restorative program had been stopped. On 1/6/12, at 2:42 p.m. the director of nursing (DON) verified a comprehensive assessment was lacking to pull all the pieces together regarding R24's range of motion. The policies and procedures were requested regarding ROM assessments and the restorative program and the facility provided the undated Restorative Protocol. The protocol indicated the oversight of the restorative nursing program remained the responsibility of the RN and timely decisions and corrective action should be the expected outcome of that oversight.	F 276		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	F278 Element 1 R 16 and R 12 assessments have been updated to reflect the fall status. R15 and R 24's assessments have been updated to reflect the deficits in ROM.	2/27/12

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F 278	Continued From page 32 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the assessment accurately reflected the resident's falls status for 2 of 3 residents (R16, R12) identified with falls and for 2 of 3 residents (R15, R24) who had deficits in range of motion; Findings include: R16's quarterly Minimum Data Set (MDS) dated 12/16/11, indicated R16 had sustained no falls since the prior assessment period.	F 278	Element 2 Resident care plans will be audited for completeness as they relate to assistive devices and resident needs Element 3 The Registered Nurses have been trained as it relates to their role and responsibilities regarding assessment and the need to include other professional's data in their assessment. Element 4 DON/ designee will audit daily x 7, weekly for 3 weeks and monthly audits for 3 months and quarterly thereafter with results to the QA committee and the administrator for further review. Element 5 March 15, 2012 02/27/2012	

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F 278	Continued From page 33 Incident reports identified: -10/24/11, at 2:15 p.m., Staff found R16 on her back on the floor in the bathroom. -11/1/11, at 1:15 a.m., R16 was found in the bathroom sitting on the floor. -11/11/11, at 6:00 p.m., R16 was found in her bathroom on the floor and yelling for help. -11/12/11, at 7:50 a.m., R16 was in the bathroom after falling. The 11/17/11, physician visit note indicated R16 was seen for follow up of an emergency room visit and identified R16 had fractures of the 6th, 7th, and 8th ribs. Additional incident reports identified: -11/26/11, at 2:30 a.m., R16 was found on the floor in the bathroom. On 1/6/12, at 2:30 p.m. registered nurse (RN)-A stated R16's severity and numbers of falls was coded inaccurately. R12's assessment did not accurately reflect the resident's status of falls. R12's annual MDS dated 10/20/11, indicated R12 had fallen since the last assessment period, but lacked the severity of the injury and the number of falls. -On 9/18/11, at 4:00 p.m. the Patient/Resident Occurance Report (PROR) indicated R12 was found sitting on the floor next to her bed.	F 278		

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F 278	Continued From page 34 -On 10/19/11, at 4:45 p.m. the PROR indicated R12 was heard calling for help and was found sitting on the floor next to her bed. On 1/6/12, at 1:00 p.m. RN-A stated R12's severity and numbers of falls was coded in error. R15's assessment did not accurately reflect the resident's status of range of motion. R15's admission MDS dated 10/3/11, indicated R15 did not have any functional limitations in range of motion (ROM). On 1/6/12, at 9:05 a.m. physical therapy assistant (PTA)-A stated R15 has functional limitation in range of motion adding R15 cannot walk or dress herself due to those limitations. PTA-A stated nursing should be reviewing the resident ROM quarterly to identify any changes that may occur. On 1/6/12, at 1:06 p.m. registered nurse (RN)-A stated they do have access to the PT evaluations in the computer but no one makes copies for the clinical record so it may have not been reviewed when R15 had her MDS assessment. R24's annual and quarterly MDS assessments inaccurately reflected lower extremity functional range of motion (ROM) limitations. R24's quarterly MDS dated 9/29/11, and 12/29/11, identified R24 had no functional ROM limitations.	F 278		

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F 278	Continued From page 35 On 1/6/12, at 9:16 a.m. nursing assistant (NA)-D stated she had worked at the facility since the resident was admitted. NA-D stated R24's knees did not really straighten and that had probably had been on-going within the last year. On 1/6/12, at 1:45 p.m. RN-A verified R24 she should have coded that R24 did have a functional limitation of the lower extremity affecting both sides.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	F 279 Element 1 R34's care plan was reviewed and updated with current interventions for a compression device. R25's care plan was reviewed and updated with interventions for assistance with urinary incontinence and toileting. The NA resident care sheets have been updated for both residents. Element 2 Resident care plans will be audited for completeness as they relate to assistive devices and resident needs Element 3 Nursing staff have been trained as it relates to their role and responsibilities regarding comprehensive care planning. Element 4 DON/ designee will audit daily x 7,	2/27/12

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	245428	A. BUILDING _____ B. WING _____	01/09/2012

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F 279	Continued From page 36 Based on interview and document review, the facility failed to develop care planning interventions for 1 of 1 resident (R34) reviewed that required a edema compression device and for 1 of 1 resident (R25) reviewed who required assistance with urinary incontinence and toileting. Findings include: R34 had diagnoses that included CVA (stroke) with left hemiparesis. The 12/7/11, admission Minimum Data Set (MDS) indicated R34 required extensive assist with dressing. The 12/7/11 Care Area Assessment (CAA) indicated R34 had paralysis of her left hand. The 12/1/11, physician order indicated R34 was to have an occupational therapy (OT) evaluation. The certified occupational therapy assistant (COTA) note dated 12/8/11, indicated an edema glove program was established and the program was written in the report book and restorative aide (RA)-A was to check daily for appropriate wear and fit. The note indicated RA-A was advised of the plan. The plan of care (POC) dated 12/2/11, lacked documentation related to the left hand edema glove. The nursing assistant (NA) resident care sheets used to direct care for individuals did not address the application of the R34's edema glove. On 1/5/12, at 2:25 p.m., COTA-A stated R34 was to be wearing an edema glove to the left hand daily applied during a.m. cares and removed at	F 279	weekly for 3 weeks, and monthly for 3 months and quarterly thereafter with results to the QA committee and the administrator for further review. Element 5 March 15, 2012 02/27/2012	

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F 279	Continued From page 37 bed time. COTA-A added all staff were responsible. On 1/5/12, at 2:30 p.m., registered nurse (RN)-B stated she was unaware of R34 requiring the use of an edema glove. On 1/6/12, at 8:35 a.m., NA-A stated the NA care sheets (used to direct individual care) did not include R34's left hand edema glove. On 1/6/12 at 2:25 p.m., RN-B stated the compression glove was not incorporated into R34's POC. R25's plan of care was not developed to reflect urinary incontinence needs. R25's diagnoses include a stroke with right sided hemiplegia, and left sided weakness. The 10/7/11, quarterly MDS indicated R25 had moderately impaired cognition, and required total assistance of one staff to toilet. The MDS also indicated R25 was occasionally incontinent of urine. The 1/29/11, Urinary Incontinence Care Area Assessment (CAA) indicated R25 was incontinent of urine and required physical assistance to toilet. The 1/25/11, facility Bowel and Bladder Assessment form identified frequent urinary incontinence indicated staff were to assist with toileting needs. The facility "MDS 7 Day Tracking Tool" dated 10/3/11 through 10/16/11, indicated R25 was	F 279		

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F 279	Continued From page 38 incontinent of bladder daily, and required set up to total staff assistance to toilet. The current plan of care dated 10/13/11, lacked identification of R25's toileting needs. On 1/5/12, at 12:57 p.m. licensed practical nurse (LPN)-B verified R25 was incontinent of urine and required physical assistance to toilet. On 1/6/12, at 9:15 a.m. registered nurse (RN)-A verified R25 was incontinent of urine, and required physical assistance to toilet. RN-A verified the plan of care lacked identification of urinary incontinence and toileting needs. RN-A stated, "whoops" when she realized the problem had been missed on the plan of care.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F 280 Element 1 R 34 care plan was reviewed and revised to include ambulation services. R15's care plan has been reviewed and revised to include the discharge plan and restorative nursing program. The resident care sheets have been updated with cares to be provided by nursing staff. Element 2 Resident care plans and resident care sheets have been audited and updated to include discharge planning, ambulation and restorative services.	2/27/12

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F 280	Continued From page 39 each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to revise the plan of care to include identified ambulation services for 1 of 3 residents (R34) in the sample identified with a planned ambulation program. In addition, the facility failed to revise the plan of care for 1 of 3 residents (R15) related to discharge planning and to a restorative nursing program. Findings include: R34 had diagnoses that included CVA (stroke) with left hemiparesis. The admission Minimum Data Set (MDS) dated 12/7/11, indicated R34 required extensive assist with walking in room. The Care Area Assessment (CAA) dated 12/7/11, indicated R34 had poor balance requiring assist with ambulation. The plan of care (POC) dated 12/2/11, indicated R34 had a walking deficit related to weakness and indicated R34 required assist of two with transferring, used a wheelchair, and was working with physical therapy/occupational therapy. The 12/16/11, Restorative Nursing Recommendation form completed by the physical therapist indicated R34 was to ambulate 3 times a week for approximately 50 feet each time. On 1/5/12, at 8:30 a.m., registered nurse (RN)-B	F 280	Element 3 Staff has been educated on care planning and documentation of cares provided. Element 4 DON/ designee will audit daily x 7, weekly for 3 weeks and monthly audits for 3 months and quarterly thereafter with results to the QA committee and the administrator for further review. Element 5 March 15, 2012 02/27/2012	

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F 280	Continued From page 40 stated she did not know what R34's Rehabilitation Nursing ambulation plan was or if she even had a plan. On 1/6/12, at 9:00 a.m., restorative aide (RA)-A stated R34 was ambulated on Tuesdays and Thursdays by restorative staff and on the weekends the nursing assistants (NAs) were to ambulate R34. At 9:30 a.m. NA-C stated she did not know that the NAs were to ambulate R34 on the weekends. NA-C verified the resident care sheet (used to direct individual care) did not indicate R34 was to be ambulated on the weekends. On 1/6/12, at 2:15 p.m. RN-A stated the Rehabilitation Coordinator (RN-A) was in charge of the Restorative program. At that time, R34's Restorative Nursing ambulation plan was reviewed. RN-C then revised the NA care sheet to identify R34 was to be ambulated by the NAs on the weekend. On 1/6/12, at 2:30 p.m. RN-A verified R34's plan of care had not been revised and needed to be updated. R15 had diagnoses of diabetes mellitus and cerebral palsy. The admission MDS dated 10/3/11, indicated R15 was cognitively intact and required total assistance from staff with activities of daily living (ADLs.) The MDS indicated an active discharge plan was in place for the resident to return to the community and local agency contacts had been made for discharge planning.	F 280		

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F 280	Continued From page 41 The plan of care dated 10/18/11, indicated R15's goal was to be discharged by Thanksgiving and referrals would be made as needed. No revisions to the plan of care had been made regarding discharge planning. In addition, the plan of care indicated R15 would continue to work with physical therapy (PT) and occupational therapy (OT) for strengthening. On 11/22/11, PT recommended a restorative nursing program which included a personal exercise program three times a week and a two times a week standing program. OT recommended Thera-Band exercises for upper extremities three times a week. Although the clinical record indicated R15 had participated in the restorative nursing program, no revision had been made to the plan of care related to the current restorative nursing program. On 1/6/12, at 1:06 p.m. RN-A stated R15's plan of care should be revised related to the restorative nursing program. At 2:15 p.m. licensed social worker (LSW)-A stated the plan of care had not been updated with discharge planning.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 282 Resident 1 has been re-evaluated by a therapist and the care plan and care sheet has been updated to reflect current recommendations.	2/27/12

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F 282	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide services in accordance with the plan of care for 1 of 3 residents (R1) in the sample who required range of motion services. Findings include: R1 was diagnosed with traumatic brain injury. The quarterly Minimum Data Set (MD'S) completed 9/30/11, indicated R1 required total assistance with all activities of daily living The plan of care (POC) revised 1/4/12, indicated R1 had a decrease in ROM to all extremities due to increased tone and spasticity related to the diagnosis of traumatic brain injury. Rehab Nursing was to offer passive range of motion (PROM) every day as tolerated to all extremities. However, the nursing assistant (NA) resident care sheets did not identify R1 was to have ROM services. On 1/3/11, at 7:00 p.m. NA-C stated the evening NAs were responsible to complete 2 resident's ROM. NA-C added R1 was one of the two residents. NA-C stated the staff were to document on the back of the resident care sheet when and how long R1 received ROM. NA-C showed the surveyor the last 3 days of the NA resident care sheets. The sheets lacked any documentation for R1's ROM. The 11/18/11, RN Restorative notes indicated R1 was to be offered PROM daily by the p.m. nursing staff.	F 282	A baseline audit was performed on all residents who are care planned to receive ROM. All care sheets have been updated to reflect the current plan of care. The care planning protocol has been updated to reflect flow to care sheets and documentation. Education has been provided to clinical nursing staff. The charge nurse will assure daily documentation occurs. The DON/Designee will audit the nurse aide flow sheets and documentation to assure follow through of care plans daily x 7 days, weekly x 3 weeks, monthly x 2 months, and quarterly thereafter. Exceptions will be reported to the administrator and reviewed at QA at least quarterly. . Corrective action completion date: March 15, 2012. 02/27/2012	

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F 282	Continued From page 43 -On 8/12/11, registered nurse (RN)-A noted ROM was documented 1 time over the past week. -On 8/12/11, RN-B indicated "reviewed." -On 9/8/11, restorative aide (RA)-A indicated ROM documented the over the past week. -On 9/2/11, RN-B indicated "reviewed." -On 10/14/11, RA-A note indicated no ROM documented over the past week. -On 10/15/11, RN-B indicated "reviewed." -On 11/10/11, RA-A indicated PROM (passive range of motion) done over the past week. -On 11/19/11, RA-A indicated R1 received PROM 1 time over the past week. -On 12/9/11, RA-A indicated no PROM completed in the past week. -On 12/10/11, RN-A indicated "reviewed." -On 12/16/11, RA-A indicated PROM completed one time in the past week by p.m. nursing staff. -On 12/18/11, RN-B indicated "reviewed." -On 12/22/11, RA-A indicated R1 received PROM to right side 3 times this past week-will continue to be offered, resident can be resistive. -On 12/24/11, RN-A indicated "reviewed." -On 12/30/11, RA-A indicated PROM 1 time over past week by nursing staff on the p.m. shift. On 1/5/12, at 1:45 p.m., RN-B verified the plan of care was correct and R1 was not receiving ROM services according to the plan of care. RN-B stated the RNs review RA-A's documentation and would then document "reviewed." However, the RNs never analyzed the data regarding if the residents were tolerating and receiving their plan according to how the program was developed by the physical therapist and the occupational therapist. RN-B stated she was unaware that the p.m. NAs were to complete R1's ROM plan.	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		2/27/12

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F 309 SS=D	Continued From page 44 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide consistent services for planned edema therapy for 1 of 1 resident (R34) who required an assistive device for edema therapy. Findings include: R34 had diagnoses that included malaise and fatigue, and CVA (stroke) with left hemiparesis. The 12/7/11, admission Minimum Data Set (MDS) indicated R34 required extensive assist with dressing. The 12/7/11 Care Area Assessment (CAA) indicated R34 had paralysis of her left hand. The 12/1/11, physician order indicated R34 was to have an occupational therapy (OT) evaluation. The certified occupational therapy assistant (COTA) note dated 12/8/11, indicated an edema glove program was established and the program was written in the report book and restorative aide (RA)-A was to check daily for appropriate wear and fit. The note indicated RA-A was advised of the plan.	F 309	F309 R34 has been reevaluated by PT/OT for the edema glove. The care plan has been updated with the need for the edema glove. The NA resident care sheets have been updated to include application of the glove. Other residents have been assessed for the need for assistive devices. Care plans and resident care sheets have been reviewed and updated to include the assistive devices needed by residents. Clinical nursing staff has been educated on the need for assistive devices and cares to maintain resident well-being. The DON/designee will audit daily x 7, weekly x 4, and monthly x 3, quarterly thereafter. Deviations will be reported to QA and the administrator. Completion date March 15, 2012 02/27/2012	2/27/12

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F 309	Continued From page 45 The COTA note dated 12/16/11, indicated R34's left hand swelling had increased and OT would be informed. The current plan of care (POC) dated 12/2/11, lacked documentation related to the left hand edema glove. The nursing assistant (NA) resident care sheets used to direct care for individuals did not address the application of the R34's edema glove. The restorative documentation from 12/8/11, to present lacked documentation regarding the application of the edema glove. On 1/4/12, at 9:30 a.m., R34 was observed dressed for the day. R34's left hand was noted to be puffy and she was not wearing the left hand edema glove. On 1/5/12, at 12:25 p.m., restorative aide (RA)-A stated she had never been responsible for putting R34's compression glove on. RA-A stated R34 was to be wearing the edema glove and the day staff should be putting it on her when she gets up for the day. On 1/5/12, at 2:25 p.m., COTA-A stated R34 was to be wearing an edema glove to the left hand daily applied during a.m. cares and removed at bed time. COTA-A added all staff were responsible. On 1/5/12, at 2:30 p.m., registered nurse (RN)-B stated she was unaware of R34 requiring the use of an edema glove.	F 309		

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F 309	Continued From page 46 On 1/6/12, at 8:30 a.m. R34 was observed sitting on her bed and at the end of the bed was an edema glove. R34 stated she thought she wore the glove at night. On 1/6/12, at 8:35 a.m., NA-A stated R34 was to wear the glove during the day shift and that the NAs would assist her with applying the left hand glove, however, R34 often would refuse the glove. NA-A stated the NA care sheets (used to direct individual care) did not include R34's left hand edema glove. On 1/6/12, at 2:25 p.m., RN-B stated the compression glove was not incorporated into R34's POC.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide planned ambulation services for 1 of 3 residents (R34) in the sample who had been identified to require these services. Findings include: R34 had diagnoses that included malaise and fatigue, end stage renal disease, CVA (stroke) with left hemiparesis, and diabetes. The admission Minimum Data Set (MDS) dated	F 311	F 311 Resident 34 is currently being ambulated per physical therapy recommendations. RN-A has been educated regarding restorative care including communication, care planning, and documentation. A baseline audit was performed of all residents who are to receive restorative care. All care plans and care sheets have been updated toreflect current plan of care and who is responsible. Clinical nursing staff have been	2/27/12

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F 311	Continued From page 47 12/7/11, indicated R34 required extensive assist with walking in room. The Care Area Assessment (CAA) dated 12/7/11, indicated R34 had poor balance requiring assist with ambulation. The plan of care (POC) dated 12/2/11, indicated R34 had a walking deficit related to weakness and indicated R34 required assist of two with transferring, used a wheelchair, and was working with physical therapy/occupational therapy. The physician order dated 12/6/11, indicated R34 was to have a physical therapy (PT) evaluation due to difficulty walking. The 12/16/11, Restorative Nursing Recommendation form completed by the physical therapist indicated R34 was to ambulate 3 times a week for approximately 50 feet each time. The restorative documentation form from 12/16/11 to present lacked documentation to indicate R34 had been ambulated. On 1/5/12 at 7:20 a.m., R34 stated she walked to the bathroom every day with staff and also had assist from rehab aide (RA)-A to ambulate with a front wheeled walker down the hall and back. She stated she felt she was getting stronger. On 1/5/12, at 8:30 a.m., registered nurse (RN)-B stated R34 was not real compliant and did not know what R34's Rehabilitation Nursing ambulation plan was or if she even had a plan. On 1/5/12,,at 8:30 a.m., R34 was observed ambulating assisted by restorative aide (RA)-A with a rolling walker from her room to the nurses	F 311	educated regarding the restorative nursing program and follow through in the absence of the restorative aide. The DON/designee will review restorative documentation daily times 7 days, weekly x 3 weeks monthly times two months and quarterly ongoing. Deviations will be reported to the Administrator and reviewed at QA at least quarterly. Completion date: March 15, 2012 02/27/2012	

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	245428	A. BUILDING _____ B. WING _____	01/09/2012

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F 311	Continued From page 48 desk which is approximately 75 feet. On 1/6/12, at 8:30 a.m. RA-A verified there was no documentation because no rehab sheet had been made out for R34. RA-A stated no sheet had been made out because she had been on vacation and she is the one who usually starts the rehab sheets on each resident. On 1/6/12, at 9:00 a.m., RA-A stated R34 was ambulated on Tuesdays and Thursdays by restorative staff and on the weekends the nursing assistants (NAs) were to ambulate R34. At 9:30 a.m. NA-C stated she did not know that the NAs were to ambulate R34 on the weekends. NA-C verified the resident care sheet (used to direct individual care) did not indicate R34 was to be ambulated on the weekends. On 1/6/12, at 2:15 p.m. RN-A stated the Rehabilitation Coordinator (RN-A) was in charge of the Restorative program. At that time, R34's Restorative Nursing ambulation plan was reviewed. RN-C then revised the NA care sheet to identify R34 was to be ambulated by the NAs on the weekend. RN-A verified R34 was not receiving ambulation services according to the physical therapy recommendations.	F 311		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion	F 317	F 317 R24 has been referred to/assessed by PT/OT. The comprehensive assessment/care plan has been updated. Other residents identified as having the potential for decline in ROM	2/27/12

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F 317	Continued From page 49 is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services to prevent a decline in range of motion related to the development of bilateral hip and knee contractures for 1 of 3 residents (R24) in the sample reviewed for range of motion. Findings include: R24's diagnoses included Alzheimer's disease and osteoporosis. The quarterly Minimum Data Set (MDS) dated 12/29/11, identified R24's memory problems and severely impaired decision making skills. The MDS identified R24 did not walk and was dependent on staff for all activities of daily living (ADLs). The MDS indicated R24 had no functional limitations in range of motion (ROM) of upper or lower extremities and no restorative nursing minutes were coded to indicate ROM had been completed. The MDS also indicated R24 had no behavioral symptoms nor resisted care. The annual MDS dated 7/1/11, identified the same information. The Activities of Daily Living Care Area Assessment (CAA) at the time of the annual MDS dated 7/1/11, was not completed as this area did not trigger. The Mood State CAA dated 7/1/11, identified R24 had altered clothing to "ease her need for range of motion." No other documentation was included in R24's CAAs from 7/1/11, regarding limitations in range of motion, restorative nursing programs, or other	F 317	have been reassessed; care plans update and are receiving cares per the care plan. Nursing staff have been educated regarding properly assessing and implementing cares for residents at risk of decreased ROM. DON/designee will review documentation daily x 1 week, weekly x 3 monthly x 3 and quarterly thereafter. Completion date: March 15, 2012 02/27/2012	

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F 317	Continued From page 50 preventative services or treatments. The last assessment areas that addressed ROM and restorative nursing were done at the time of the annual assessment under the Psychological Well Being and Mood State CAA sections dated 10/7/10. The CAAs identified R24 did not walk. The Mood State CAA identified restorative nursing had noted that due to R24's advancing dementia the resident "does not always understand most of what is stated to her and she becomes fearful after things are explained." The CAA also indicated R24 will often refuse restorative nursing but indicated the continuation of restorative nursing for maintaining PROM (passive range of motion) and AROM (active range of motion). However, R24's corresponding MDS dated 10/4/10, did not indicate R24 received any restorative nursing services at that time. All previous restorative nursing documentation was requested and indicated the last time R24's ROM program was documented was 6/30/09, and the restorative program that was specifically for transferring was last documented 8/31/09. No further restorative notes or nursing notes regarding R24's restorative nursing program had been made after that date. The current plan of care (POC) dated 10/5/11, included "therapy deficit r/t (related to) decreased mobility, cognitive deficits from dementia dx (diagnosis)." The identified goal was, "No decline in ROM will be noted." The POC identified R24's restorative program was discontinued related to refusals. The interventions included to "monitor for any declines, therapy screens prn" (as needed). Restorative Services forms indicated	F 317		

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F 317	Continued From page 51 R24 had received restorative nursing services until 2009. On 1/03/12 at 4:57 p.m. R24 was observed sleeping in bed with legs to the side, knees flexed at approximately a 90 degree angle. No splints were in place. On 1/5/12, at 9:27 a.m. R24 was observed during a transfer from the regular wheelchair (w/c) to the toilet with assist of 2 staff and a mechanical stand-up lift. As R24 sat in the w/c and staff uncrossed her legs to place on the stand-up lift platform, R24 said "ow ow ow". R24 then stood with the mechanical lift, and the resident's legs did not completely straighten, both knees were flexed throughout the transfer. R24's medical records were reviewed from 2009-current. R24's medical record did not indicate contractures were present prior to 11/29/11. R24 had pain documented on 6/26/11, when a nursing note identified pain during transfers. A Memo To Physician form dated 8/29/11, identified signs and symptoms of pain during transfers. A nursing note dated 10/26/11, identified R24 complained of pain, saying "ouch" when right knee and foot were manipulated or moved. Another nursing note dated 11/29/11, indicated R24's knee was stiff and sore and not bending at knees. A Physician's Telephone Order form dated 11/29/11, indicated physical therapy (PT) and occupational therapy (OT) to evaluate and treat	F 317		

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F 317	Continued From page 52 for LE (lower extremity) joint contractures. PT documentation indicated R24 received skilled services twice a week for 1 month for bilateral hip and knee joint contractures. The PT evaluation dated 12/5/11, identified the medical diagnosis of LE (lower extremity) joint contractures with treatment diagnosis of bilateral hip and knee joint contractures. The assessment by PT indicated R24 had substantial hip and knee joint contractures making transfers difficult at that time. The PT discharge note dated 12/29/11, indicated R24 "continued to have contractures but with gentle stretching we were able to get her hip abduction to neutral on the right and 15-20 degrees on the left, and knee extension within 20-30 degrees bilaterally to approximately 90 degrees of flexion." R24 was then discharged from PT and restorative nursing was set up for further range of motion of the knee and hips. OT documentation indicated an evaluation was completed 12/13/11, which identified R24's bilateral hip and knee contractures. The evaluation indicated R24 required a custom w/c to ensure proper positioning of the pelvis given LE hip contractures, and to elevate leg rests to accommodate for LE knee contractures. On 1/5/12, at 7:25 a.m. nursing assistant (NA)-A stated when R24 was first admitted no problems were noted. NA-A stated she did not know when the knee problems started and could not recall if it had been over a year or not.	F 317		

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F 317	Continued From page 53 On 1/5/12, at approximately 8:00 a.m. restorative aide (RA)-A stated R24 was not receiving ROM services and it had been well over a year since she had. She added it could be a couple years since she last had restorative services. RA-A stated R24 no longer received restorative nursing due to the degree of her dementia. On 1/5/12, at 9:30 a.m. NA-B and NA-C assisted with R24's transfer with the mechanical lift and both stated at that time R24's knees had gotten gradually worse. On 1/5/12, at 1:45 p.m. the physical therapist (PT)-A and the physical therapy assistant (PTA) -A were interviewed. PT-A stated R24's hips and knees had become arthritic. PT-A stated on 12/5/11, R24 was seen for hip and knee contractures, and the goal was for no further pain and complications, to ease the staff when helping to transfer and dress R24, and to help with ROM. PT-A stated R24 would continue with restorative nursing with hip and knee stretching which would start today. PT-A stated he did not know if a restorative program would have prevented the contractures and added it might have but could not say that for sure. PT-A stated their department last assessed R24 in '09 and that last screen indicated R24 was attempting to participate with rehab nursing. When asked if ROM would irritate R24's arthritis, PT-A stated it would not if it was gentle. PT-A stated R24 did not demonstrate signs or symptoms of pain when he had been working with R24. PTA-A stated there was only one time when working with R24 during abduction of the hips that the resident had muscle guarding, but other than that had not expressed pain symptoms.	F 317		

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F 317	Continued From page 54 On 1/5/12, at 2:33 p.m. registered nurse (RN)-B stated the only time ROM assessments were done was if residents had a decline or if something was observed such as a change in positioning in the w/c. RN-B stated the NAs report if the residents aren't transferring the same, then they do a screen and then PT does an assessment. When RN-B was asked when the last time restorative/range of motion services were attempted she stated the last sheets in chart were from '09. RN-B verified documentation to indicate why restorative services had stopped was lacking. On 1/5/12, at 2:35 p.m. PTA-A stated he could not find anything in the electric record about R24 being assessed by PT since '09. On 1/6/12, at 9:04 a.m. PTA-A stated R24 did not have complete functional ROM up to 180 degrees of flexion in the knees. PTA-A stated he could comfortably get them to 90 degrees. PTA-A stated it looked like R24 had been semi-participating in the restorative program and with increased confusion that program stopped. PTA-A verified even though R24 could no longer participate in an active ROM program, R24 could have still had a passive program. On 1/6/12, at 9:16 a.m. NA-D stated she had worked at the facility since the resident was admitted. NA-D stated R24's knees did not really straighten and that had probably had been on-going within the last year. NA-D stated it had gotten worse. NA-D stated "I don't think her hips work right either", and added it was hard for R24 to sit up.	F 317		

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F 317	Continued From page 55 On 1/6/12, at 1:45 p.m. RN-A stated there had been a loss of function in R24's legs. RN-A stated she just noticed the loss of function on 11/29/11, when staff told her they were having a hard time straightening R24's legs. RN-A stated she did a PT referral then and because R24 was recently sliding down in the wheelchair, OT saw her then too. RN-A verified she did not know of any prior documentation in R24's record about contractures. When RN-A was asked when the contractures developed, she stated she first noticed it was when R24 was not sitting in the w/c properly around 11/29/11. RN-A stated she did not know that R24's restorative program had stopped and could not recollect why it was stopped. RN-A verified there was no documentation as to why R24's restorative program had been stopped. On 1/6/12, at 2:42 p.m. the director of nursing (DON) verified a comprehensive assessment was lacking to pull all the pieces together regarding R24's range of motion. The policies and procedures were requested regarding ROM assessments and the restorative program and the facility provided the undated Restorative Protocol. The protocol indicated the oversight of the restorative nursing program remained the responsibility of the RN and timely decisions and corrective action should be the expected outcome of that oversight.	F 317		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318	F318 Element 1 Resident R1 was reassessed for ROM and a referral to PT/OT was	2/27/12

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F 318	Continued From page 56 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide planned range of motion treatment and services for 1 of 3 residents (R1) in the sample identified with a limitation in range of motion. Findings include: R1 was diagnosed with traumatic brain injury. The quarterly Minimum Data Set (MD'S) completed 9/30/11, indicated R1 required total assistance with all activities of daily living, was non-ambulatory, and had bilateral limitations in range of motion (ROM) of upper and lower extremities. The Care Area Assessment (CAA) dated 6/30/11, indicated R1 used a Hoyer (mechanical) lift and a tilt in space chair (special positioning wheelchair) and required total assist with activities of daily living. The plan of care (POC) revised 1/4/12, indicated R1 had a decrease in ROM to all extremities due to increased tone and spasticity related to the diagnosis of traumatic brain injury. The POC indicated R1 had right ankle and right hand contractures-present on admission. Rehab Nursing was to offer passive range of motion (PROM) every day as tolerated to all extremities. R1 was to have screening by PT/OT (physical	F 318	made. The resident care sheets have been updated and reflect the cares needed by R1. Element 2 All residents will be assessed upon admission, quarterly and with a change in condition s for ROM capabilities and referrals will be made when appropriate. Element 3 Staff were educated on the importance of restorative nursing and on proper restorative nursing techniques and documentation. Element 4 The DON or designee will audit restorative nursing documentation 3 times per weekly x one month, them weekly for 3 months. Variances will be brought to QA and the administrator quarterly. Element 5 Date of Correction: ~~March 15, 2012~~ 02/27/2012	

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F 318	Continued From page 57 therapy/occupational therapy) when needed. The nursing assistant (NA) resident care sheets did not identify R1 was to have ROM services. On 1/3/11, at 7:00 p.m. NA-C stated the evening NAs were responsible to complete 2 resident's ROM. NA-C added R1 was one of the two residents. NA-C stated the staff were to document on the back of the resident care sheet when and how long R1 received ROM. NA-C showed the surveyor the last 3 days of the NA resident care sheets. The sheets lacked any documentation for R1's ROM. The 11/18/11, RN Restorative notes indicated R1 was to be offered PROM daily by the p.m. nursing staff. -On 8/12/11, registered nurse (RN)-A noted ROM was documented 1 time over the past week. -On 8/12/11, RN-B indicated "reviewed." -On 9/8/11, restorative aide (RA)-A indicated ROM documented the over the past week. -On 9/2/11, RN-B indicated "reviewed." -On 10/14/11, RA-A note indicated no ROM documented over the past week. -On 10/15/11, RN-B indicated "reviewed." -On 11/10/11, RA-A indicated PROM done over the past week. -On 11/19/11, RA-A indicated R1 received PROM 1 time over the past week. -On 12/9/11, RA-A indicated no PROM completed in the past week. -On 12/10/11, RN-A indicated "reviewed." -On 12/16/11, RA-A indicated PROM completed one time in the past week by p.m. nursing staff. -On 12/18/11, RN-B indicated "reviewed." -On 12/22/11, RA-A indicated R1 received PROM	F 318		

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F 318	Continued From page 58 to right side 3 times this past week-will continue to be offered, resident can be resistive. -On 12/24/11, RN-A indicated "reviewed." -On 12/30/11, RA-A indicated PROM 1 time over past week by nursing staff on the p.m. shift. On 1/5/12, at 8:25 a.m., R1 was observed being assisted up by NA-A and NA-B using a Hoyer lift to assist her into the wheelchair. R1 was observed to require total assist from the staff. On 1/5/12, at 9:00 a.m., RA-A stated she documents weekly on each resident who is receiving a Restorative plan. RA-A stated she really did not do anything with the information and added the RNs review her documentation on a weekly basis. On 1/5/12, at 1:45 p.m., RN-B verified the plan of care was correct and R1 was not receiving ROM services according to the plan of care. RN-B stated the RNs review RA-A's documentation and would then document "reviewed." However, the RNs never analyzed the data regarding if the residents were tolerating and receiving their plan according to how the program was developed by the physical therapist and the occupational therapist. RN-B stated she was unaware that the p.m. NAs were to complete R1's ROM plan.	F 318		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 A comprehensive assessment has been conducted on Resident's 16, 12, and 25. The assessments include: Therapy evaluation, Medication review, Sensory needs, mood, cognition, and pain. A root cause of	2/27/12

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F 323	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision and adequate interventions were implemented to minimize the risk of further falls and accidents based on a comprehensive assessment for 3 of 3 residents (R16, R12, R25) reviewed for falls. R12 had sustained harm related to rib fractures following a fall. R16 had sustained harm related to a fractured pelvis following a fall. R25 had sustained harm related to pain and bruising following a fall. Findings include: R16 lacked adequate assessment, supervision and interventions to minimize falls and had sustained harm following falls on 11/11/11, and 11/12/11, which resulted in rib fractures of the 6th, 7th, and 8th rib. R16 was admitted to the facility on 6/15/11, and was diagnosed with Alzheimer's disease, congestive heart failure, osteoporosis, anemia, malaise and fatigue, and a history of falls. The quarterly Minimum Data Set (MDS) dated 12/16/11, indicated R16 had severe cognitive impairment, was independent with bed mobility, required supervision with transfers, and limited assistance for ambulation, toileting, and personal hygiene. R16 was also identified with unsteady balance at times and as continent of bowel and bladder. The MDS indicated R16 had sustained	F 323	falls during last six months was performed analyzing time of day, location, and activity. Individualized proactive preventative interventions are in place. All residents have been audited for risk assessments with preventative interventions. A baseline audit and assessment was performed on all residents who fell during the past 6 months. The assessments include: Therapy evaluation, Medication review, Sensory needs, mood, cognition, and pain. A root cause of falls during last six months was performed analyzing time of day, location, and activity. Individualized proactive preventative interventions are in place. A new falls prevention system has been implemented. The new system includes a psychosocial approach to: Assessment for risk, prevention, investigation immediately following the fall, interventions, and interdisciplinary brain storming sessions. Education has been provided to all staff. The DON/designee will review falls assessment and prevention for new admissions and all falls for	

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	245428	A. BUILDING _____ B. WING _____	01/09/2012

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F 323	Continued From page 60 no falls since admission or the prior assessment period. The Falls Assessment dated 12/19/11, indicated R26 did not call for assist, and staff was to offer assist with toileting every 2 hours. Bed and chair alarms were to continue. The 12/27/11, plan of care (POC) indicated R16 was independent in ambulation on most days and required assistance occasionally related to confusion and pain. The POC indicated R16 required assist with toileting and for staff to assist as she would allow. On 6/16/11, R16 had a physical therapy (PT) evaluation due to weakness and unsteady ambulation. At that time, the PT recommendation was to discontinue R16's bed and chair alarm. On 7/1/11, R16 was discharged from physical therapy. The PT indicated R16 required standby assist with ambulation and transfers. On 1/5/12, at 8:00 a.m. R16 was observed ambulating with a front wheeled walker and assist of nursing assistant (NA)-A into the dining room. The incident reports identified falls over the last 6 months: -7/9/11, at 12:55 a.m., R16 was found by bed on her back with her pants halfway down. R16 had bumped the back of her head. R16 was identified to be confused and that it was the 1st time R16 had not pulled her pants up after toileting. Staff were to check on R16 when she went to the bathroom.	F 323	appropriate investigation, and interventions daily for 7 days and weekly at IDT falls brainstorming sessions ongoing. Variances will be reported to the Administrator and reviewed at QA at least quarterly. Date of Completion: ~~March 15,~~ 2012 02/27/2012	

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F 323	Continued From page 61 - 7/25/11, at 7:55 a.m., R16 was found beside her bed sitting on buttocks and was very confused. No injury was noted. A new intervention of a bed alarm was added to be used at night. -10/24/11, at 2:15 p.m., R16 was in the bathroom by the nursing desk, she had told staff to leave, and then was heard yelling. Staff found R16 on her back on the floor. R16 had sustained no injuries. -11/1/11, at 1:15 a.m., R16 was found in the bathroom sitting on the floor. No injuries were noted. R16 had gone to the bathroom by herself and was noted to not always ring for assist related to dementia. Staff noted "continue to monitor. " -11/11/11, at 6:00 p.m., R16 was found in her bathroom on the floor and yelling for help. R16 had stated she hit her head and neuro checks were completed. R16 had not pulled her pants up or down appropriately, continued to independently ambulate and slips. R16 was also noted to have dementia and did not use the call light. No new interventions were put in place. -11/12/11, at 7:50 a.m., R16 was in the bathroom and an alarm was sounding. R16 was identified to not have sustained injuries from the 11/11/11 and 11/12/11 falls. No new interventions were put in place. The Incident Report and nursing notes following the falls lacked a comprehensive assessment and investigation into the falls. Documentation failed to include potential causes of the falls	F 323		

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F 323	Continued From page 62 including whether current interventions had been implemented, when the resident had last been toileted, or if any new interventions had been implemented. The 11/13/11, nurse progress note indicated R16 complained of left rib cage pain and was sent to the emergency room (ER) for x-rays. The x-rays at that time revealed no fracture, but R16 was noted to have sustained a left rib contusion. R16 was also noted to have a urinary tract infection (UTI) and received treatment. The 11/13/11, ER report indicated R16 had complaints of anterolateral chest pain after losing her balance and falling. The report indicated R16 was discharged from the ER with Vidocin (narcotic pain medication) and advised to ice and heat intermittently. The 11/17/11, physician visit note indicated R16 was seen for follow up of an ER visit. The report indicated R16 was seen in ER on 11/13/11, for a prior fall and diagnosed with a left rib contusion. Radiology had recommended a repeat x-ray in a week to recheck for occult fracture versus parenchymal disease on left rib cage. The report indicated R16 continued to have left chest wall discomfort. The findings at that time revealed R16 had fractures of the 6th, 7th, and 8th ribs. Additional incident reports identified: -11/26/11, at 2:30 a.m., R16 was found on the floor in the bathroom and had been independently ambulating. R16 had sustained no injury. The note indicated R16 had dementia, did not use call light, and forget to pull her pants up. R16 was to be checked on often, to be assisted every 2 hours with toileting, staff were to encourage R16 to wait	F 323		

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F 323	Continued From page 63 for assistance, and continue the bed alarm. -12/19/11, at 12:20 a.m., R16 was found on the floor in her room, trying to change her pajamas. R16 had sustained no injury. Staff were to continue the bed alarm and review a possible room change and assist with toileting every 2 hours. The Incident Report and nursing notes following the falls lacked a comprehensive assessment and investigation into the falls. Documentation failed to include potential causes of the falls including whether current interventions has been implemented, when the resident had last been toileted, or if any new interventions had been implemented. On 1/5/12, at 12:25 p.m. licensed practical nurse (LPN)-B stated R16 had been in the same room for over 6 months and could not recall any room changes. On 1/5/12, at 1:10 p.m. NA-A stated R16 had a bed alarm and no chair alarms. NA-A added toileting was offered every 2 hours on everybody. On 1/6/12, at 2:30 p.m. registered nurse (RN)-A stated they review falls during interdisciplinary team (IDT) meetings, but did not document any of what was discussed in R16's record. RN-A verified the 12/16/11, quarterly MDS lacked the accuracy related to falls. RN-A stated R16 lacked a comprehensive fall assessment. RN-A added about a year ago staff were advised to use new Fall forms that lacked information and made it hard for RNs to complete comprehensive fall	F 323		

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F 323	Continued From page 64 assessments. RN-A stated the facility did not have a policy and procedure regarding Accidents/Falls. R12 had a history of falls and lacked appropriate assessment, interventions and supervision, to minimize the risk of further falls/accidents. R12 sustained harm following a fall on 12/10/11, which resulted in a fractured pelvis. R12's diagnoses included Alzheimer's disease. R12's annual MDS dated 10/20/11, identified R12 with severe cognitive impairment, as independent with bed mobility and locomotion on the unit and as requiring limited assistance with walking and activities of daily living (ADLs). The MDS indicated R12 had sustained falls since the prior assessment period, but lacked indication of how many falls had occurred or if injuries were sustained. The Fall Risk Assessment dated 10/17/11, indicated R12 was at risk for falls due to confusion at all times, assistance with elimination, history of falls, ambulation with an assistive device, and an unsteady gait. The plan of care dated 10/22/11, directed staff to monitor R12 closely, utilize bed and chair alarms at all times, and to put on gripper socks at bedtime due to unsteady gait and self-transferring. The Falls Care Area Assessment (CAA) dated 10/23/11, indicated R12 had a history of falls. R12	F 323		

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F 323	Continued From page 65 was noted to have bed and wheelchair alarms due to self transferring and had a recent fall with no injury. Diagnosis reviewed included general muscle weakness, macular degeneration, Alzheimer's disease. No other causal factors related to falls were indicated in the CAA. On 1/3/11, at 6:00 p.m. R12 was observed with a chair alarm attached to her wheelchair. On 1/5/11, at 8:46 a.m. R12 was observed to propel herself into her room. R12 scooted to the end of her chair and set off her chair alarm for a split second. R12 appeared to want to transfer out of her wheelchair but could not. R12 did not place on her call light and continued to sit in her room until staff assisted her into her bed. The bed alarm was placed in the bed when in bed. On 1/6/11, at 9:45 a.m. R12 stated that she wanted to lay down in bed. R12 was encouraged to stay in her wheelchair until staff could assist and the resident stated "Oh, that's right. Because of the fall." The resident then waited for staff assistance. A review of R12's record indicated: -On 2/1/11, at 12:30 a.m. the Patient/Resident Occurrence Report (PROR) indicated R12 was found sitting on the floor next to her bed with her pajama pants down. The bed alarm was not sounding. R12 stated she was trying to go to the bathroom. No injuries were sustained. No new interventions were identified.	F 323		

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F 323	Continued From page 66 No further falls were identified until: -On 9/18/11, at 4:00 p.m. the PROR indicated R12 was found sitting on the floor next to her bed. R12 stated she landed easy and no injuries were sustained. The Root Cause Analysis and Action Taken section of the assessment dated 9/1/11, indicated there were no contributing factors to the fall and to continue with bed and chair alarms. The PFA dated 9/18/11, indicated R12 had a history of self transferring, continued to have bed and chair alarms to alert staff, and no changes to the plan of care were recommended. No further assessment of causal factors were determined to implement further interventions was completed. -On 10/19/11, at 4:45 p.m. the PROR indicated R12 was heard calling for help and was found sitting on the floor next to her bed. R12 stated she was trying to get candy out of her drawer. The floor was noted to be wet with water and a water glass was found under the bed. No alarm sounded when R12 fell. R12 had stockings on her feet and stated she just slid down. No injury was sustained. The Root Cause Analysis and Action Taken section of the assessment dated 10/21/11, indicated staff was to remind the resident to ask for help and that there were no contributing factors to the fall. The PFA dated 10/19/11, noted a history of falls and self transferring and no changes to the plan of care were recommended. No further assessment of causal factors were determined to implement further interventions was completed. The documentation did not address why the alarm did not sound. -On 12/10/11, at 11:30 p.m. the PROR indicated	F 323		

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F 323	Continued From page 67 R12 was found laying on her left side in the doorway to her bathroom. R12's alarm was sounding. R12 was noted to be upset and crying. R12 had sustained a 1 cm bruise to left elbow and 2 cm abrasion to left shoulder blade. R12 had complained of left hip pain and was sent to the emergency room with no fracture noted. The Root Cause Analysis and Action Taken section of the assessment dated 12/11/11, indicated dementia was a causal factor, and to continue with bed and chair alarms and check on the resident often. The PFA dated 12/11/11, indicated R12's patterns in falls included the resident gets up by self, does not use the call light and the alarm goes off. Staff could not normally get to the resident before an incident occurred. R12 was noted to have dementia and be very forgetful. No changes to the plan of care were recommended. On 12/19/11, R12 continued to have left hip pain and a follow up x-ray was obtained on that date and identified a left pubic rami hairline fracture. On 12/20/11, physical therapy and pain management was ordered for the resident. On 1/5/11, at 9:05 a.m. NA-C stated R12 frequently self transferred prior to her hip fracture, sometimes all the time, but had not been attempting that since the fracture. NA-C added she thought R12 will start attempting to self transfer again once she is stronger. At 9:43 a.m. NA-C stated R12 can use her call light when she needs assistance. NA-C stated as far as she knew, R12 could not turn off her alarms. At 9:44 a.m. rehab aide (RA)-A stated R12 had	F 323		

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F 323	Continued From page 68 declined and required the use of the wheelchair more since her injury. RA-A stated she had noted R12 was not self-transferring as she had been before her fracture. She stated R12 was able to turn off her alarms, but had not seen her do this since her fracture. RA-A added R12 can use her call light even though she is cognitively impaired. At 12:11 p.m. LPN-B stated R12 rarely attempted to self transfer now and uses her call light. LPN-B indicated interventions for R12 included alarms and check on the resident often. LPN-B stated nothing more had been implemented for R12 after her recent falls. The LPN stated R12 can turn off her alarms but usually does not. At 12:22 p.m. RN-B stated R12 attempts to self transfer and gets very disoriented. RN-B stated she could not tell by reviewing the PRORs and assessments of the falls if all factors contributing to falls had been identified or why alarms did not always work. The RN stated she was unsure what else they could do for R12 besides providing alarms to alert staff of self transfers. RN-B added she thinks they need to change the forms they use to complete fall assessments because they are not getting the all the information they need to assess falls. At 1:03 p.m. the interim director of nursing (DON) stated they had identified a concern with fall assessments and would like to enhance a form to apply more of a root cause analysis approach. The DON stated more data should be gathered to assess falls. She stated the forms are also lack areas that should be assessed such as	F 323		

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F 323	Continued From page 69 medications which could be a contributing factors to falls. The DON stated alarms just alert the staff that a resident is making an attempt to self transfer but often residents have already gotten up and staff may not reach them in time. The DON stated these are all issues that will be a focus of more intensive training in the near future. At 1:26 p.m. NA-A stated R12 was self transferring all the time before the last fall and added sometimes R12 would stand next to her bed and reach into her drawer. She stated the last fall had really "brought her down." She added R12 was not attempting to do things independently like she did before the fracture. She stated R12 could have possibly been able to turn off her own alarm, but she had not seen her do it. On 1/6/12, at 12:57 p.m. RN-A stated R12 does self transfer and is unsure of any other interventions that could be implemented to prevent falls for this resident. R25 had a history of falls and and lacked appropriate assessment, interventions and supervision to minimize the risk of further falls/accidents. R25 sustained harm following a fall on 12/3/11, that resulted in extensive bruising, swelling, and pain of the right leg, shin and knee area. R25's diagnoses included a stroke with right sided hemiparesis, restless leg syndrome, and osteoarthritis. The quarterly MDS dated 10/7/11,	F 323		

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F 323	Continued From page 70 indicated R25 had moderately impaired cognition, required total assist with toileting, set up assistance for walking in the hallway, and set up assist for transfers. In addition, the MDS indicated R25 was occasionally incontinent of urine. The Cognitive Loss CAA dated 1/29/11, identified R25's belief she could ambulate independently. The Activities of Daily Living CAA dated 1/29/11, indicated R25 was unable to remember recent things and indicated R25 believed she could ambulate independently. The Falls CAA dated 1/29/11, identified a recent stroke with paralysis and impaired balance, and that R25 required assistance for mobility. It also indicated R25 had sustained two falls since admission related to self transfers. The Fall Risk Assessment form dated 1/4/12, identified R25 at risk for falls. The POC dated 10/13/11, indicated R25 ambulated with assistance of one and transferred independently most of the time. The POC update 12/3/11, indicated R25 utilized a bed alarm at night. Other interventions included to keep call light within reach, to monitor for decline, and to utilize a wheelchair for great distances and walk with staff short distances. The current, undated, East Hall Work Assignment form, utilized daily by the nursing assistants, indicated R25 required one staff assist to toilet, transfer, and ambulate. The form also indicated R25 utilized non skid socks, and a bed and chair alarm. However, during interview on 1/6/12, at 9:15 a.m. RN-A crossed off the chair alarm, and stated R25 no longer utilized it.	F 323		

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F 323	Continued From page 71 The Patient/Resident Occurrence Report (PROR) forms identified multiple falls without injury from 1/23/11 to 2/8/11: -1/23/11, R25 was found on the floor in bedroom at 4:30 a.m. R25 was re-educated to use the call light. R25 was identified to utilize a concave mattress and bed and chair alarms. -1/24/11, R25 was found kneeling on the floor at 6:50 a.m. R25 told staff she wanted to use the bathroom. R25 was directed to use the call light. An additional intervention of a mat on floor was identified. -1/27/11, R25 had fallen out of recliner and was found lying on back in living room at 11:10 p.m. R25 was reminded to call for help. -2/4/11, R25 was found kneeling on mat next to bed at 2:00 a.m. No interventions was identified. -2/4/11, R25 was found kneeling on mat next to bed at 8:30 p.m. R25 told staff she needed to use the toilet. No new intervention was identified. -2/4/11, R25 was found kneeling on mat next to bed at 10:45 p.m. R25 stated she needed to go to the bathroom. No new intervention was identified. -2/5/11, R25 was found on knees on mat next to bed at 1:00 a.m. No new intervention was identified. An additional intervention of a low bed was identified. - 2/5/11, R25 was found on knees on mat next to bed with upper body on bed at 1:10 a.m. -2/5/11, R25 was found lying on back in living room by chair at 1:50 p.m. R25 was reminded to call for help and staff were to check frequently. -2/5/11, R25 was found on kneeling on mat next to bed at 11:15 p.m. R25 was reminded to call for assistance. -2/6/11, R25 was found kneeling on mat next to	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	1002 COMSTOCK DRIVE DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 72 bed with upper body in bed at 3:00 a.m., and 4:00 a.m. R25 was reminded to call for assistance. No new interventions were identified. -2/6/11, R25 was found kneeling on mat next to bed with upper torso lying over bed at 11:30 p.m. No new interventions were identified. -2/8/11, R25 was found kneeling on mat next to bed at 5:30 a.m. No new interventions were identified. No further falls were identified until July 2011. The dated PROR forms identified further falls on: -7/20/11, R25 was found sitting in urine on floor at 4:15 a.m. R25 had slipped and fell landing on buttocks in own room and was barefoot. No injuries sustained. Plan was to monitor. The form indicated R25 had bladder urgency at night. Actions to be taken were to continue offer incontinence pad at night, however, the form also indicated R25 had refused use in past. R25's gait and balance was noted to be good with no problems noted. Night staff were to check R25 frequently and evening staff were to offer an incontinent pad. No referrals or changes were made in the plan of care. The Nurse Progress Note, dated 8/29/11, indicated R25 toileted self, and dribbled urine on the floor on the way to the bathroom, in the bathroom, or on the floor by the bed and had many urinary incontinent episodes during the night. In addition, R25 would remove the incontinence product. R25 had a history of slipping in urine resulting in falls, however, R25 did not understand the importance of leaving the incontinence product on and using the call light to	F 323		

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F 323	Continued From page 73 ask for help. The Diagnostic Imaging Report form dated 9/6/11, indicated R25 had a right shoulder full thickness tear of the rotator cuff. The Nurse Progress Noted dated 9/15/11, at 6:30 p.m. indicated R25 was ambulating slowly while hanging onto nurses desk, stopped passing physician, and informed the doctor she had "terrible knee pain." The PRORs noted: -10/9/11, R25 was found sitting on floor next to recliner in living room at 6:40 a.m. R25 had complained of chronic right shoulder pain for which R25 had received medical treatment for in recent past. Action taken was to place call bell next to her, however, also indicated R25 had not used. R25 attempted to self transfer and did not use call bell to ask for assistance. It also indicated R25 had been receiving medical treatment sine July 2011, related to right shoulder pain. Action to be taken was give R25 another dose of pain medication at 7:30 a.m. The Post Fall Assessment (PFA) dated 10/9/11, indicated R25 had chronic complaints of right shoulder pain with the physician following. No referrals or changes were made to the plan of care. The Nurse Progress Note dated 10/19/11, at 3:40 a.m. indicated R25 was found in bathroom attempting to void in garbage can and subsequently urinated on the floor. R25 complained her legs "hurt so bad." Two staff assisted into wheelchair and into bed.	F 323		

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F 323	Continued From page 74 -11/2/11, R25 was found on the floor in own bathroom at 7:00 a.m. The floor was wet from outside the bathroom and leading into it. A skin tear to left forearm and bruising was noted. Later that day R25 complained of right ankle pain when standing. R25 was incontinent of urine and dribbled on the floor in the past. R25 was reminded to ask for help when incontinent of bladder. Actions to be taken was to obtain an order for ankle x-ray. The PFA dated 11/2/11, indicated R25 had fallen on 10/9/11, and 7/20/11, due to slipping on urine when self transferring. R25 sustained a left forearm skin tear and bruises and suffered from right shoulder pain with medical follow up. No referrals or changes were made to the plan of care made. The consultation report dated 11/2/11, indicated a follow up to right shoulder pain. R25 was diagnosed with severe right shoulder rotator cuff tear. No further treatment recommended. The PROR dated 11/4/11, indicated at 9:00 p.m. R25 was found by housekeeping sitting on the floor in room doorway. R25 informed staff she had fallen in the bathroom and scooted to the doorway. R25 was steady on feet at all times during transfers, and this event was a one time occurrence as R25 had not fallen in the past 6 months or longer. A possible malfunction of the bathroom door was identified, and the door may have hit R25 as she was going through it. Action taken was to continue to monitor R25, and a maintenance work order slip was completed to check to door. No injuries sustained.	F 323		

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F 323	Continued From page 75 The Nurse Progress Note dated 11/14/11, at 9:00 p.m. indicated housekeeping found R25 on the floor in room doorway. The note also indicated R25 had a large bruised area on the left side. The Nurse Progress Note dated 11/15/11, at 9:45 pm. indicated R25 had a large bruise on the left side. The PFA dated 11/15/11, indicated R25 had fallen 11/14/11, and had not fallen since 10/9/11, with no injuries at that time. However, the form indicated R25 had received bruising to an unidentified area on 11/15/11. The post fall findings were identified as staff to continue to monitor, does not have alarms. No referrals or changes were made to the plan of care. Facility staff was unable to locate the 11/14/11, PROR for this fall. The Nurse Progress Note dated 11/17/11, at 3:00 p.m. indicated R25 was at risk for falls, and required close observation especially during the night. R25 was reminded to use the call light for assistance. The PROR dated 12/3/11, indicated at 4:55 a.m. R25 was found sitting on floor in the bathroom. R25 stated she had lost her balance. No injuries sustained. R25 was reminded to ask for help when going to the bathroom. Actions to be taken were identified as "none." The Nurse Progress note dated 12/3/11, at 4:55 a.m. indicated R25 was found sitting on bathroom floor. Range of motion within normal limits. At 2:00 p.m. the note indicated R25 denied pain or	F 323		

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F 323	Continued From page 76 discomfort from fall. At 10:15 p.m. the note indicated R25 denied pain or discomfort from fall. The PRORs and nursing notes following the falls lacked comprehensive assessment and investigation into the falls to identify whether current interventions were adequate and to determine if additional appropriate interventions had been implemented related to potential causes of the falls. The Nurse Progress Note dated 12/4/11, at 7:15 a.m. indicated R25 had bruising to the right knee, and denied pain. The Memo To Physician form dated 12/5/11, indicated R25 had fallen on 12/3/11, and was still complaining of pain in the right shin and knee area with bruising and swelling noted. R25 had been treated with Tylenol #3 for pain every 4 hours as needed. The physician ordered a knee x-ray as well as ice, elevation and Tylenol for discomfort and range of motion to prevent stiffening. The Nurse Progress note dated 12/5/11, at 9:40 a.m. indicated R25 had widespread bruising to the right knee and shin area and the leg was swollen. The note indicated R25 was sent to the clinic at that time with x-rays negative. The Nurse Progress Note dated, 12/6/11, at 4:45 a.m. indicated R25 had removed gripper socks, and toileted self. The routine physician visit Progress Note dated 12/8/11, indicated R25 had fallen (on 12/3/11), hit right knee causing a 2 centimeter abrasion with	F 323		

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F 323	Continued From page 77 yellow discharge, and pain in right knee with x-rays negative. The note also indicated R25's right arm basically dangled off the side with R25's ability to gently abduct and rotate it, but not significantly so. R25 was diagnosed with a right knee injury, and right shoulder degenerative joint disease with rotator cuff pathology. The nurse progress note dated 12/30/11, indicated R25 now had a bed alarm at night for safety. On 1/3/11, at 3:00 p.m. R25 was observed lying in bed. The wheelchair was placed away from the bed, near the closet. At 5:00 p.m. R25 was observed to sit self up in bed with great effort. On 1/4/11, at 2:54 p.m. R25 was observed sitting in the wheelchair, next to the bathroom door. R25 stated she had just used the bathroom. R25 also stated she independently walked into the bathroom. On 1/5/11, at 7:15 a.m. RA-A stated R25's physical abilities varied day to day. At 7:54 a.m. R25 was observed walking in the hall from own room to dining room with restorative aide (RA)-A. RA-A was observed holding onto a gait belt that was applied around R25's waist while pulling a wheelchair from behind. R25 was observed to have a wobbly, unsteady gait and voiced fear of falling. R25 was observed to sigh in relief when reached the nurses station ledge for weight bearing support. R25 was also observed to be short of breath with the exertion. R25 had requested to sit down frequently throughout the observation which	F 323		

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F 323	Continued From page 78 required RA-A to give verbal encouragement to continue. R25 again stated she did not want to fall. At 8:57 a.m. R25 was observed propelling self into own room from the dining room. R25 was observed to position self next to the bathroom door. R25 used the bathroom door for weight bearing support to stand. Once up, R25 was observed to take a few steps using a sliding/shuffling gait until into the bathroom doorway. R25's balance was unsteady. R25 lunged/leaned forward grabbing onto the opposite bathroom walls grab bar. R25 was observed to sigh with relief when the grab bar was reached. R25 toileted self with audible grunting while attempting to pull up pants. At 9:03 a.m. R25 was observed to take two sliding/shuffling steps, gait unsteady, turn self backwards away from the door, then leaned backward, and plopped self into unlocked wheelchair. The wheelchair was observed to lunge backwards away from R25. R25 landed 1/2 on and 1/2 off the wheelchair seat. On 1/4/11, at 3:13 p.m. NA-E verified R25's abilities varied day to day. NA-E verfied R25's recent fall with knee injury and pain resulted in limited ambulation. NA-E also stated staff had to keep R25's wheelchair by the bed and locked to remind her to use it. NA-E also verified R25 utilized a bed alarm at night only due to history of falls. On 1/5/11, at 9:21 a.m. NA-A stated R25 believed she could drive herself home to stay. NA-A verified R25's falls usually happened at night due to toileting self, urinating on the floor, and then	F 323		

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F 323	Continued From page 79 slipping and falling. NA-A verified R25 had also fallen on the day shift in the past while bringing self back and forth from the bathroom. NA-A verified R25 utilized a bed alarm at night, however, stated R25 should use one during the day when lying down to alert staff when rising. NA-A stated R25 struggled getting pants up and down because R25 had only one functional arm to use. NA-A went on to state R25 did not have a wheelchair alarm. At 12:57 p.m. LPN-B stated R25 was pleasantly confused daily, and required one staff assist to toilet. LPN-B verified R25 utilized a bed alarm at night due to self transferring/ambulation, voiding on the floor, and not asking for assistance which has resulted in R25 falling. LPN-B verified there were no current fall interventions in place during the day time hours other than R25 needing to call/ask for help when needed. LPN-B verified R25 was not able to effectively pull pants up/down. LPN-B added R25 could walk "real" short distances and also verified a recent fall with knee injury had resulted in increased pain and limited ambulation ability. In addition, LPN-B stated the nurse on duty was responsible to implement new fall interventions if needed after a resident fell. At 1:10 p.m. NA-B verified R25 had very poor short term memory, and was paralyzed on one arm. NA-B also verified R25 required a lot of help with cares daily, however, toileted self during the day. NA-B verified R25 should not be walking by self due having an unsteady gait when walking, and tiring easily. NA-B also verified R25 did not have fall interventions in place during the daytime hours because R25 primarily fell at night due to	F 323		

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F 323	Continued From page 80 slipping and falling in urine on the floor. At 1:25 p.m. RA-A stated R25 was unable to grasp things with right hand. RA-A verified she assisted R25 with cares daily Monday through Friday. RA-A stated R25 was incontinent of bladder or voided on the floor every morning. RA-A also stated R25 utilized a bed alarm at night only. Additionally, RA-A verified R25 had been trained how to lock the wheelchair brakes before standing, however, stated R25 did not remember to lock the brakes due to memory loss. RA-A stated R25 had been walking independently, however, stated R25's legs don't carry her anymore. RA-A also verified R25 sustained a post fall knee injury which had resulted in decreased ability to walk. In addition, RA-A stated R25 had utilized a walker in the past and could probably use a walker again and stated she would "dig one up." RA-A also verified R25 was fearful of falling. RA-A verified R25 was at risk for falling. At 2:06 p.m. PTA-A verified R25 had some physical declines which had been talked about in the past daily team meetings, but would have to look at those notes as to what was discussed. At this time, physical therapist (PT)-A added the therapy department used to complete quarterly screens on all residents, however, the nursing staff complete them now. PTA-A stated a quad cane would be beneficial for R25's use, then added, R25 had her own quad cane. PTA-A was not sure why R25 was not using it. At 2:27 p.m. the DON reviewed R25's fall reports with the surveyor. The DON verified to keep reminding R25 to use call light was not an	F 323		

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F 323	Continued From page 81 effective intervention due to R25's inability to retain information due to short term memory loss. Additionally, the DON stated the fall report forms lacked accuracy, and comprehensive assessments related to causal factors as well as identification and implementation of new interventions were lacking. The DON also verified R25 was at risk for falls. At 10:30 p.m. NA-G verified R25 was up/down most of the night going to the bathroom. NA-G stated R25 had early morning confusion episodes and requested to go home. NA-G verified R25's falls were related to slipping on urine that was on the floor. Additionally, NA-G stated R25 never used the call light, therefore, staff had to wait to hear the bed alarm sounding in order to know R25 was getting out of bed. At 10:35 p.m. LPN-C verified R25 was very confused and was often upset because staff would not take her home or allow her to drive self home. LPN-C also verified R25 had never used the call light, even with reminders. LPN-C added R25 was a very slow walker with a shuffling/dragging gait and stated R25's feet barely moved forward. LPN-C stated the bed alarm was put into place in December 2011, following a respiratory illness. LPC-C stated there was no fall interventions in place prior to that time as the bed alarm had been removed from use off and on in the past. LPN-C stated she did not believe R25 could utilize a walker due to the weak arm. LPN-C stated R25 would remove incontinent product, void on floor, then slip and fall. LPN-C also stated when R25's bed alarm sounds, R25 is already in the bathroom when staff arrive as R25 would not wait for assistance.	F 323		

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F 323	Continued From page 82 On 1/6/11, at 8:50 a.m. PTA-A verified R25 worked with physical therapy until 4/4/11, as R25 demonstrated safe ability to transfer, and ambulate self with a one handed device such as a cane. PTA-A verified physical therapy had not worked with R25 sine then. PTA-A also stated the discontinuation of bed/chair alarms would not be documented, rather discussed at team meetings. PTA-A verified physical therapy had not received a referral related to R25's functional decline/falls and would have expected one. At 9:15 a.m. RN-A verified R25's bed/chair alarms had been removed and reinstated in the past related to falls. RN-A stated R25 did not like the alarms and would shut them off herself which is why they were discontinued at one time. RN-A stated physical therapy stated R25 did not need the fall alarms. However, due to falling at night it was reinstated. In addition, RN-A verified R25 was incontinent of urine at times, and would dribble on the floor, and had difficulty pulling her pants up independently. RN-A also stated R25 would not call for assistance especially at night, and required staff stand by assist when walking. RN-A verfied R25 sustained a post fall knee injury with increased pain resulting in limited ambulation recently. Additionally, RN-A stated the facility fall forms were not comprehensive enough and would love to go back to the old forms the facility used to have. RN-A verified the only fall interventions currently in place for R25 was a bed alarm at night and to remind R25 to use the call light to call for assistance when needed. RN-A also stated R25 would forget to lock the wheelchair brakes when standing. RN-A verified R25 required one staff assist to transfer, toilet,	F 323		

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F 323	Continued From page 83 and ambulate. At 10:10 a.m. the DON verified the facility did not have a fall/accident policy and procedure. At 1:05 p.m. the Occupational Therapist (OT) verified she had worked with R25 related range of motion, however, due to increased right shoulder pain had to stop. The OT stated she was not sure if R25's severed rotator cuff was the result of a fall or accident, and was not sure when the tear occurred.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	F 356 Element # 1 The Staff posting was corrected and placed in a public area. . Element # 2 Nurse staffing information is posted daily in an area and at a height readily seen by residents and families. Staffing posts are kept in a book at the nurse's station for 18 months. Element # 3 RN's and LPN's have been educated regarding the requirements of nursing staff postings. Element # 4 Postings will be audited by the DON/Designee daily x 7 days, weekly x three weeks and monthly x 2 months. Random audits of staffing book and posting will be at least quarterly ongoing. Exceptions will be	2/27/12

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F 356	Continued From page 84 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the posted nurse staffing hours did not include the total number, but only the actual hours, worked by nursing staff which had the potential to affect all 26 residents residing at the facility. Findings include: On 1/5/12, at 9:30 a.m., the posted nursing staff hours indicated how many registered nurses (RN), licensed practical nurses (LPN), trained medication aides (TMA) and nursing assistants (NA) worked per shift. The hours posted included the actual hours worked, but not the total number of hours worked by each nursing staff category. On 1/5/12, at 10:00 a.m. RN-B stated the night staff prepared the form for the day. RN-B stated she did not know about what was required on the form. RN-B stated the form was made by a former administrative person and they were to complete it as directed on the form. At 3:30 p.m. the acting director of nursing (DON) verified the hours were not totaled and she would be revising the form.	F 356	reported to the administrator and reviewed by QA at least quarterly. . Element # 5 Corrective action completion date: February 8, 2012. 02/27/2012	
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		2/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	01/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	1002 COMSTOCK DRIVE DEER RIVER, MN 56636

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F 371	Continued From page 85 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate infection control measures were maintained during 2 of 2 ice water distribution observations which had the potential to effect all 26 residents residing in the facility. Findings include: On 1/3/12, during the initial facility tour at approximately 1:30-2:00 p.m.and on 1/5/12, at 2:10 p.m. nursing assistant (NA)-F was observed delivering ice water to each individual resident room. The ice was observed in a bucket placed on top of a rolling cart. An ice scoop was observed inside the bucket. NA-F had gloves on. NA-F was observed entering each individual resident room with the gloves on. NA-F picked up the individual ice water mugs, removed the lids, emptied contents in to bathroom sink. NA-F was then observed to bring the mug to the ice cart, fill it with ice and replace the same lid. NA-F returned the mug to the resident's bedside stand. The ice scoop was observed to touch the inside upper wall and lid of the mug while filling with ice.	F 371	F371 (NA)-F was immediately educated regarding infection control and the water pass protocol. A cooler and cart have been purchased that will be used specifically for ice distribution. The cart has a holder for the ice scoop. There were no negative consequences as a result of this deficiency. A protocol for water pass and ice distribution has been developed and implemented. Clinical staff has been educated regarding the new water pass protocol. The DON/Designee will randomly observe water pass daily x 5 days, weekly x 3 weeks, monthly x 2 months, and randomly ongoing. Variances from protocol will be reported to the Administrator and reviewed at QA at least quarterly. Compliance date ~~February 15, 2012~~ 02/27/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HOMESTEAD REHABILITATION & LIVING CENTER	1002 COMSTOCK DRIVE DEER RIVER, MN 56636

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F 371	Continued From page 86 NA-F then returned the scoop back into the ice bucket. NA-F was observed to repeat this process without removing or changing gloves during the observations. On 1/6/12, at 10:10 a.m. the director of nursing (DON) verified staff did not follow facility infection control practices. In addition, the DON stated the facility did not have a policy and procedure related to ice water distribution.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F 441 LPN-A was educated to disinfect the multi-use glucometer machine between resident use. . Clinical Nursing staff were educated on the proper disinfection of equipment, handwashing. and use of gloves. A protocol for disinfecting the glucometer has been developed. The Nursing staff LPN's and RN's will review the procedure and test out with the DON/designee. The DON/designee will observe random blood glucose checks by nursing staff weekly times 4 weeks, monthly times 4 months, and quarterly times 4. Variances will be reported to QA and Administrator at least quarterly.	2/27/12

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F 441	Continued From page 87 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to disinfect the multi use glucometer machine between resident use for 4 of 9 residents (R6, R34, R52, R9) observed during blood sugar monitoring observations. Findings include: On 1/3/12, at 5:19 p.m. licensed practical nurse (LPN)-A was observed to complete R6's glucometer test, and return the glucometer machine back into the plastic carrying case. After completion of R6's glucometer test, LPN-A entered R34's room, applied gloves, removed the glucometer machine from the carrying case and performed R34's glucometer test. LPN-A returned the glucometer machine to the carrying case, removed gloves and exited the room. At 5:34 p.m., upon completion of R34's glucometer test, LPN-A entered R52's room, applied gloves, removed the glucometer from the case, and performed the test. LPN-A returned the machine to the case, and removed gloves. At 5:38 p.m. upon completion of R52's glucometer test, LPN-A	F 441	Completion ~~March 15, 2012~~ 02/27/2012	

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F 441	Continued From page 88 went directly to R9's room. LPN-A applied gloves, removed glucometer from case, performed test, returned machine back into carrying case, then exited the room. At 5:43 p.m. LPN-A was observed to wipe the glucometer machine with "Cavi" disinfecting wipes. LPN-A was not observed to wipe the machine in between resident glucometer tests performed. The "Blood Glucose Monitoring" Policy and Procedure dated 10/1/03, indicated all testing will be performed in accordance with standard precautions for handling of blood and body fluids. The policy also directed staff to clean the machine with facility disinfectant wipes between each resident use. At 6:23 p.m. registered nurse (RN)-A verified staff was to disinfect the glucometer machine between each resident use. Additionally, RN-A stated LPN-A did not follow facility policy. At 7:10 p.m. LPN-A verified she had not followed facility policy, and stated "I forgot." On 1/6/12, at 10:10 a.m. the director of nursing (DON) verified staff did not follow facility infection control practices.	F 441		
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be	F 497	497 HRLC Nursing Staff have received training on components identified in the survey. A policy expecting twelve hours of training has been developed.	2/27/12

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F 497	Continued From page 89 sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 nursing assistants (NA-G, NA-H, NA-I, NA-J) received the required 12 hours of annual in-service training. This had the potential to affect all 26 residents in the facility. Findings include: NA-G had been hired by the facility on 6/10/10. A review of the employee training record revealed NA-G lacked the 12 hours of continuing education required annually. During the calendar year of 2011, the employee completed 7 & 1/2 hours of continuing education. NA-H had been hired by the facility on 8/2/07. A review of the employee training record revealed NA-H lacked the 12 hours of continuing education required annually. During the calendar year of 2011, the employee completed 3/4 of an hour of continuing education. NA-I had been hired by the facility on 1/25/05. A review of the employee training record revealed	F 497	Element 3 Nursing staff will receive 12 hours of inservice training each year to ensure their competence. A new program of training is being implemented March 1, 2012 for the training of staff.The training will address annual required training. Additional training will be conducted throughout the year on areas of weakness as determined by performance reviews and special needs of residents. Element 4 The DON will update the employee training log on a monthly basis. Completion Date: ~~April 30, 2012~~ 02/27/2012	

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F 497	Continued From page 90 NA-I lacked the 12 hours of continuing education required annually. During the calendar year of 2011, the employee completed 7 & 3/4 hours of continuing education. NA-J had been hired by the facility on 4/27/10. A review of the employee training record revealed NA-J lacked the 12 hours of continuing education required annually. During the calendar year of 2011, the employee completed 7 & 3/4 hours of continuing education. The facility lacked a formal policy indicating all direct care employees were expected to complete twelve hours of education annually. However, the continuing education tracking log form read "Twelve hours of education required annually." On 1/9/12, at 10:50 a.m. the acting director of nursing stated she had reviewed the log of education for the NAs in December, and had already identified they were not up to date.	F 497		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520	F520 The QA Committee met on 1-24-12 to review the findings of the survey and approve the Quality Council Policy. HRLC maintains a quality assessment and assurance committee consisting of the director of nursing, a physician and 3 other members of the staff. The committee meets quarterly to identify issues with	2/27/12

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F 520	Continued From page 91 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the Quality Assessment and Assurance (QAA) committee developed and implemented appropriate plans of action to correct identified quality deficiencies, related to the lack investigation related to restorative nursing program. This had the potential to affect all 25 residents who resided in the facility. Findings include: On 1/5/12, at 1:45 p.m., registered nurse (RN)-B stated the RNs no longer evaluate the Rehabilitation Nursing program. The RNs review rehab aide (RA)-A's documentation on the resident's rehabilitation plan. RN-B stated that the change happened about a year ago. RN-B stated the RNs read the documentation and document "reviewed" however, the RA-A was responsible for the program. RN-B stated they were told they did not have to do anything else with the resident's rehabilitation plan.	F 520	respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies. The committee will develop and implement appropriate plans of actions to correct identified deficiencies related to the restorative nursing program. The Quality Council Policy has been updated to include identified quality deficiencies and monitoring activities to evaluate the effective of the action items. The Policy was presented at the Quality Council Meeting Jan 24, 2012 and has been approved. The Agenda Format has also been updated to include Survey results and monitoring activities. The Quality Council minutes will be monitored by the QA officer and the Administrator to verify that the current survey quality deficiencies and monitors have been approved by the members and that the ongoing Agenda continues to address the action plans. Date of compliance: March 16, 2012	

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F 520	Continued From page 92 On 1/5/12, at 1:45 p.m. physical therapist (PT)-A stated their department used to assess residents on a quarterly basis until 2009. PT-A stated they now screen residents upon admit, after hospitalization, or as requested by nursing. On 1/5/12, at 2:33 p.m. RN-B stated the only time range of motion (ROM) assessments were done was when they do another therapy screen which would be done if residents had a decline or if they see something happening like a change in positioning in the wheelchair. RN-B stated the nursing assistants tell them if the residents aren't transferring the same, then they put through a screen, then PT does an assessment. On 1/6/12, at 1:06 p.m. RN-A stated physical therapy use to do quarterly assessments of function status of the resident but had stopped doing this. She stated she guessed nursing would have to start doing this and stated they do not document an assessment at this time. At 2:46 p.m. the director of nursing (DON) stated a review of the QA meeting minutes lacked an evaluation the changes in the restorative and range of motion oversight when therapy discontinued quarterly assessments of the resident. In addition, the DON stated no review of the previous survey results were noted when she reviewed the minutes. (ROM concerns identified at the last recertification survey). She added she would have expected this as well as continued follow up of quality concerns until measurable improved outcomes had occurred. Refer to F311 R34 failed to receive planned ambulation	F 520		

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F 520	Continued From page 93 services. Refer to F317 R24 failed to receive necessary care and services to prevent a decline in range of motion related to the development of bilateral hip and knee contractures. Refer to F318 R1 failed to receive planned range of motion treatment and services.	F 520		

Deer River
HealthCare Center
Quality, Compassionate HealthCare for Life

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FEB 14 2012
Minnesota Department of Health
Bemidji

February 14, 2012

All completion dates have been changed to February 27, 2012

TAG 276

Quarterly assessment every three months

Element 1
The plan of care, fall risk assessment, and chart documentation for R16 and R25 have been reviewed and updated to indicate the risk and potential causes of falls and individualized interventions to prevent falls/injury. R24's assessments and plan of care have been updated to include limitations in range of motion, restorative nursing program and other preventative services. (I'm unsure of the response here, particularly for r24)

Element 2
What should I be evaluating?

Element 3
Nursing staff have been educated to thoroughly document resident risks and individualized interventions on comprehensive and quarterly assessments. Nursing staff have been educated on the need to document discussions/decisions made in the team meeting in the chart. The care planning protocol has been updated to reflect flow to care sheets and documentation. Forms for assessment and documentation of falls are being revised to include investigation documentation and interventions.

Element 4
DON/designee will audit quarterly assessments.

Correction Date: February 27, 2012

DEER RIVER HEALTHCARE CENTER SERVICES

Community Memorial Hospital

Comstock Court Apartments

Deer River Ambulance

Deer River Home Care

Friendship Haven Adult Day Services

Homestead Rehabilitation & Living Center

Meridian Medical Clinic

Rehabilitation Services

Silverline Bus Services

"This institution is an equal opportunity provider and employer"

Deer River
HealthCare Center
Quality, Compassionate HealthCare for Life

F 497

HRLC Nursing Staff have received training on components identified in the survey.

A formal policy expecting twelve hours of training has been developed.

Nursing staff will receive 12 hours of inservice training each year to ensure their competence. The training will address annual required training. Additional training will be conducted throughout the year on areas of weakness as determined by performance reviews and special needs of residents. The training program will be implemented on March 1, 2012.

The DON will update the employee training log on a monthly basis x 6months, Quarterly x 2. QA updates quarterly.

Completion Date: February 27, 2012

DEER RIVER
HEALTHCARE
CENTER SERVICES

Community
Memorial Hospital

Comstock Court
Apartments

Deer River Ambulance

Deer River Home Care

Friendship Haven
Adult Day Services

Homestead Rehabilitation
& Living Center

Meridian Medical Clinic

Rehabilitation Services

Silverline Bus Services

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	245428	A. BUILDING **01 - NURSING HOME** B. WING _____	**01/05/2012**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Homestead Rehabilitation and Living Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Homestead Rehabilitation and Living Center is a 1-story building without a basement that is attached to a hospital. The building was constructed in 2 major stages. The original building was constructed in 1973, was determined to be of Type II(111) construction. In 1990 an addition to the north of the building was constructed and was determined to be of a Type II(111) construction. The hospital is separated from the nursing home building with two hour fire barriers and was not inspected at this time. The building is divided into 2 smoke compartments. The building is completely sprinkler protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads. The facility has a fire alarm system with smoke detection throughout the corridor system, in spaces open to the corridors and in all sleeping rooms that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition).	K 000		

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

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

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	245428	A. BUILDING **01 - NURSING HOME** B. WING _____	**01/05/2012**

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K 000	Continued From page 1 Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition) The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings the facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		