DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: ISKC
	PART I -	TO BE COMPL	ETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00355
<ol> <li>MEDICARE/MEDICAID PROVIDE (L1) 245535</li> </ol>	ER NO.	3. NAME AND AD (L3) JOURDAIN			FAC	4. TYPE OF ACTION: 7
(L1) <b>245535</b> 2.STATE VENDOR OR MEDICAID N	JO	(L4) 24856 HOSP			ine	1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) <b>833840000</b>		(L5) REDLAKE,			(L6) <b>56671</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
0. Bill of Sold El	<b>/2014</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	12/31
2 AOA 3 Other		04 5141	00 01 1/31	12 KIIC	10 HOSI ICE	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complian				The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> </ul>
12. Total Facility Beds	<b>47</b> (L18)	1. Ac	cceptable POC		4. 7-Day RN (Rural SN	IF)8. Patient Room Size
13.Total Certified Beds	<b>47</b> (L17)	B. Not in Com	pliance with Prog	gram	5. Life Safety Code	9. Beds/Room
15. Total Continue Deas	<b>4</b> 7 (==+)	Requireme	ents and/or Appli	ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
		. ,	. ,			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Jana Bromenshenkel	, HFE NEII	1	1/25/2014	(L19)	Enforcement	
PAI	RT II - TO BE	COMPLETED B	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	JTY		PLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to P	Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
	( )					
22. ORIGINAL DATE	23. LTC AGREE		. LTC AGREEN	1ENT	26. TERMINATION ACTION:	
OF PARTICIPATION <b>12/30/1991</b>	BEGINNINC	<b>J</b> DATE	ENDING DAT	ΓE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(125)		03-Risk of Involuntary Termination	on OTHER
		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D D	Deter	(L44)			00-Active
	B. Rescind Si	uspension Date:	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	. ,		30. REMARKS	
	2)	00400			Posted 01/02/2015 C	0
	(L28)	00100		(L31)	1 031cu 01/02/2013 C	0.
21 DO DECEIDT OF CMS 1520	22	. DETERMINATION		DATE		
31. RO RECEIPT OF CMS-1539	32	07/15/2014	OF AFFRUVAL			
	(L32)			(L33)	DETERMINATION APPI	ROVAL

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: ISKC PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00355

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On November 20, 2014 a health and FMS PCR was completed and verified correction of deficiencies issued pursuant to a PCR completed on October 17, 2014. Based on our visit, we have determined the facility has corrected the deficiencies pursuant to the October 17, 2014 revisit, effective November 20, 2014.

As a result of the November 20, 2014 PCR and the facility achieving substantial compliance, this Department discontinued the Category 1 remedy of State monitoring, effective November 20, 2014.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letters of July 8, 2014 and November 3, 2014:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 be discontinued effective November 20, 2014. (42 CFR 88.417 (b))

• Per day civil money penalty of \$800.00, effective October 17, 2014, be discontinued, effective November 20, 2014.

• Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014, be rescinded.

Refer to the CMS 2567b for both the health FMS for the results of this visit.

Effective November 22, 2014 the facility is certified for 47 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245535

November 25, 2014

Mr. Gary Hjelmstad, Administrator Jourdain Perpich Extended Care Facility 24856 Hospital Drive Redlake, Minnesota 56671

Dear Mr. Hjelmstad:

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 November 20, 2014 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Weath

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

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 25, 2014

Mr. Gary Hjelmstad, Administrator Jourdain Perpich Extended Care Facility 24856 Hospital Drive Redlake, Minnesota 56671

RE: Project Number S5535025; S5535027

Dear Mr. Hjelmstad:

On October 29, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 2, 2014. (42 CFR 488.422)

On July 8, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

This was based on the deficiencies cited by this Department for a standard completed on May 22, 2014 and a Federal Monitoring Survey (FMS) completed on June 27, 2014 and failure to achieve substantial compliance at the health and FMS Post Certification Revisits (PCRs) completed on August 12, 2014. The most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a health and FMS PCR, completed on August 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2014. Based on our visit, we have determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on August 12, 2014.

Minnesota Department of Health • Compliance Monitoring General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer Jourdain Perpich Extended Care Facility November 25, 2014 Page 2

The October 17, 2014 revisit resulted in an extended survey where substandard quality of care (SQC) was identified. The most serious deficiencies were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), whereby corrections were required. As a result of this visit, the Category 1 remedy of State monitoring remained in effect.

In addition, CMS Region V office notified you of the following actions related to the imposed remedies in their letter of November 3, 2014:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 remains in effect. (42 CFR 488.417 (b))

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 August 22, 2014

Furthermore, CMS Region V office notified you in their letter of November 3, 3014, that the following additional remedies were being imposed:

• Per day civil money penalty of \$800.00, effective October 17, 2014 (and continues to accrue until substantial compliance is achieved). (42 CFR 488.430 through 488.444)

• Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014

As CMS Region V office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

On November 20, 2014 a health and FMS PCR was completed and verified correction of deficiencies issued pursuant to a PCR completed on October 17, 2014. Based on our visit, we have determined the facility has corrected the deficiencies pursuant to the October 17, 2014 revisit, effective November 20, 2014.

As a result of the November 20, 2014 PCR and the facility achieving substantial compiance, this Department discontinued the Category 1 remedy of State monitoring, effective November 20, 2014.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letters of July 8, 2014 and November 3, 2014:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014 be discontinued effective November 20, 2014. (42 CFR 88.417 (b))

• Per day civil money penalty of \$800.00, effective October 17, 2014, be discontinued, effective November 20, 2014.

Jourdain Perpich Extended Care Facility November 25, 2014 Page 3

• Mandatory Termination of your Medicare and Medicaid Provider Agreements, effective November 22, 2014, be rescinded.

The CMS Region V office will notify you of their determination regarding the imposed remedies.

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 related to this eNotice.

Sincerely,

Mark Meeth

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

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

5535r3\_FY14&15\_htlh&FMS

#### **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 245535	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 11/20/2014	
Name of Facility			Street Address, City, State, Zip Code		
JOURDAIN PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE		
			REDLAKE, MN 56671		

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)	ltem	(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction Completed				Correction Completed					Correction Completed
ID Prefix	F0157		11/20/2014	1	D Prefix	F0241	11/20/2014		ID Prefix	F0272		11/20/2014
•	483.10(b)(11)					483.15(a)			-	483.20(b)(1)		_
LSC					LSC				LSC			
ID Prefix	F0276		Correction Completed 11/20/2014		D Prefix	F0279	Correction Completed 11/20/2014		ID Prefix	F0281		Correction Completed 11/20/2014
Reg. #	483.20(c)				Reg. #	483.20(d), 483.20(k)(1)			Reg. #	483.20(k)(3)(i)		
LSC					LSC		•		LSC			_
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 11/20/2014	1		F0309 483.25	Correction Completed 11/20/2014			(00.05(-)		Correction Completed 11/20/2014
ID Prefix Reg. # LSC			Correction Completed 11/20/2014	1		F0356 483.30(e)	Correction Completed 11/20/2014		ID Prefix Reg. # LSC	F0490 483.75		Correction Completed 11/20/2014
ID Prefix Reg. # LSC	F0496 483.75(e)(5)-(7	)	Correction Completed 11/20/2014	1		F0497 483.75(e)(8)	Correction Completed 11/20/2014			F0520 483.75(o)(1)		Correction Completed 11/20/2014
Reviewed By		Reviewed E	-	Date		Signature of Surve	-				Date:	0/0014
State Agency	, 	LB/mm			5/201	1	517					0/2014
Reviewed By CMS RO	·	Reviewed E	Зу	Date	:	Signature of Surve	yor:				Date:	
Followup to	Survey Compl 5/22/	eted on: 2014				-				a Summary of to the Facility?	YES	NO

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245535	<b>(Y2) Multiple Construction</b> A. Building B. Wing	(Y3) Date of Revisit 11/20/2014		
Name of Facility			Street Address, City, State, Zip Code		
JOURDAIN PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE		
			REDLAKE, MN 56671		

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)	ltem	(	Y5)	Date	(Y4	ltem	1	(Y5)	Date
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0157		11/20/2014		ID Prefix	F0279		11/20/2014		ID Prefix	F0282		11/20/2014
•	483.10(b)(11)				-	483.20(d), 483.20(k)(1)				•	483.20(k)(3)(ii)		
LSC				<u> </u>	LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0309		11/20/2014		ID Prefix	F0465		11/20/2014		ID Prefix	F0520		11/20/2014
	483.25					483.70(h)					483.75(o)(1)		
LSC					LSC					LSC			_
			<b>a</b>					<b>a</b> "					<b>a</b>
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #			-		Reg. #					Reg. #			
LSC													
			Correction					Correction					Correction
ID Prefix			Completed					Completed		ID Profix			Completed
Reg. # LSC					Reg. # LSC					Reg. # LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
Reviewed B	y	Reviewed E	Зу	Dat	te:	Signature of Su	urve	yor:				Date:	
State Agenc	у	LB/mr	n	11	/24/20	14		186	17			11/	20/2014
Reviewed B	y	Reviewed E	Зу	Dat	te:	Signature of Su	irve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	eted on:					-				a Summary of		
	6/27/2	2014				Uncorre	ecte	d Deficiencies	(CN	IS-2567) Sent	to the Facility?	YES	NO

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
	-		-		AND TRANSMITTAL	ID: ISKC
1. MEDICARE/MEDICAID PROVID           (L1)         245535           2.STATE VENDOR OR MEDICAID           (L2)         833840000	DER NO.	TO BE COMPL           3. NAME AND AE           (L3) JOURDAIN           (L4) 24856 HOSP           (L5) REDLAKE,	DRESS OF FAC PERPICH EX PITAL DRIVE	CILITY <b>XT CARE</b>	<b>FAC</b> (L6) <b>56671</b>	Facility ID: 00355         4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF (L9)</li> <li>6. DATE OF SURVEY 10/</li> </ol>	F OWNERSHIP 17/2014 (L34)	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD02 SNF/NF/Dual06 PRTF10 NF			<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	ON 47 (L18) 47 (L17)	Complianc 1. Au X B. Not in Com	nce With equirements e Based On: cceptable POC spliance with Prog	gram	2. Technical Personnel     3. 24 Hour RN     4. 7-Day RN (Rural SN     5. Life Safety Code	9. Beds/Room
		Kequiteine	ents and/or Appli	led walvels.		(L12)
14. LTC CERTIFIED BED BREAKD					15. FACILITY MEETS	
18 SNF 18/19 SNI 47 (L37) (L38)	F 19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE).		
See Attached Remarks	(			).		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Jana Bromenshenke	l, HFE NEII	1	1/25/2014	(L19)	Mark Meath, Enfo	prcement Specialist 01/02/2015 (L20)
PA	ART II - TO BE	COMPLETED H	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIB</li> <li><u>X</u> 1. Facility is Eligible to</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	o Participate ble		PLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
	(L21)					
22. ORIGINAL DATE OF PARTICIPATION <b>12/30/1991</b>	23. LTC AGREEN BEGINNINC		LTC AGREEN		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00       01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change
(L27)	-	n of Admissions: uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00400			Posted 01/02/2015 Co	).
	(L28)			(L31)	1 00000 01/02/2013 00	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/15/2014		(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

ID: ISKC

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

# PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00355 C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5535

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 12, 2014. At the time of the PCR an extended survey was conducted and determined conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. We presumed based on your plan of correction, that the facility had corrected these deficiencies as of October 3, 2014. Based on our revisit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant our PCR, completed on August 12, 2014. The deficiencies not corrected pursuant to our PCR conducted October 13, 14, 15, 2014 and the extended survey conducted October 16 and 17, 2014 are as follows:

F0279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

F0309 -- S/S: G -- 483.25 -- Provide Care/services For Highest Well Being

10309 3/3. 0 403	.25 I TOVIGE Care/servi	ces ror righest	wen being
F0314 S/S: H 483	.25(c) Treatment/svcs	To Prevent/heal	Pressure Sores

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

At the time of our PCR and extended survey, the following deficiencies were identified:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)

F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality

F0272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments

F0276 -- S/S: E -- 483.20(c) -- Quarterly Assessment At Least Every 3 Months F0291 = S/S = -482.20(1)/(2)/(2)

F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

F0355 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information

F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Starling Information

F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being F0496 -- S/S: F -- 483.75(e)(5)-(7) -- Nurse Aide Registry Verification, Retraining

F0497 - S/S: F - 483.75(e)(8) -- Nurse Aide Registry Vermeation, Retraining F0497 -- S/S: F -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice

In addition, this Department conducted the revisit related to the FMS. The deficiencies not corrected are as follows:

F0279-Develop Comprehensive Care Plans-483.20(d), 483.20(k)(1)

F0282-Services By Qualified Persons/per Care Plan-483.20(k)(3)(ii)

F0309-Provide Care/services For Highest Well Being-483.25

F0520-Qaa Committee-Members/meet Quarterly/plans-483.75(o)(1)

Furthermore, at the time of the FMS PCR the following deficiencies were identified:

F0157-Notify Of Changes (injury/decline/room, Etc)-483.10(b)(11)

F0465-Safe/functional/sanitary/comfortable Environ-483.70(h)

The most serious deficiencies in the facility during the October 17, 2014 visit were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), 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 July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

The facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014. Furthermore, this Department recommended the following additional enforcement action to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309, effective October 17, 2014 (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F314, effective October 17, 2014 (42 CFR 488.430 through 488.44

Refer to the CMS 2567b, CMS 2567 along with the facility's plan of correction for the results of this visit.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 29, 2014

Mr. William Eckblad, Administrator Jourdain Perpich Extended Care Facility 24856 Hospital Drive Redlake, Minnesota 56671

RE: Project Number S5535025, S5535027

Dear Mr. Eckblad:

On July 8, 2014, CMS Region V Office, informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

In addition, 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 August 22, 2014.

On August 28, 2014, this Department inform you that the following enforcement remedy was being imposed:

• State Monitoring effective September 2, 2014. (42 CFR 488.422)

This was based on deficiencies cited by this Department for a standard survey completed on May 22, 2014, a comparative Federal Monitoring Survey (FMS) completed on June 27, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on August 12, 2014. The most serious deficiencies at the time of the PCR were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 12, 2014. At the time of the PCR an extended survey was conducted and determined conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. We presumed based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2014.

Jourdain Perpich Extended Care Facility October 29, 2014 Page 2

Based on our revisit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant our PCR, completed on August 12, 2014. The deficiencies not corrected pursuant to our PCR conducted October 13, 14, 15, 2014 and the extended survey conducted October 16 and 17, 2014 are as follows:

F0279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0309 -- S/S: G -- 483.25 -- Provide Care/services For Highest Well Being F0314 -- S/S: H -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

At the time of our PCR and extended survey, the following deficiencies were identified:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc) F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality F0272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments F0276 -- S/S: E -- 483.20(c) -- Quarterly Assessment At Least Every 3 Months F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being F0496 -- S/S: F -- 483.75(e)(5)-(7) -- Nurse Aide Registry Verification, Retraining F0497 -- S/S: F -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice

In addition, this Department conducted the revisit related to the FMS. The deficiencies not corrected are as follows:

F0279-Develop Comprehensive Care Plans-483.20(d), 483.20(k)(1) F0282-Services By Qualified Persons/per Care Plan-483.20(k)(3)(ii) F0309-Provide Care/services For Highest Well Being-483.25 F0520-Qaa Committee-Members/meet Quarterly/plans-483.75(o)(1)

Furthermore, at the time of the FMS PCR the following deficiencies were identified:

#### F0157-Notify Of Changes (injury/decline/room, Etc)-483.10(b)(11) F0465-Safe/functional/sanitary/comfortable Environ-483.70(h)

The most serious deficiencies in your facility during the October 17, 2014 visit were found to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), 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.

Jourdain Perpich Extended Care Facility October 29, 2014 Page 3

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 8, 2014:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

As CMS Region V Office notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

Furthermore, this Department is recommending the following additional enforcement action to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F309, effective October 17, 2014 (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F314, effective October 17, 2014 (42 CFR 488.430 through 488.444)

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

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

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

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

<u>Substandard Quality of Care</u> - 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;

<u>Electronic Plan of Correction</u> - 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 3 and 6 months after the survey date; and

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

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

### DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §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. <u>If you have not already provided the</u> <u>following information, you are required to provide to this agency within ten working days of</u> <u>your receipt of this letter the name and address of the attending physician of each resident found</u> <u>to have received substandard quality of care.</u>

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

Jourdain Perpich Extended Care Facility October 29, 2014 Page 5

care. Therefore, Jourdain Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective August 22, 2014. 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: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 allegation of compliance and/or plan of correction.

Jourdain Perpich Extended Care Facility October 29, 2014 Page 7

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.

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2014 (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.

Jourdain Perpich Extended Care Facility October 29, 2014 Page 8

# 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 November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions related to this eNoice

Sincerely,

Mark Weath

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ľ		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	`´CO№	E SURVEY IPLETED
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NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA		RE FAC			856 HOSPITAL DRIVE		
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F 157 SS=D	of this department of 10/15/14, 10/16/14, compliance with Fe during a resurvey e visit substandard qu F314 related to failu pressure ulcer treat sustained harm as An extended survey Minnesota Departm 10/16/14-10/17/14. 483.10(b)(11) NOT (INJURY/DECLINE A facility must immediate consult with the res	FY OF CHANGES /ROOM, ETC) ediately inform the resident; ident's physician; and if	F 15	57			11/18/14
	or an interested fan accident involving ti injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life ti clinical complication significantly (i.e., a existing form of treat consequences, or ti treatment); or a deo the resident from the §483.12(a). The facility must als and, if known, the re or interested family	sident's legal representative nily member when there is an he resident which results in potential for requiring physician ficant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial hreatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in so promptly notify the resident esident's legal representative member when there is a	NATURE		TITLE		(X6) DATE
	ically Signed						11/07/2014

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

PRINTED: 11/13/2014

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
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F 157	change in room or r specified in §483.1 resident rights under regulations as speci- this section. The facility must reac- the address and ph- legal representative This REQUIREMEN- by: Based on observat review, the facility fa- was notified of a ch- wound developmen- sample who had a v- great toe and third to reported to the physi- treatment was prov Findings include: R4's Cumulative Di- 2/12/14, indicated Fd- diabetes, anemia, b- persisting amnesic disease, edema and with medical treatmen- to his health. R4's quarterly Minin 7/4/14, indicated R4 physical and verbal significantly interfer- also indicated R4 h- quarterly MDS shoulders.	<ul> <li>Foommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of</li> <li>cord and periodically update one number of the resident's or interested family member.</li> <li>NT is not met as evidenced ion, interview and document ailed to ensure the physician ange in condition related to t for 1 of 1 resident (R4) in the wound develop on the right oe that was not identified and sician to ensure appropriate</li> </ul>	F 15	<ul> <li>R4 has had family and physician notifications completed to wound or toe.</li> <li>The quarterly MDS that was due on 10/4/14 has been completed and submitted.</li> <li>A policy and procedure for Resident Change of Condition Notifications h been reviewed by the Medical Direct Staff have had training on the policy/procedure for Resident Change of Conditions.</li> <li>The DON or designee will be responder and the policy of the compliance conducted to maintain compliance.</li> <li>Audit results will be reviewed by the Committee and action plans develop needed to maintain compliance.</li> <li>ADDENDUM F157 11/10/14</li> <li>MD will be notified via phone or fax 24 hours of any pressure or non-presented skin condition as stated in the policy for timely notification of change condition. Family will be notified via telephone by the licensed staff withited via the policy for timely notification of change condition.</li> </ul>	t as ctor. ge of nsible d daily onthly x e QA ped as within essure ne ge of	

Facility ID: 00355

If continuation sheet Page 2 of 79

PRINTED: 11/13/2014

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F 157	Continued From pa	ae 2	F ·	157			
	data was not availa	•	•	101	hours and all notifications will be		
		510).			documented in the medical record.	Staff	
		dical record revealed missing			has been educated on 11/13/14 of	this	
	or a lack of docume	entation related to skin issues			policy and procedure.		
	and ulcers.				Daily audits will be completed durin stand-up during the week and the c		
	R4's physician prog	ress notes on 8/14/14,			nurse will review on weekends and		
	indicated R4 had a	new ulcer on the dorsum of			provide oversight for those residen	ts that	
		which was to be treated with			have new or changing pressure or		
	Bactroban and dry	dressings daily.			non-pressure related wounds.		
	not mentioned any wounds. The round dermatitis on bilate	nding note dated 9/22/14, had issues related to open skin ling note identified stasis ral lower extremities with in from stasis dermatitis.					
	the following orders needed for swelling lower extremities tw	ers dated 9/22/14, identified :: Una boot to right leg as I. A&D ointment to bilateral vice a day. Left second toe over with gauze dressing and					
		a day) until resolved. Wash					
	legs daily and apply	/ moisturizing cream BID.					
	the following: -on 9/20/14, license documented R4 ha and one wound on nurse (RN) to asses A&D ointment, gau left plantar toe has (cm) in length and 3 A&D ointment, gau Koban.	s notes and wound n 9/1/14-10/14/14, revealed ed practical nurse (LPN)-C d two new wounds on toes right big toe. The registered ss. Wounds cleansed and ze applied and Koban. R4's a skin tear 3.0 centimeters 3.0 cm in width, area cleansed, ze applied and wrapped with cumentation indicated R4's					
		s changed, however, the note					

If continuation sheet Page 3 of 79

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
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F 157	where it had been. R4's medical record physician was notifi great toe or indicati- related to this wound The wound book do 9/1/14-10/14/14 wa documentation rela on the right foot, no On 10/16/14, at app confirmed R4 had a however, stated he or current ones. On 10/16/14, at 10: (NA)-C stated on th on his right toe and his bath. NA-C state and had started to b stated she had not wound. On 10/16/14, at 11: weeks ago R4's ski RN-C stated she wa new wound on his f during his bath. On 10/16/14, at 11: not have any pressi diabetic foot ulcers. was currently intact stated staff continue	th dressing was changed or d lacked indication the ed of the wound on the right on of a management plan d which had developed.	F	157			

If continuation sheet Page 4 of 79

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
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JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 4	F 1	157			
	(DON) stated she w great toe and third to because R4's medi any feet related skin the physician was n wounds so approprinitiated. The DON expected the licens physician of the wo to the physician was was not provided. On 10/16/14, at app facility provided a p dated 10/16/14, wh	6 p.m. the director of nursing vas not sure when R4's right toe wounds had occurred cal record had not identified in issues. The DON confirmed not notified of R4's right foot iate treatment could be stated she would have ed nurses to notify the unds. A policy for notification s requested from the DON but proximately 2:00 p.m. the icture of R4's right great toe ich revealed an open ulcer the f a pea on the dorsal surface e.					
F 241 SS=D	seated on the edge interviewed. During toe was observed to and the third toe of and bloody. It was r apparent circulation extremity as the leg was no dressing on 3rd toe wound.	3 a.m. R4 was observed of the bed and was the interview R4's right great o have a pea size open ulcer the right foot was macerated noted that there was an o problem with the right lower of was purple in color. There the right great toe or right foot	F 2	241			11/18/14
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.					

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PRINTED: 11/13/2014

		AND HUMAN SERVICES			F	FORM	11/13/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED R	
		245535	B. WING	÷			< 7/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From pa	ige 5	F	241			
	by: Based on observat review, the facility fa dignity was promote the sample who was out for transferring provided assistance Findings include: R4's Cumulative Di 2/12/14, indicated F diabetes, anemia, b persisting amnesic disease, edema an with medical treatm to his health. R4's quarterly Minin 7/4/14, indicated R4 highly impaired visit behavioral symptom with cares. The MD maximum assistant and bed mobility. R4's care plan date planned interventio to use a call light an R4 in summoning s than repeatedly yell On 10/14/14, at 8:4 dressed, seated in	NT is not met as evidenced tion, interview and document ailed to ensure respect and ed for 1 of 1 resident (R4) in is observed repeatedly calling assistance without being e as requested. seases Index Report dated R4's diagnoses included blindness, alcohol induced disorder, chronic kidney d a history of non-compliance ent which presented hazards mum Data Set (MDS) dated 4 had impaired cognition, on and physical and verbal ns that significantly interfered DS also indicated R4 required ce of two staff for transfers ed 10/6/14, revealed no ns related to R4 being unable nd developing a plan to assist staff in another manner rather ling from his bedroom.			R4 has been reassessed for the type device he can utilize to notify staff he needs assistance. The care plan has been updated to re- his current needs. Staff have been re-educated on the importance of meeting the residents needs/requests in a timely manner. A policy/procedure for Call Light Response Time has been reviewed b Medical Director. Staff have been educated on the Res Bill of Rights and the Policy for Call L Response Time. The DON or designee will be response for audits for call light placement and timely response to the residents requidaily x 2 weeks, weekly x 4 weeks an monthly x 2 months. Audit results be reviewed by the QA Committee and action plans developed needed to maintain compliance. ADDENDUM F241 11/10/14 Resident R4 has had his communica and behaviors reassessed by the SW a care plan developed to better meet needs. Staff will be educated on the behavior plan and interventions adde the NAR care sheet on 11/13/14. All other residents that this may affec have their behavior reassessed and monitored by Social Services beginni with those that have difficulty in communication of needs and then the residents with the most challenging	eflect by the sident ight sible lest nd ed as ttion / and this ed to ct will ing	

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If continuation sheet Page 6 of 79

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				3	F	र
		245535			10/17/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 241	throughout two of th 75 feet away. - At 9:37 a.m. conti room. R4 was observed wheelchair. R4 was he wanted and he of to bed. R4 did not he that time this surved assistant (NA)-C th room for assistance bed. NA-C stated, ' -at 9:47 a.m. R4 ha from his room and ob- seated in the whee available. R4 again bed. At that time th that R4 was yelling wanted to go to be someone to help." -at 9:57 a.m. R4 co from his room and to bed. This survey medication aide (TI from his room for o assistance to go ba had asked two othe R4 without success -at 10:05 a.m. TMA bed in which R4 wa quiet. No further ye On 10/14/14, at 10 were working short reason R4 did not r to bed.	could be heard repeating this he nursing units approximately nued to holler out from his erved in his room seated in the s asked by the surveyor what clearly stated he wanted to go have his call light available. At yor reported to nursing hat R4 was yelling from his e because he wanted to go to 'OK I will take care of it." ad continued to repeatedly yell this surveyor again went down served R4 had remained lchair with no call light stated he wanted to go to is surveyor reported to NA-B from his room because he d. NA-B stated, "OK I will find ontinued to repeatedly yell out again stated he wanted to go for reported to trained MA)-A that R4 had been yelling over an hour that he wanted ack to bed and this surveyor er nursing assistants to assist S. A-A and NA-C assisted R4 to as observed to rest and remain	F 24	behaviors. Care plans and NAR of sheets will be updated with interv- to use for challenging behaviors. be completed within the next 30 of 12/10/14. Daily audits on varying shifts will be completed by an assigned nurse observe for any resident with vert calling out issues and results will documented on the audit tool and forwarded to the IDT for review at adjustment to plan of care. Immediate intervention will be implemented be nurse when needed. ADDENDUM 2 F241 Staffing levels are monitored daily ensure there are enough staff avar respond to resident needs. Pleas to F353 for revised staffing plans.	entions All will ays by be o al be diate by the e to ilable to	

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		AND HUMAN SERVICES			FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY PLETED
		245535	B. WING			R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	go to bed." R4 was until 11:46 a.m. who bed. R4 was obser- assisted to bed. Review of the resid dated 5/30/14, rever- would like staff to k them to hear other and make loud sou staff to help these p have to hear that." On 10/15/14, at 1:0 (DON) stated R4 w light to summon for yell from his room t The DON stated the when residents sun call light was less th confirmed that allow yell for assistance f respectful nor digni stated she thought used to R4 repeate because it happene	Iroom "Hey Hey Hey I want to heard to repeatedly yell this en R4 was assisted back to ved to remain quiet after being ent council meeting minutes ealed the following:"Residents now how 'disturbing' it is for residents calling out for help nds. Residents request for beople right away so they don't 4 p.m. the director of nurses as blind and did not use a call assistance, rather R4 would o obtain needed assistance. e goal for providing assistance nmoned for assistance with a han 10 minutes. The DON wing a resident to repeatedly or longer than an hour was not fied treatment. The DON he facility staff had gotten dly yelling for assistance and ed so frequently the staff e loud yelling R4 used to	F 241			
F 272 SS=D	of staff assistance of requested, but not 483.20(b)(1) COMF ASSESSMENTS The facility must co		F 272	2		11/18/14

Facility ID: 00355

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245535	B. WING				२ 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	functional capacity. A facility must make assessment of a re resident assessment by the State. The a least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by to Data Set (MDS); ar Documentation of p	sment of each resident's e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; patterns; being; g and structural problems; and health conditions; hal status; and procedures; ; summary information regarding asment performed on the care the completion of the Minimum	F 2	272			
	by:	and document review the			The facility will conduct initially and		

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	-	AND HUMAN SERVICES			OMB NO.	APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245535	B. WING _		F 10/1	₹ 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, Z		1/2014
	IN PERPICH EXT CA			24856 HOSPITAL DRIVE		
JOOKDA		RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 272	Continued From pa	ae 9	F 27	72		
	<ul> <li>Continued From page 9 <ul> <li>facility failed to complete a comprehensive</li> <li>Minimum Data Set (MDS) within 366 days from</li> <li>the last comprehensive assessment or after</li> <li>admission to the facility as required for 3 of 3</li> <li>residents (R2, R24, R59) who were due for a</li> <li>comprehensive MDS.</li> </ul> </li> <li>Findings include: <ul> <li>R2 had a significant change MDS assessment</li> <li>completed on 10/1/13. R2's comprehensive MDS</li> <li>assessment was due to be completed on 10/2/14</li> <li>and as of 10/15/14, it had not been competed (13</li> <li>days past due).</li> </ul> </li> <li>R24's comprehensive MDS assessment was due 9/20/14, and as 10/15/14, it had not been</li> </ul>			periodically a comprehe standardized reproducib each resident's function Residents R2, R24, and comprehensiveMDS ass completed and submitte All other residents affect have had MDS's schedu and submitted per policy The policy and procedur comprehensive MDS as been reviewed and upda system for scheduling a the MDS process has be The MDS RN has been November 13th on the s completion process per The DON or designee w for auditing of MDS com	le assessment for al capacity. R59 have had a sessment d to CMS. ted by this practice iled, completed y and procedure. re for sessments has ated as needed. A nd maintenance of een implemented. educated on cheduling and CMS guidelines. rill be responsible	
	10/15/14, a compre	to the facility on 6/16/14. As of shensive MDS assessment leted (107 days past due).		schedule weekly for 4 w for 3 months. Audit resu reported to the QA Com plans developed as nee compliance. ADDENDUM F272 11/10 The problem with the MI	ults will be mittee and action ded to ensure 0/14	
	(RN)-B (MDS nurse a current comprehe	07 a.m. registered nurse confirmed R59 did not have ensive MDS completed and d on some of the quarterly and S assessments.		occurred when the previous terminated the previous without a plan in place to forward. The DON will meet with coordinator weekly to re	ous NHA MDS coordinator carry the system the MDS	
	(DON), with the Adr they had been away facility was behind of submission of the M	1 p.m. the director of nursing ministrator present, verified re for over a year that the on the completion and MDS assessments. 7 a.m. a telephone interview		and plan for the week. review all validation repo submissions and match schedule to ensure all re have been completed, s been accepted by CMS. has been created denot	The DON will then orts on all it against the equired MDS's ubmitted and An auditing tool	

Facility ID: 00355

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED R 	
		245535	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 272 F 276 SS=E	The MDS consulta number of MDSs the completing. She st all the MDSs the fa give it to the DON. DON would respon- know." The facility's policy directed staff to co assessment on any of admission, quar of the policy was to initiate a care plan assessment instrue The facility's Electr policy [undated] ind would be complete in accordance with regulations. The facility's MDS Timeframes policy would conduct and in accordance with submission time fra specifically outlined 483.20(c) QUARTH LEAST EVERY 3 M A facility must asse quarterly review inst	h the facility MDS consultant. Int stated she was aware of the he facility was behind on in ated she made a weekly list of acility was behind on and would The consultant stated the hd by stating, "We know, we I [untitled] dated 6/12/14, mplete the comprehensive y new resident with seven days terly and yearly. The purpose o gather resident information, and complete the required ments including the MDS. Fonic Transmission of the MDS dicated all MDS assessments and electronically submitted current federal and state Completion and Submission [undated] indicated the facility I submit resident assessments current federal and state ames. These time frames were d in the policy. ERLY ASSESSMENT AT MONTHS ess a resident using the strument specified by the State CMS not less frequently than	F 27	census and the planned require In addition, at the newly implem IDT/stand-up team meetings, a the 24 hour board is in place fo significant changes and if need MDS will be added to the scheo The Melyx computer software s be utilized to review scheduling planning for the future. Contingency planning for a sec MDS RN will be facilitated by th Presently, an RN nurse consult assisting the facility with MDS coordination and completion.	ented daily review of r any ed this Jule. ystem will and ondary e DON.	11/18/14

Facility ID: 00355

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			STRUCTION	OMB NO. ( (X3) DATE	SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	IG			LETED
		245535	B. WING			R	7/2014
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COI	•	//2014
JOURDA	IN PERPICH EXT CA	RE FAC			OSPITAL DRIVE KE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 276	Continued From pa	ge 11	F 2	76			
		NT is not met as evidenced					
	Based on interview facility failed to com Minimum Data Set of 10 residents (R3 R14, R31, R21, R2 were due for a com Findings include: R38's comprehensi due on 9/10/14, as completed (35 days R22's comprehensi due on 9/16/14, as completed (29 days R46's comprehensi due on 9/16/14, as completed (29 days R46's comprehensi due on 9/27/14, as completed (18 days R42's comprehensi due on 9/29/14, as completed (16 days	ive MDS re-assessment was of 10/15/14, it had not been s past due). ive MDS re-assessment was of 10/15/14, it had not been s past due). ive MDS re-assessment was of 10/15/14, it had not been s past due). ive MDS re-assessment was of 10/15/14, it had not been		usin spec CMS 3 m Resi R14 MDS the p and beer curre The 13th quar The for a wee mon the 0 deve com ADD The occu term with forw The	e facility will assess each i g the quarterly review insi- cified by the state and app S not less frequently that a onths. idents R38, R22, R46, R4 , R31, R21, and R25 had S completed and submitter policy and procedure for s completion of quarterly N in reviewed and revised to ent standards. MDS RN has educated on on the scheduling and con- terly MDS's. DON or designee will be auditing for quarterly MDS kly for 4 weeks and then ths. Audit results will be QA committee and action eloped as needed to ensu- pliance. DENDUM F276 11/10/14 problem with the MDS con- urred when the previous N ininated the previous MDS out a plan in place to carri- rard. DON or designee will me S coordinator weekly to re-	trument broved by at least every 44, R42, R4, a quarterly ed to CMS. scheduling 1DS's has o reflect on November completion of responsible completion monthly for 3 reported to plans ire coordinator y the system eet with the	
	completed (11 days	ive MDS re-assessment was of 10/15/14, it had not been		DON valic mate requisubr	edule and the plan for the N or designee will then rev lation reports on all subm ch it against the schedule uired MDS's have been co mitted and been accepted auditing tool has been cre	view all issions and to ensure all ompleted, by CMS.	

Facility ID: 00355

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		E & MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
							र	
		245535	B. WING _			10/17/2014		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE <b>\$856 HOSPITAL DRIVE</b>	JODE		
JOURDA	IN PERPICH EXT CA	RE FAC			EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 276	Continued From pa	age 12	F 27	76				
		sive MDS re-assessment was	. 21		denoting the entire census and the			
	due on 10/11/14, as of 10/15/14, it had not been				planned required MDS's. In additio			
	completed (4 days	past due).			IDT/stand-up team will review the 2 reports for any significant changes			
	R21's comprehens	ive MDS re-assessment was			needed this MDS will be added to the			
		s of 10/15/14, it had not been			schedule.			
	completed (4 days	past due).			The Melyx computer software syste be utilized to review scheduling and			
	R25's comprehens	ive MDS re-assessment was			planning for the future.	1		
	due on 10/12/14, a	s of 10/15/14, it had not been			Contingency planning for a seconda			
	completed (3 days	past due).			MDS RN will be facilitated by the D			
	On 10/15/14. at 10	:07 a.m. registered nurse			Presently, an RN nurse consultant assisting the facility with MDS	15		
	(RN)-B (MDS nurse	e) confirmed he was behind on			coordination and completion.			
		rly and comprehensive MDS B provided a Standard						
		port which identified the						
	residents whose co MDS were overdue	omprehensive re-assessment e.						
	On 10/17/14, at 3:2	21 p.m. the director of nursing						
	(DON), with the Ad	ministrator present, verified the						
		ware they have been behind on discussion of the MDS						
	assessments for or							
		57 a.m. a telephone interview						
		h the facility MDS consultant.						
		nt stated she was aware of the he facility was behind on in						
	completing. She st	ated she made a weekly list of						
		acility was behind on and would The consultant stated the						
	DON would respon	nd by stating, "We know, we						
	know." The facility's policy	[untitled] dated 6/12/14,						
	directed staff to co	mplete the comprehensive						
		y new resident with seven days						
		terly and yearly. The purpose						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R <b>17/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 4856 HOSPITAL DRIVE	•	
JOURDA	AIN PERPICH EXT CA	RE FAC			EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 276 {F 279} SS=E	of the policy was to initiate a care plan assessment instrum The facility's Electro policy [undated] ind would be completed in accordance with regulations. The facility's MDS ( Timeframes policy) would conduct and in accordance with submission time fra specifically outlined 483.20(d), 483.20(f COMPREHENSIVE A facility must use to to develop, review a comprehensive plan The facility must use to to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	gather resident information, and complete the required nents including the MDS. onic Transmission of the MDS icated all MDS assessments d and electronically submitted current federal and state Completion and Submission [undated] indicated the facility submit resident assessments current federal and state mes. These time frames were in the policy. (1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 2	276			11/18/14

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		& MEDICAID SERVICES			MB NO. 0	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE S COMPL	
		245535	B. WING _		R 10/17/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE (	(X5) COMPLETIO DATE
{F 279}	Continued From pa under §483.10(b)(4	-	{F 279	9}		
	by: Based on observat review, the facility fa plan included appro- monitoring 24 hour (R59, R46, R61) re- the facility failed to which included targ residents (R38) rev medications. Findings include: R59 was on a 1500 prescribed fluid res comprehensive car daily total and moni R59's care plan dat diagnoses as conge in heart function to hypertension (high on buttock and on S chronic kidney dise added. The care pla with nutrition and po approaches identifie and output monitori restriction with delir for 60 ml to be give with each meal. Ho direction for staff to	e plan did not direct staff to for the 24 hour intake. and 6/24/14, identified R59's ested heart failure (decrease pump blood), diabetes, blood pressure), open wound 0/3/14, a new problem area of ase with renal dialysis was an also identified a problem otential for fluid overload. The ed on 9/3/14, included intake ing and a 1500 ml fluid neation of the fluid distribution n with medications and 420 ml wever, the care plan lacked total the fluid intake daily and o do if R59 should exceed the		The facility will use the results of t assessment to develop, review and the resident's comprehensive care include measurable goals and time to meet the resident's medical, nur and mental and psychological nee have been identified in the compre- assessment. Residents R59, R46, and R61 hav their care plans updated to include appropriate interventions for monit 24 hour fluid intake. Resident R38 had their care plan updated to inclu- target behaviors for the use of antipsychotic medications. All other residents affected by this have had their care plans reviewed updated to reflect monitoring of 24 fluid intake and those residents cu having orders for antipsychotic medications will have their care pla updated to reflect target behaviors The professional nursing staff and have been trained on November 1 care plan updating to reflect reside current assessed needs per the comprehensive assessment. The DON or designee will be respo- for auditing 3 care plans per week weeks then 2 monthly for 3 months ensure care plan is current for 24 I fluid monitoring and target behavior Audit results will be reports to the 0	d revise plan to etables sing ds that hensive e had oring of has ude practice d and hour rrently an the IDT 3th on ent's onsible for 4 s to nour ors. QA	

Facility ID: 00355

		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING	i			R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 279}	Continued From pa	ige 15	{F 2	{F 279}			
	9/12/14, indicated F hour fluid restriction monitor intake and On 10/16/14, at 10: her expectations we the individual care p were needed the ca reassessed and up resident. R46 was on a prese (cc) daily fluid restri	35 a.m. the DON confirmed ere that the staff would follow plan for R59 and as changes are plan should be dated to meet the needs of the cribed 1500 cubic centimeter iction and the facility had not			needed to ensure compliance.		
	addressed monitori R46's Admission Fa diagnosed with end secondary to chron	n interventions which ing of R46's daily fluid intake. ace Sheet indicated R46 was I stage renal disease (ESRD) ic kidney disease, type II ntercerebral hemorrhage and sease.					
	a 1500 cc fluid restr allowed with each n pass, was to have r and fluid with meals restrictions allowed R46's physician ord physician ordered a	t revised on 9/23/14, indicated riction with 420 cc fluid neal, 80 cc with each med no water pitcher at bedside s and evening as fluid ders revealed on 12/18/13, the a 1500 cc per day fluid pronic kidney disease and					
	need for hemodialy						

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION		<u>0938-0391</u> E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					IPLETED
						ŗ	R
		245535	B. WING			10/	17/2014
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE		
				ŀ	REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 279}	Continued From pa	-	{F 27	79}	•		
	from 10/3-10/13, re	dministration Records (TAR) vealed daily total fluid intake and monitored consistently.					
	The revealed R46's been calculated on	total daily fluid intake had not 10/3, 10/4, 10/5, 10/6, 10/7,					
	date of correction o	/12/14, (8 of 10 days since the n 10/3/14.) On 10/14/14, oted to have been 1620 cc					
	(120 cc over the flu	id restriction). There was no					
	excess fluid intake						
		30 a.m. the DON confirmed not identify how the daily total ng to be monitored.					
		cribed 1500 cc fluid restriction of monitor or calculate total					
		ace Sheet indicated R61 was stage renal disease (ESRD).					
	physician ordered a	lers revealed on 8/5/14, the a 1500 cc per day fluid pronic kidney disease and sis.					
	fluid intake had not monitored consister	/13/14, revealed that daily total been calculated and ntly. R61's total daily fluid ulated on 10/3, 10/4, 10/5,					

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PRINTED: 11/13/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES						PRINTED: 11/13/2014 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245535	B. WING		R 10/17/2014		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
JOURDAIN PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671				
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	LD BE COMPLETION		
{F 279}	<ul> <li>279} Continued From page 17 10/6, 10/7, 10/8, 10/9, 10/10,10/11, and 10/13/14, (10 of 10 days since the date of correction on 10/3/14.)</li> <li>R61's care plan dated 8/19/14, revealed R61 was on a 1500 cc fluid restriction. However, the care plan had not delineated how much fluid each discipline would provide R61 (i.e dietary, nursing, activities) nor who would be responsible for monitoring the 24 hour total fluid intake.</li> <li>On 10/15/14 at 12:53 p.m. the DON the care plan had not delineated how much fluid each discipline would provide nor who would be responsible for monitoring the 24 hour total fluid intake.</li> <li>The Intake, Measuring and Recording policy [undated], specified as its purpose to accurately determine the amount of liquid a resident consumed in a 24 hour period.</li> </ul>		{F 279}				
		Plan policy [undated] Plan would be developed to daily care needs.					
		e behaviors and the facility care plan to include jet behaviors.					
	was diagnosed with	dated 2/2/14, identified R38 a an intracranial injury, ry and a subarachnoid					
	1						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 279}	R38's nurse notes f revealed R38 had b banging his head of swearing at the stat throwing objects in voiding in inappropri- revealed R38 had p changes 9/14 and w professional. R38's care plan dat moved self from his laid next to his bed checks. The care p crawl out into the has The head board of an injury hazard du The care plan direct behaviors and inter- target behaviors we On 10/15/14, at 10: a low bed anxiously the side rails and sl On 10/15/14, at 1:5 bed restlessly movi R38's head board w wallpaper and deep plaster. On 10/16/14, at 8:3 bed watching TV. W communicate with F	the dining room, disrobing and riate places. The notes also by the dining room, disrobing and riate places. The notes also by chotropic medication was followed by a psych red 12/20/14, indicated R38 s bed onto the mattress that and required hourly safety lan also indicated R38 would allway and call out for help. the bed was removed due to e to R38 kicking and hitting. ted staff to document ventions as they occur. No	{F 2	79}			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	(X2) MUL	TIP	LE CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	. ,		i		PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
(E 270)	O antinua d Easterna		( <b>F</b> o-	-01			
{F 279}	Continued From pa	on the floor next to his bed,	{F 27	79}			
		and put it back up onto his					
		6 a.m. R38 was observed in nent product / underwear on.					
	R38's penis was ex	posed and he was openly					
		nd periodically saying "f, f, 38's room was open and R38					
		no passed by his room.					
	(RN)-C confirmed F injury. When asked R38 displayed RN-0 stating " f, f, f" RN-0 physically abusive to scratch at the walls	20 a.m. registered nurse R38 had a traumatic brain what inappropriate behavior C stated he would swear C stated R38 was not but would pull at his bed and and also would remove his and throw it about his room.					
	had behaviors whic throwing objects an without appropriate confirmed R38's tar	05 a.m. the DON verified R38 h consisted of hitting, biting, id scooting self out in the hall clothing on. The DON rget behaviors were not are plan and they should have					
	Review policy dated comprehensive car tool, changing with	e Care Plan Development & d 9/2/14, indicated the e plan should be a dynamic changes in the resident's nanges should be documented ne medical record.					

Facility ID: 00355

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PRINTED: 11/13/2014

		AND HUMAN SERVICES			FC	DRM	11/13/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3)		E SURVEY PLETED
		245535	B. WING	i		-	< 17/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 281	Continued From pa	-		281			
F 281 SS=D	483.20(k)(3)(i) SER PROFESSIONAL S	VICES PROVIDED MEET STANDARDS	F 2	281			11/18/14
		led or arranged by the facility onal standards of quality.					
	by: Based on observat review, the facility f admission/ initial ca pressure ulcers and chest dialysis cathe admitted residents. Findings include: R62's 24 Hour-Vita was admitted to the Discharge Summar R62's diagnoses in diabetes, chronic ki treatments via a po appliance that is ins which a catheter co R62's Admission/R undated and blank. The undated nursin lacked identification	I Sign Record indicated R62 e facility on 10/2/14. R62's by dated 10/2/14, indicated included two pressure ulcers, idney disease with dialysis rtacath (a small medical stalled beneath the skin in onnects the port to a vein). eadmission Care Plan was			The facility will provide services that m professional standards of quality. Resident R62 has had a comprehensive care plan developed following the comprehensive assessments and the MDS completion to include pressure ulcers and their care and treatment and identification and care of the right chest dialysis catheter. All other newly admitted residents have had a temporary care plan developed based on observation, interview and document review to direct care and treatment until the comprehensive assessment process is completed and the comprehensive care plan is develop per the RAI process. The policy and procedure for temporar care plan upon admission has been reviewed and revised as needed to me the current standards of quality. Professional nursing staff have been educated on November 13th on development of a temporary care plan upon admission that will direct quality of	ve d st ped y eet	
	indicated R62 receiportacath and a wo completed every ot	lication Administration Record ved dialysis via a right chest und treatment order to be her day. 9 a.m. R62 stated she had			for each individual resident. the DON or designee will audit all new admission temporary care plans weekl for 2 months and monthly for 3 months Audit results will be reported to the QA	у 5.	

Facility ID: 00355

TATEMEN	F OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		045505				R
		245535			10/	17/2014
	PROVIDER OR SUPPLIER	RE FAC	2	STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 281	(RN)-C was observent reatment. An appropriate the servent reatment. An appropriate the servent reatment. An appropriate the servent reatment. An appropriate servent reatment. An appropriate servent reatment of the servent	<ul> <li>5 a.m. registered nurse red to provide R62's wound oximate quarter size stage two kin loss involving epidermis, d an approximate dime size s observed on the right lower,</li> <li>03 p.m. trained medication d she was unaware of a formal r care plan.</li> <li>07 p.m. licensed practical nurse initial care plan was not nor did the NA cheat sheet th or pressure wounds.</li> <li>9 p.m. RN-B stated an are plan was to be developed ent was admitted to the facility. had a portacath and pressure would expect to see both the are of the portacath along with on the initial care plan. RN-B not have an initial care plan ed it was not completed.</li> <li>10 p.m. R62 was observed A portacath was observed on The dialysis RN stated the ed R62's portacath dressing, e nursing home. proximately 12:00 p.m. the stated the facility did not have dure related admission</li> </ul>	F 281	Committee and action plans dev needed to ensure compliance. ADDENDUM F281 11/10/14 The facility is currently not taking admissions to the facility. Once admissions begin again, the tem care plan will be audited within 4 of admission by the DON or des ensure compliance. Staff will be re-educated/coached/disciplined needed as audit results dictate.	the porary 8 hours ignee to	11/18/14

		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED <b>R</b>
		245535	B. WING				、 17/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			356 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From pa	ige 22	{F 28	32}			
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	by: Based on observat review, the facility f plan related to wou measurement for 2 had a pressure ulca Findings include: R59 had a stage 4 thickness loss of tis tendon or muscle) v and was not monito to her care plan. R59's care plan dat diagnoses as cong in heart function to wound on buttock a area of chronic kidr was added. R59's of impaired skin integ coccyx wound to de the next 90 days. R photograph and me two weeks and doc On 10/14/14, at 11: request, the directo and confirmed R59	pressure ulcer (ulcer with full ssue with exposed bone, which had increased in size ored and measured according ted 6/24/14, identified R59's ested heart failure (decrease pump blood), diabetes, open and on 9/3/14, a new problem ney disease with renal dialysis care plan also identified rity with a goal for R59's ecrease in size by 1.0 cm in 259's care plan directed staff to easure the coccyx wound every sument this information.			The services provided or arranged facility will be provided by qualified persons in accordance with each residents written plan of care. Resident R59 and R42 have had the care plans reviewed and updated w current status of pressure ulcers an care and treatment. Nursing assists assignment sheets have been upda needed to reflect current care needs All other residents with current pres areas have had their care plans rev and updated as needed and nursing assistant assignment sheets update reflect current care needs. The policy and procedure for following plan of care has been reviewed and updated as needed. Professional nursing staff and nursing assistants have been educated on November 13th on the policy and procedure for follow through on the of care ant treatment of pressure ull The DON or designee is responsible auditing that care plans are being for related to pressure ulcer care and treatment per policy and procedure. Through direct observation audits w completed on 5 residents with press ulcers to observe that the care plan	eir ith id their ant ated as s. sure iewed g ed to ing the f ng plan cers. e for blowed	

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		6		PLETED
		045505				२
	PROVIDER OR SUPPLIER	245535		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	17/2014
				24856 HOSPITAL DRIVE		
JOURDA	IN PERPICH EXT CA	RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 282}	length, 5.0 cm in w 0.5 cm of undermin the surface on the o'clock through 1 o wound had a mode (drainage) and slou stated the wounds by facility staff. The Photographic V dated 8/13/14, iden wound which meas in width and a dept of 1.5 cm at 12 o'cl 0.9 cm at 9 o'clock assessment, meas wound was last con ago). R59's nursing note until 10/15/14, lack of the assessment, of the coccyx woun - on 9/3/14, NN ind measured and dete 5.4 cm in width, an -on 9/11/14, NN ind dressing was chan to have some light On 10/14/14, at 1:3 she didn't know wh documentation with measurement and between 8/13/14, w	idth and 1.5 cm in depth with hing (separation of tissue from edge of a wound) at the eleven 'clock area of the wound. The erate amount of exudate ugh (dead tissue). The DON were to be measured weekly Wound Documentation Form htified R59 as having a stage 4 sured 4.1 cm in length, 3.4 cm h of 1.5 cm. with undermining lock, 1.2 cm at 3 o'clock and . The DON confirmed an surements and photo of R59's mpleted on 8/13/14 (63 days s (NN) reviewed from 8/13/14, ed consistent documentation , measurement and monitoring nd. licated the wound was ermined to be 5.6 cm length,	{F 282		nonths. he QA reloped as will be s for one provided al focus d en be as irected by	

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CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED //B NO. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CO         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245535 B. WING		R 10/17/2014
NAME OF PROVIDER OR SUPPLIER STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
I JOURDAIN PERPICH EXT CARE FAC	56 HOSPITAL DRIVE DLAKE, MN 56671	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
{F 282}       Continued From page 24 measurement which had been done that day.       {F 282}         On 10/16/14, at 10:35 a.m. DON confirmed her expectations were that the staff would follow the individual plan of care for R59.       R42 had a stage 4 pressure ulcer and staff failed to consistently assess, monitor and implement interventions to assist with pressure ulcer healing as directed by the care plan.         R42's Admission Face Sheet dated 5/28/14, identified R42's diagnoses included a stage 4 coccyx pressure ulcer, type II diabetes mellitus, sepsis and chronic anemia.         R42's care plan dated 7/3/14, identified R42 had an alteration in skin integrity related to a coccyx ulcer and vulnerable area on right ankle. Interventions included the following: medication and treatments as ordered to coccyx and right ankle. Monitor for signs and symptoms of infection. Weekly skin checks, wound clinic as ordered. Photo documentation and measurements at least every 2 weeks. Air mattress on bed and pressure relief cushion on wheelchair. PRAFO (specialized splint devices for the lower extremities) bilaterally. The care plan did not address R42's repositioning plan.         R42's wound clinic documentation dated 9/26/14, indicated R42's wound healing was complicated by diabetes, pressure, and stool incontinence with associated skin maceration. The wound on the sacrum measured 4.0 cm x 1.3 cm x 0.6 cm with circumferential undermining. There is a 1.7 cm	DEFICIENCY	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 11/13/2014 APPROVED 0. 0938-0391
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245535	B. WING				R / <b>17/2014</b>
NAME	OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOUF	RDAIN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4)   PREF TAG	IX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 28	documentation ider Hydrofera blue for t bioburden. Heavy S sacrum and intergle Continue pressure bottom. General su patient is interested this visit on 9/26/14 Roho cushion [a sp optimizes weight re soon as possible]." A comprehensive p R42 was requested facility. Registered responsible for the was interviewed on that he was not sur comprehensive pre RN-B provided a C summary complete R42 was at mild ris stage 4 ulcer to cod ordered and a licen skin assessment at assistants were to a report concerns to The Photographic N dated 8/13/14, indid 4 pressure ulcer wh cm x 1.1 cm. The p the wound bed, wo tissue / skin was no monitoring, assess facility could be fou since 8/13/14.	httified the following plan: the next month to help with SensiCare application to uteal cleft for skin barrier. alleviation efforts to her urgery consult for colostomy if d. The written clinic referral for l, identified "Patient needs becialized cushion that edistribution] ordered ASAP [as pressure ulcer assessment for d, but was not provided by the Nurse (RN)-B who was comprehensive assessments in 10/15/14, at 2:55 p.m. stated re that R42 had a essure ulcer assessment. are Area Assessment ad on 1/6/14, which identified sk for skin breakdown, had a ccyx with dressing changes as insed nurse was to do a weekly fter baths and nursing monitor skin with cares and	{F 2	82}			

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		AND HUMAN SERVICES			FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245535	B. WING	 		R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	AIN PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282} {F 309} SS=G	her room, seated in have a pressure req underneath the but R42 was interviewe how long she sat up and how long it had cushion to sit on wh R42 stated she sat times a day for ove not had a cushion in time." On 10/14/14, at 11: R42's care plan sho measurements and including the press have been impleme also confirmed the facility staff regardin assessment and m on 8/13/14, (63 day The Using the Care indicated the care p meet the resident's documentation mus residents' plan of ca 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	a wheelchair. R42 did not distribution cushion tocks to minimize pressure. ed at this time and was asked p in the wheelchair every day d been since she had a hile seated in the wheelchair. t up in the wheelchair 3-4 r an hour each time and had n her wheelchair "for a long 15 a.m. the DON confirmed ould have been followed and d pressure ulcer interventions ure reducing cushion should ented as directed. The DON last documentation from ng R42's pressure ulcer easurements was completed /s ago). e Plan policy [undated] blan would be developed to daily care needs and that st be consistent with the are. CARE/SERVICES FOR	{F 2:			11/18/14

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CENTERS FOR MEDICARE & MEDICALD SERVICES         OMB NO. 0938-0391           AND PLAN OF CORRECTION         (X1) PROVIDERS SUPPLIER: LAURANCE OF PROVIDER OR SUPPLIER: LESS 5         (X2) MULTIPLE CONSTRUCTION         (X3) DATE SUPPLIER: LESS 5         R           JOURDAIN PERPICH EXT CARE FAC         24535         STREET ADDRESS, CITY, STATE, ZIP CODE         R         10/17/2014           (K4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER SPLAN OF CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC DENTIFYING INFORMATION)         ID         PREFIX         RECULATORY OR LSC DENTIFYING INFORMATION)         ID         Const.         Cons.         Const.         Const.		-	AND HUMAN SERVICES			FORM	APPROVED
245535         B. WING         R         10/17/2014           NAME OF PROVIDER OR SUPPLER         STREET ADDRESS, CITY, STATE, ZIP CODE         2455 HOSPITAL DRIVE REDLAKE, MN 56671           JOURDAIN PERPICH EXT CARE FAC         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDLAKE, MN 56671         PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDLAKE, MN 56671         0           (F 309)         Continued From page 27         (F 309)         (F 309)         (F 309)         Continued From page 27         (F 309)           This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a non pressure related wound was appropriately assessed, monitored our treated for 1 01 seident (R62) dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site.         Resident R61 will have daily I&O monitored per policy and the care plan has been updated to include monitoring and emergency care for the access site.           R4 had identified wounds on the right great to and 3rd toe that had not been appropriately assessed, monitored and treated.         Resident R62 has had the dialysis acceess catheter monitoring of thuid intake.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		(X3) DATE	SURVEY
245535         B. WING         10/17/2014           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STREET, 2/P CODE         24566 HOSPTAL DRIVE         REDLAKE, IM S6671           JOURDAIN PERPICH EXT CARE FAC         SUMMARY STATEMENT OF DEFICIENCIES (FACO DEFICIENCY MART STATEMENT OF DEFICIENCIES)         PRETX (FACO CORRECTIVE ACTION SHOLLD BE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REDLAKE, IM S6671         COMMETON (FACO CORRECTIVE ACTION SHOLLD BE (EACH DEFICIENCY)         COMMETON (FACO CORRECTIVE ACTION SHOLLD BE (FACO CORRECTIVE)         COMMETON (FACO CORRECTIVE)	AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CUTY, STATE, ZIP CODE           JOURDAIN PERPICH EXT CARE FAC         2456 HOSPITAL DRIVE REDLAKER, MN 56671           (P4) D PEERX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDE BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDER STAL DRIVE REDLAKER, MN 56671           (F 309)         Continued From page 27         (F 309)           This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a non pressure related wound was appropriately assessed, monitored or treated for 1 of 3 residents (R4) in the sample reviewed for non pressure related skin issues. This deficient practice caused actual harm for R4. In addition, the facility failed to consistently monitor daily full intake for 3 of 3 residents (R46, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R20) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site.         R4 had identified wounds on the right great toe and 3rd toe that had not been appropriately assessed, monitored and include?         Resident R62 has had the dialysis access catheter monitoring of fluid intake.           R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, non-compliance with medical treatment, blindness, alcohol induced persisting annesic disorder, chronic kidney disease, edema and a personal history of non-compliance with medical treatment with presented hazards to         Relocy and procedure for wound care			245535	B. WING _			
JOURDAIN PERFICH EXT CARE FAC         REDLAKE, MN 56671           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PROVIDENS PLAN OF CORRECTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (%)           (F 309)         Continued From page 27         (F 309)         (F 309)         Each resident will receive the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan.           residents (R4, 6, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R2) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site.         Resident R4 has been reassessed for skin risk and all wounds have been completed and the treatment plan have been completed and R61 will have daily (80 monitored and treated.           R4's Cumulative Diseases Index Report dated 2/12/14, indicated R4's diagnoses included diabetes, anemia, non-compliance with medical treatment wich presentising amnesic disorder, chronic kidney disease, edema and a personal history of non-compliance with medical treatment wich presented hazards to         Reident R61 will have daily (80 monitored per policy and the care plan has been updated to include monitoring and emergency care for the access site.	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHURKE, IM 986/1         CRUCKARE, IM 986/1           PRETX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           (F 309)         This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a non pressure related wound was appropriately assessed, monitored or treated for 1 of 3 residents (R4) in the sample reviewed for non pressure related skin issues. This deficient practice caused actual harm for R4. In addition, the facility failed to consistently monitor daily fluid intake for 3 of 3 residents (R46, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R4 has been reassessed for skin risk and all wounds have been care planned per the assessment. Weekly wound measurement plan have been completed and the treatment and care plan have been adjusted as directed by the access site.           Findings include:         R4 had identified wounds on the right great to and 3rd toe that had not been appropriately assessed, monitored and treated.         Resident R46, R59 and R61 will have daily 180 monitored per policy and procedure. Care plans have been updated to reflect monitoring of fluid intake.           R4 had identified wounds on the right great to and 3rd t					24856 HOSPITAL DRIVE		
PREFIX TAG         IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         Continued From page 27         Cash Construction Should be CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         Continued From page 27         CF 309}           (F 309)         Continued From page 27         (F 309)         (F 309)         Each resident will receive the necessary care and services to attain the highest practicable physical, mental and psychosocial, well-being, in accordance with the comprehensive assessed for skin issues. This deficient practice caused actual harm for R4. In addition, the facility failed to consistently monitor daily fluid intake for 3 of 3 residents (R46, R61, R59) who had chronic kidney disease, received dialysis and were on a prescribed fluid restriction; and failed to monitor 1 of 1 resident (R62) dialysis access catheter site nor develop a care plan to include interventions related to the monitoring and emergency care of the access site.         Weekly wound measurements have been completed and the treatment plan have been assessed and treatment plan have been completed and the treatment and care plan have been adjusted as directed by the physician.           R4 had identified wounds on the right great to and 3rd to te that had not been appropriately assessed, monitored and treated.         R4's Cumulative Diseases Index Reptor tated 2/12/14, indicated R4's diagnoses included diabetes, anemia, non-compliance with medical treatment, bindness, alcohol induced peristing amesic disorder, chronic kidney disease, edema and a personal history of non-compliance with medical treatment which presented hazards to         All other residents that may be affected by the splore and procedure for wound care	JUURDA				REDLAKE, MN 56671		
PREFIX TAG         CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED         COMMENTION DATE           (F 309)         Continued From page 27         (F 309)         (F 309)         (F 309)         (F 309)         (F 309)         Each resident will receive the necessary care and services to attain the highest practicable physical, mental and psychosocial, fish and alter atment plan have been completed and treatment and care plan have been agrees site.         Neekly wound measurements have been completed and the treatment and care plan have been adjusted as directed by the physical, metal to the monitored per policy and the care plan have been updated to include diabetes, anemia, non-compliance with medical treatment which presented hazards to         Neekly wound measurements have been caccess site.	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
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and a personal history of non-compliance with medical treatment which presented hazards tostatus.The policy and procedure for wound care							
medical treatment which presented hazards to The policy and procedure for wound care					•	rent	
						d care	
health. and monitoring will be reviewed and							
R4's quarterly Minimum Data Set (MDS) dated updated to include weekly measurements,			num Data Set (MDS) dated				
7/4/14, indicated R4 had impaired cognition with and the process of updating of care plan.		7/4/14, indicated R4	4 had impaired cognition with		and the process of updating of care		
physical and verbal behaviors that significantly The policy and procedure for I&O							
interfered with the resident's care. The MDS also monitoring for residents on fluid restriction							
indicated R4 had diabetic foot ulcers. (A quarterly MDS should have been completed by 10/4/14, has been reviewed and revised as needed to include updating of care plans when							

Facility ID: 00355

If continuation sheet Page 28 of 79

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				. 0938-039
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	( )	E SURVEY IPLETED
			A. BUILDI	IG		R
		245535	B WING			
		245355	D. WING _			17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRI REDLAKE, MN 560		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
{F 309}	Continued From pa	age 28	{F 30	9}		
. ,		been completed and the data	(. 00	indicated.		
	was not available).				procedure for monitoring	
	,	gress notes dated 8/14/14,			ess sites has been reviewed	
		new ulcer on the dorsum of			needed to include updating	
	the left second toe	to be treated with Bactroban		of care plans.		
	and dry dressings of				I nursing staff have been	
		ling note dated 9/22/14, did not			e policies and procedures	
		s related to open skin wounds.			ring, wound monitoring and	
		indicated R4 had stasis			heter site care and	
		ral lower extremities with			November 13, 2014. This	
		in from the stasis dermatitis.			lating of care plans as	
		vsician orders dated 9/22/14, ving: Una boot to right leg as			anges in condition. signee will be responsible	
		g. A&D ointment to bilateral			esidents with one or more	
		vice a day. Left second toe			sues weekly of 2 months	
		over with gauze dressing,			or 3 months. Results will	
		a day) until resolved. Wash			the QA Committee and	
		isturizing cream BID.			lans developed as needed	
		s notes and wound		to ensure comp		
	documentation from	n 9/1/14-10/14/14, revealed		ADDENDUM F	309 11/10/14	
	the following:			MD's have bee	n contacted to obtain	
		ed practical nurse (LPN)-C			striction orders. Care	
		d two new wounds on toes			en updated and restrictions	
	and one wound on			added to NAR		
		cated the registered nurse			intake and output	
		s. Wounds cleansed and A&D			for all four residents	
		pplied and Koban. The note plantar toe had a skin tear 3.0			alysis, R46, R59, R61, and iducted by licensed nurses	
		length and 3.0 cm in width,			is to ensure fluid restriction	
		D ointment, gauze applied and			and totaled each day.	
	wrapped with Koba	<b>3</b>			ent to the DON daily for	
		cumentation indicated R4's			up and staff intervention	
		as changed, however, the note			rvation and record review.	
	did not identify which	ch dressing was changed.		At least two obs	servational audits will be	
		er documentation related to			censed nurses daily on	
		und in R4's progress notes nor			or one month to observe	
		ssessment of the wounds			provided per the plan of	
	found in the medica				cial focus on pressure	
	9/20/14-10/14/14. H	R4's medical record also		ucer prevention	n and treatment. Audit	

Facility ID: 00355

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				IPLE CONSTRUCTION	OMB NO. 0	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	(X3) DATE S COMPL	
			A. BOILDI		R	
		245535	B. WING _			/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETIO DATE
{F 309}	lacked indication the of the wound on the indication that a may wound had develop Review R4's Treatr (TAR) was reviewed TAR notes revealed perform a weekly s to provide diabetic documentation to ir completed at all du 2014. The wound book do 9/1/14-10/14/14, wa documentation rela wound on any toes implemented. On 10/13/14, at 3:0 responsible for the a foot ulcer on the I could not identify w the wound. At 3:04 mistaken, that R4 c either foot and state currently healed, th monitor R4's right g on the toe opened notified. LPN-B the any open foot wour asked if an observa R4 became upset a LPN-B to leave his honored. On 10/16/14, at app	e physician had been notified e right great toe, or any anagement plan related to the bed. nent Administration Record d from 10/1/14-10/14/14. The d the nurse was directed to kin integrity assessment and nail care. There was no hdicate this task had been ring the month of October ocumentation from as reviewed and there was no ited to R4 having an open , nor any treatment 22 p.m. LPN-B who was care of R4, stated R4 still had left foot second toe, however, hat treatment was provided for p.m. LPN-B stated she was did not have any wounds on ed all of R4's wounds were at nursing staff continued to great toe, and that if the area up the physician would be n again stated R4 did not have nds. At 3:06 p.m. R4 was ation of his feet could be made. and yelled for the surveyor and room. R4's request was	{F 30		stated above d by the QA revised cols. its and	
	confirmed R4 had a however, stated he any new or current On 10/16/14, at 10:	a history of foot wounds, was unsure whether R4 had				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	off during his bath. appeared red and h bit." NA-C stated si regarding the woun On 10/16/14, at 11:: two weeks ago R4's sores. RN-C stated had a new wound of fallen off during his On 10/16/14, at 1:4 (DON) stated she w great toe and third to because R4's medi foot related skin iss physician was not n wounds so approprinitiated. The DON expected the licens physician of the wo On 10/16/14, at app facility provided a p dated 10/16/14, wh approximate size of of the right great too On 10/17/14, at 9:3 seated on the edge interviewed. During toe was observed to and the third toe of and bloody. In addit was observed to be no dressing on the toe wound. DIALYSIS: R46 was on a preso	and that the scab had fallen NA-C stated the wound ad started to bleed "a little he had not notified a nurse d. 03 a.m. RN-C stated that as of s skin was intact and free from she was totally unaware R4 n his foot or that any scab had bath. 6 p.m. the director of nursing vas not sure when R4's right oe wounds had occurred cal record did not identify any ues. The DON confirmed the otified of R4's right foot tate treatment could be stated she would have ed nurses to notify the unds. proximately 2:00 p.m. the icture of R4's right great toe ich revealed an open ulcer the a pea on the dorsal surface e. 3 a.m. R4 was observed	{F 3(	9}			
		ace Sheet indicated R46's					

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING _				R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	diagnoses included (ESRD) secondary type II diabetes met hemorrhage and ce R46's physician ordered a restriction due to ch need for hemodialy R46's care plan las R46's was on a 150 to have 420 cc fluid each med pass, no fluids with meals ar allowed. R46's TAR from 10, daily total fluid intak monitored consister intake was not calc 10/6, 10/7, 10/8, 10 10/14/14, R4's fluid over the fluid restrict that action was take intake on 10/14/14. On 10/15/14, at 10: R46's total fluid intak monitored consister intake on 10/14/14.	d end stage renal disease to chronic kidney disease, llitus, intercerebral erebrovascular disease. ders indicated on 12/18/13, the a 1500 cc per day fluid nronic kidney disease and vis. at revised on 9/23/14, indicated 00 cc fluid restriction and was d with each meal, 80 cc with o water pitcher at bedside and nd evening as fluid restrictions //3-10/13/14, revealed that ke was not calculated and ntly. R46's total daily fluid vulated on 10/3, 10/4, 10/5, 0/11, and 10/12/14. On l intake was 1620 cc (120 cc ction). There was no evidence en related to the excess fluid constructions and totaled and ntly. cribed 1500 cc fluid restriction sistently totaled and monitored heation of fluid provided by ad not been developed. ace Sheet indicated R61 was	{F 30	09}			

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 309}	R61's physician or order for a 1500 cc chronic kidney dise hemodialysis. R61's care plan dat a 1500 cc daily fluid plan had not deline discipline would pro- nursing, activities) a for monitoring the 2 R61's TAR records that daily total fluid and monitored cons- intake had not beer 10/5, 10/6, 10/7, 10 10/13/14. On 10/15/14, at 12: R61's daily total fluid been completed an delineated how mu- provide or who wou monitoring the 24 h R59 was on a prese hour fluid restrictior not consistently tota R59's care plan dat diagnoses included (decrease in heart f diabetes, hypertens- open wound on but infarction (heart atta problem area of chi dialysis was added.	ders revealed on 8/5/14, an c per day fluid restriction due to ase and need for ase and need for and set in the set in the set in the set ated how much fluid each ovide R61 (i.e., dietary, and who would be responsible the hour total fluid intake. from 10/3-10/13/14, revealed intake had not been calculated sistently. R61's total daily fluid in calculated on 10/3, 10/4, intake monitoring had not d intake monitoring had not d the care plan had not ch fluid each discipline would and be responsible for our total fluid intake. cribed 1500 milliliter (ml) 24 in and her 24 hour intake was	{F 3	09}			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/13/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	NIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	for fluid overload. T 9/3/14, included inta a 1500 ml fluid rest fluid distribution for medications and 42 R59's medical reco review, however, R Assessment (CAA) which indicated R59 impairment and wa tray set-up assistan R59's Physician Or dated 9/12/14, indic /24 hour fluid restric monitor intake and dialysis three days and Friday). R59's October 2014 1500 ml / 24 hour fluid coumentation indic 10/1/14 - lacker amount of fluid con the 24 hour total wa total for the shifts d exceeding the fluid ml). 10/2/14 - lacker amount of fluid con 24 hour total was n 10/3 & 4/14 - lacker amount of fluid con 24 hour total was n 10/3 & 4/14 - lacker amount of fluid con 24 hour total was n 10/3 & 4/14 - lacker amount of fluid con 24 hour total was n	The approaches identified on ake and output monitoring and riction with delineation of the 60 ml to be given with 20 ml with each meal. rd lacked a completed MDS N-B provided a Care Area summary dated 6/23/14, 9 had moderate cognitive s independent with eating after rice. ders and Progress Notes cated R59 was on a 1500 ml ction and directed staff to output. In addition, R59 had a week (Monday, Wednesday 4, TAR indicated R59 was on a uid restriction. The cated the following: d documentation for the sumed during the night and as not completed (the fluid ocumented equaled 1540 ml - restriction for the day by 40 d documentation for the sumed in the evening and the ot completed. acked documentation for the	{F 3	09}			

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	-	AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	וחוד				
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` '					
			A. BOILD			,	R	
245535			B. WING					
NAME OF F	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CAI	RE FAC						
			(x2) MULTIPLE CONSTRUCTION       (x3) DATE SURVEY COMPLETED         A. BUILDING       R         B. WING       ID/17/2014         STREET ADDRESS, CITY, STATE, ZIP CODE       24856 HOSPITAL DRIVE REDLAKE, MN 56671         D       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)       COMPLETION DATE         ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLETION DATE         (F 309)       (F 309)       (F 309)       (F 309)					
(X4) ID				v			(X5) COMPLETION	
PREFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROP			
					DEFICIENCY)			
			SERVICESOMB NO. 0938 SERVICESOMB NO. 0938 UPPLER/CLIA A BUILDING					
{F 309}	Continued From pa	-	{F 30	09}	•			
		al (the fluid total for the shifts						
		9/14, equaled 1520-						
	ml).	restriction for the day by 20						
		our fluid intake documented						
	and totaled (1060 m							
		acked documentation for the						
	24 hour fluid intake	total. our fluid intake documented						
	and totaled (1320 m							
		our fluid intake documented						
		nl - exceeding the fluid						
	restriction for the da	ay by 140 ml).						
		cian's (RD) Medical Nutrition						
		ed 9/4/14, indicated R59 was estriction. The RD's Medical						
		lotes dated 9/30/14, indicated						
		er to ascertain actual intake						
	from the medication	n administration record.						
		2 p.m. trained medication aide						
		any resident on dialysis						
		our total fluid intake recorded						
		med it was the responsibility total R59's 24 hour total intake						
		hould be documented on her						
		MA-A confirmed for the						
		014, R59's total fluid intake						
		d on 10/10/14, 10/13/14, and						
		I fluid intake on 10/14/14, was						
	restriction by 140 m	eeded the 24 hour fluid I for the day.						
		2 p.m. the dialysis unit RN						
		familiar with R59 and her						
		RN verified that on 10/13/14, or her scheduled dialysis						
		grams which was 5.5						

Facility ID: 00355

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		AND HUMAN SERVICES			FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 309}	body weight withour nurse confirmed Re- kilograms and R59 dialysis treatments dialysis RN confirm been monitoring Re- within her 1500 ml/d dialysis RN stresse monitor R59's total never be over four l was on 10/13/14). T exceeding the 24 her 1500 ml would plac complications such heart attack or resp On 10/15/14, at 2:1 hour total fluid intake incomplete and that the month of Octob been tallied. On 10/16/14, at 10: her expectations we the individual care p The facility's Intake policy [undated], sp accurately determin resident consumed The facility's Using indicated the care p meet the resident's documentation musi- residents' plan of c	dry weight (the amount of t extra fluid). The dialysis 59's dry weight goal was 64.5 had routinely come in for her around 66 kilograms. The ed the facility should have 59's fluid intake and staying day fluid restriction. The d it was very important to fluid intake and she should kilograms on fluid (which she This lack of monitoring and our fluid intake restrictions of e R59 at risk for clinical as congested heart failure, biratory failure. 8 p.m. the DON verified the 24 ce records for R59 where t three out of the 14 days for er 2014, the totals had not 35 a.m. the DON confirmed ere that the staff would follow blan for R59. , Measuring and Recording ecified as its purpose to he the amount of liquid a in a 24 hour period. the Care Plan policy [undated] blan would be developed to daily care needs and that at be consistent with the	{F 309}			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	(X2) MUL	TIP	LE CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245535	B. WING _				R / <b>17/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE		
			L		REDLAKE, MN 56671		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 309}	Continued From pa	ge 36	{F 30	_ )9}			
	(a small medical ap beneath the skin in	pliance that is installed which a catheter connects the					
	site and develop a d	the facility failed to monitor the care plan to identify the access					
	provided should dis	ency care procedures to be slodgment and/or bleeding					
	occur.	I					
		Physical dated 10/1/14, recently started on dialysis nset.					
	was admitted to the Discharge Summar R62's diagnoses ind	I Sign Record indicated R62 e facility on 10/2/14. R62's ry dated 10/2/14, indicated cluded diabetes and chronic dialysis treatments via a					
	R62's Admission/Reundated and blank.	eadmission Care Plan was					
	R62's progress note was cognitively aler	e dated 10/2/14, indicated R62 rt.					
	indicated following a at 2:30 p.m. for dial indicated R62 return p.m., however, the regarding the appea	Sign Record dated 10/2/14, admission R62 left the facility lysis. The record further ned from dialysis at 10:00 record lacked notation arance of the catheter site 52 tolerated the dialysis.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA		RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	The Nurses' Admis	ge 37 sion Assessment dated R62 had a central line inserted	{F 3	09}			
	lacked identification	g assistant (NA) cheat sheet of R62's dialysis catheter of the catheter site.					
		ers dated 10/8/14, indicated dialysis every three times a					
	the right chest porta directed staff to cha soiled. The staff sig Treatment Sheets I	4, Treatment Sheets identified acath for dialysis access and ange the dressing as needed if nature section was blank. The acked indication of monitoring or emergency care.					
		<ol> <li>Medication Administration ked indication of monitoring of</li> </ol>					
		7 p.m. LPN-A confirmed R62 porary care plan developed.					
	admission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmiss	9 p.m. RN-B stated an sion care plan was to be as a resident was admitted to ated R62 received dialysis, ss site and was not to have ken from the left arm. ted he wasn't sure if the NAs or not. RN-B verified he was plete the care plans, however, ave "a lot" of information on ed R62's admission care plan ed it should have been					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 309}	emergency care of restrictions such as arm. On 10/15/14 at 3:0 the dialysis unit of t dialysis. The portace observed covered w The dialysis nurse s changed weekly du On 10/15/14, at 3:0 confirmed dialysis s dressing weekly an home protocol to m However, the RN st monitoring the cath and/or bleeding. Th occurred, staff shou unable to control th to be seen in the er on 10/15/14, at 3:04 the facility had look On 10/15/14, at 3:00 occasionally worked not sure where R62 On 10/16/14, at 7:55 had a right chest dia which the dialysis u dressing. TMA-A st catheter site for ble however, verified th indicating such.	<ul> <li>e dialysis access site, the site as well as any no blood pressures on the left</li> <li>0 p.m. R62 was observed in he adjoining hospital receiving ath insertion site was with a clean, white dressing. stated the dressing was ring dialysis services.</li> <li>1 p.m. the dialysis unit RN staff changed R62's portacath d stated there was no nursing onitor the access site. tated staff should have been eter site for dislodgment e RN stated if bleeding uld apply pressure and if e bleeding, R62 would need nergency department.</li> <li>4 a.m. R62 stated no one at ed at her dialysis access site.</li> <li>9 p.m. NA-B verified she d with R62 and stated she was 2's access site was.</li> <li>8 a.m. TMA-A confirmed R62 alysis catheter in place in nit staff took care of the ated she monitored R62's eding three times a day, iere was no documentation</li> </ul>	{F 3	09}			
	At 12:00 p.m. the D	ON stated the facility did not					

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			FORM	APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	EPARTMENT OF HEALTH AND HUMAN SERVICES       O         ENTERS FOR MEDICARE & MEDICAID SERVICES       O         TREMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         245535       B. WING         DURDAIN PERPICH EXT CARE FAC       STREET ADDRESS, CITY, STATE, ZIP CODE 2455 HOSPITAL DRIVE REDLAKE, MN 56671         DURDAIN PERPICH EXT CARE FAC       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRETX TAG       PROVIDER OCROSS-REFERENCED TO HEAPPROP DEFICIENCY         F 309)       Continued From page 39 have a policy and procedure related to the development of temporary admission care plans.       {F 309}         The facility's Hemodialysis Access Care policy and procedure dated 5/13, indicated the catheter must be kept clean and dry at all times and to never pull or tug on catheter tubing. The policy also indicated the general nurse should document each shift in the resident's medical record as follows: 1. location of the catheter will be documented in the MAR with the notation not to take blood pressures in the arm, if a shunt is placed. 2. The condition of the dressing and any interventions, if needed 3. If dialysis was done during shift. 4. Any part of a report the dialysis nurse may have provided post-dialysis. 5. observations post dialysis.         The facility's Using the Care Plan policy [undated] indicated the care plan would be developed to meet the resident's daily care needs and that documentation must be consistent with the residents' plan of care.						R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER		[	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	11/2014
				2	4856 HOSPITAL DRIVE		
JOONDA				F	REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	•	-	{F 30	09}			
	and procedure date must be kept clean never pull or tug on also indicated the g each shift in the res follows: 1. location of documented in the take blood pressure placed. 2. The cond interventions, if nee during shift. 4. Any nurse may have pro	d 5/13, indicated the catheter and dry at all times and to catheter tubing. The policy eneral nurse should document ident's medical record as of the catheter will be MAR with the notation not to es in the arm, if a shunt is dition of the dressing and any ded. 3. If dialysis was done part of a report the dialysis ovided post-dialysis. 5.					
{F 314} SS=H	indicated the care p meet the resident's documentation mus residents' plan of c 483.25(c) TREATM	blan would be developed to daily care needs and that st be consistent with the are. ENT/SVCS TO	{F 3 <sup>.</sup>	14}			11/18/14
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote	must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and					
	This REQUIREMEN	NT is not met as evidenced					

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CENTE	-	AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245535	B. WING			२ 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE,		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
{F 314}	Continued From pa	age 40	{F 31	14}		
	review, the facility f (R59, R42, R62) wi were consistently a provided intervention current pressure ul development of new facility's failure to a interventions result for R42, R59, and F Findings include: R59 had a stage 4 thickness loss of tis tendon or muscle) without adequate m the pressure ulcer.	pressure ulcer (ulcer with full ssue with exposed bone, which had increased in size nonitoring and assessment of		The facility will ensure to enter the facility without will not develop pressur individual clinical conditi that they are unavoidab that has a pressure ulce care and services neces healing, prevent infection sores from developing. Residents R42, R59, and comprehensively reasse ulcer risk, care plans up assessment findings and assistant assignment shareflect care plan interve All other residents with a 15 or below have been care plans and nursing assignment sheets upda assessment findings an The policy and procedu	pressure ulcers e ulcers unless the ion demonstrates le and a resident er receives the ssary to promote on and prevent new and R62 have been essed for pressure odated to reflect d nursing neet updated to ntions. current pressure Braden score of reassessed and assistant ated to reflect d care needs. re for treatment	
	(MDS) dated 6/23/ extensive assist of transfers and was r indicated R59 was a stage 4 pressure repositioning scheo redistribution device wheelchair. R59's F Assessment (CAA) indicated R59 had impairment, require mobility, transferrin hygiene. The CAA 4 pressure ulcer or	sessment Minimum Data Set 14, indicated R59 required one staff for bed mobility, non ambulatory. The MDS also at risk for pressure ulcers, had ulcer, was on a turning and dule and utilized a pressure e in both the bed and Pressure Ulcer Care Area dated 6/23/14, which moderate cognitive ed extensive assist with bed g, toileting and personal also indicated R59 had a stage of her coccyx (tailbone) area aily dressing change and		and prevention of press been reviewed and revis current standards of pra All professional nursing educated on November pressure ulcer prevention to include weekly asses current treatment protoco Nursing assistants have on November 3, 2014 of on the plan of care inclu positioning per assignment interventions. The DON or designee w for auditing of 5 residen weekly for two months a	sed to reflect actice. staff has been 13, 2014 on on and treatment sments and cols. been educated n follow-through uding turning and eent sheet vill be responsible t with wounds	

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	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245535	B. WING			२ 1 <b>7/2014</b>
	PROVIDER OR SUPPLIER	RE FAC		STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE REDLAKE, MN 56671	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
{F 314}	monthly follow up to medical record lack R59's Care Plan Fo indicated R59 was pressure ulcer and should be complete R59's care plan da diagnoses included (decrease in heart diabetes, hypertens open wound on but infarction (heart att problem area of ch dialysis was added R59's care plan da problem area of im for R59's coccyx w 1.0 cm in the next 9 directed staff to phy coccyx wound even this information. Th had decreased mo assistance for mob utilized an air mattr redistribution in the directed staff to tur hour and to monito and to report areas R59's Checklist of	by the wound clinic. R59's ked a current MDS. br Skin Integrity dated 6/20/14, at risk for development of a weekly skin assessments ed by a licensed nurse. ted 6/24/14, indicated R59's d congested heart failure function to pump blood), sion (high blood pressure), ttock, a history of myocardial ack), and on 9/3/14, a new ronic kidney disease with renal	{F 314	<ul> <li>months that weekly assessmen completed and care plans are u Audit results will be reported to Committee and action plans de needed to ensure compliance.</li> <li>ADDENDUM F314 11/10/2014 The week of November 3, 2014 licensed nurses had 1:1 educat protocol including the body audi incident reporting and skin asse Additional training will be compl November 12, 2014.</li> <li>Formal education will occur on staff training on 11/13/14 related pressure and non-pressure rela issues and related interventions repositioning, pressure relief de other appropriate interventions pressure ulcers.</li> <li>Resident R42 was assessed by consultant RN for appropriate w treatments, weekly wound mean have been completed and at this treatment is appropriate.</li> <li>Resident R59 was assessed by consultant RN for appropriate w treatments, weekly wound measurements and assessment been completed and at this time treatments are appropriate.</li> <li>Resident R62s wounds are curring healed but skin is being checked by licensed staff to look for any breakdown.</li> <li>Nursing staff will be educated o completion of weekly body audi reporting changes to the nurse pressure and non-pressure relations and pressure and non</li></ul>	pdated. the QA veloped as all ion on skin it tool, essment. eted on icensed all d to ted skin s, vices and to prevent the round surements s time the round ts have ently d weekly n ts and and	

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
						R
		245535	B. WING		10	/17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE		
JOURDA	IN PERPICH EXT CA	RE FAC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
{F 314}	ulcer and identified ulcer on her coccys weekly skin assess member, wound ca turn and reposition pressure relieving bed. R59's most current predict pressure so	age 42 I R59 had a stage 4 pressure x area. Interventions included sment by a licensed staff are consultation as ordered, every two hours and to use devices in her wheelchair and t Braden Scale (tool utilized to ore risk) dated 9/6/14, indicated erate risk for developing a	{F 314	<ul> <li>and care plan updated to addre issues identified.</li> <li>ADDENDUM 2 F314</li> <li>Daily observation audits will be residents with pressure ulcers to treatments are being completed ordered.</li> </ul>	done for o assure	
	directed staff to ch every other day an wound was to be c Aquacel (a wound healing by absorbin applied to the woun securely with a dre	heet order dated 9/23/14, ange coccyx wound dressing d PRN (when needed). The leansed with normal saline, dressing that supports wound ng wound exudate) was to be nd bed and the wound covered ssing. On 10/14/14, R59's scheduled for a dressing				
	until 10/15/14, lack	s (NN) reviewed from 8/13/14, ed documentation of the surement and monitoring of the				
	(DON) was observ perform R59's dres observed positione her right side and t	:45 a.m. the director of nursing ed to gather her supplies to ssing change. R59 was ed in her bed laying slightly on he head of the bed was observed to have a pressure				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING _			R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
{F 314}	relieving mattress of introduced the surver requested to observe dressing change. From the survey was going to measure responded she was she sure could. The measurement of the On 10/14/14, at 11: the measurements 5.0 centimeters (cm and 1.5 cm in depth (separation of tissure edge of a wound) at o'clock area of the wound had a mode (drainage) and sloud confirmed R59's wo measured weekly. was not taken. Upon request, the If wound measureme On the Photograph Form dated 8/13/14 was identified as a length, 3.4 cm in wi undermining of 1.5 o'clock, and 0.9 cm confirmed the date	<ul> <li>bon her bed. The DON veyor and permission was ve the DON conduct the R59 responded that she did yor to watch the dressing yor queried the DON if she ure the wound. The DON sn't planning on it, however, e surveyor requested for a le wound to be completed.</li> <li>c10 a.m. the DON confirmed of R59's coccyx wound were n) in length, 5.0 cm in width h with 0.5 cm of undermining le from the surface on the at the eleven o'clock through 1 wound. The DON stated the erate amount of exudate ugh (dead tissue). The DON ound should be assessed and A photograph of the wound.</li> <li>DON provided the most recent ents for R59's coccyx wound type stage 4, measured 4.1 cm in idth and a depth of 1.5 cm with cm at 12 o'clock, 1.2 cm at 3 n at 9 o'clock. The DON written on the photograph and as the last time the wound was</li> </ul>	{F 314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	R59's Nurses Admi 9/3/14, indicated R5 5.6 cm length, 5.4 c depth. R59's Hospital Enco	ssion Assessment form dated 59's coccyx wound measured cm in width and 1.7 cm in ounter dated 9/16/14,	{F 3	14}			
	wound measureme cm in width, and 0.7	a stage 4 pressure ulcer. The nts were 4.4 cm in length, 4.0 7 cm in depth with 1.4 cm area n 12 o'clock to 2:00 o'clock.					
	Center wound care indicated the wound 4.0 cm in width and of undermining from certified nurse prace assessed the woun assessment that the tissue (dead tissue) over the most prom tissue) that appear from unrelieved pre plan that pressure a be continued. Desp pressure ulcer, the	Sanford Bemidji Medical clinic visit dated 9/23/14, d measured 4.5 cm in length, 1.5 cm in depth with an area n 8 o'clock to 1 o'clock. The titioner (CNP)-A, who d also indicated in her ere was some devitalized in the center of the wound inent area of granulation (new ed to be recent tissue injury ssure. CNP-A indicated in her abatement measures should ite the increase in size of the facility failed to conduct a ssure ulcer assessment for					
	not know why there assessment/measu documentation betw	veen 8/13/14, to 10/4/14. The bund had increased in size					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .			PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
{F 314}	Continued From pa	ge 45	{F 31	14}			
	monitor trends in we completed on 10/12 R59 scored a 15 (se	er Healing Chart (tool to ound healing) initiated and 4/14, by the DON, indicated core range of 0-17, with 0 d was healed to the highest					
	had assessed and t clinic and was famil and treatment. CNF from R59's visit on wound clinic had se facility and stated s staff the importance the bottom, importa continued pressure CNP-A stated she w resident with a woun month at the wound seen it was the faci pressure abatemen CNP-A was unsure available at the faci	1 a.m. CNP-A, confirmed she treated R59 at the wound care liar with R59's wound process P-A also verified her notes 9/23/14. CNP-A verified the een several residents from the he often had to reiterate to e of keeping pressure off of unce of repositioning and abatement interventions. was often frustrated when a nd was only seen once a d care clinic and when they are lity had not followed the it interventions recommended. of the resources they had lity, however, stated they often ir recommendations to aling.					
		35 a.m. the DON confirmed ere that staff would follow e plan.					
	administrator prese at the facility had br	0 p.m. the DON, with the nt, stated the wound program oken down. The DON stated assigned the wound program					

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING _				R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 314}	was evidently not de she ultimately had r the wound program evident the facility w pressure ulcer care R42 had a stage IV assessed, monitore consistently implem pressure ulcer heal increased in size. R42's Admission Fa indicated R42's diag ulcer stage IV (cocc sepsis, chronic ane depressive disorder R42's quarterly MD R42 had intact cogr assistance of two si assist of one staff fo wheelchair for locor inappropriate behav R42's care plan dat an alteration in skin ulcer and vulnerable Interventions includ and treatments as o ankle. Monitor for s infection. Weekly sl ordered. Photo doc measurements at le mattress on bed an wheelchair. PRAFC	oing it. The DON confirmed responsibility for oversight of The DON stated it was was not in compliance for and interventions were not the pressure ulcer that was not ed, and interventions were not the pressure ulcer that was not ed, and interventions were not the pressure ulcer has ace Sheet dated 5/28/14, gnoses included a pressure cyx), type II diabetes mellitus, emia, rheumatoid arthritis and r. S dated 6/29/14, indicated nition, required extensive taff for bed mobility, extensive or transferring, utilized a motion and displayed no vioral symptoms. ted 7/3/14, identified R42 had n integrity related to a coccyx e area on the right ankle. Hed the following: medication ordered to coccyx and right igns and symptoms of kin checks, wound clinic as	{F 31	4}			

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLET R	
		245535	B. WING				17/2014
NAME OF F	PROVIDER OR SUPPLIER	L	•[	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	-	{F 3′	14]	}		
	had not addressed	a repositioning plan for R42.					
		ressure ulcer assessment for l, but was not provided by the					
	8/13/14, indicated F ulcer on the coccyx cm x 1.1 cm. with n bed and the surrou were normal. No fu	c Wound Documentation dated R42 had a healing stage four which measured 3.7 cm x 2.4 to exudate, a normal wound nding skin and wound edges urther wound monitoring by the nd for R42 since 8/13/14.					
	information dated 9 healing was compli and stool incontiner maceration. The fo wound measured 4 circumferential und at 5:00 o'clock. The following plan: Hydr to help with bioburch application to sacru skin barrier, continu to her bottom and g colostomy if patient clinic referral for thi instructions that "Pa specialized cushior redistribution] order possible]."	bund clinic documentation visit //26/14, indicated R42's wound cated by diabetes, pressure ince with associated skin rm also indicated the sacrum .0 cm x 1.3 cm x 0.6 cm with ermining with a 1.7 cm tunnel e documentation identified the rofera blue for the next month len, heavy SensiCare im and intergluteal cleft for ue pressure alleviation efforts general surgical consult for t was interested. The written s visit dated 9/26/14, indicated atient needs Roho cushion [a that optimizes weight red ASAP [as soon as					

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		245535	B. WING				≺ 17/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	ige 48	{F 3	14}			
	care provider on 10 requested a surgica	visit R42 made to her primary 0/13/14, the physician had al consult for a colostomy due arrhea and stool incontinence.					
	(LPN)-B stated R42 on the coccyx and v	9 p.m. licensed practical nurse 2 had a stage IV pressure ulcer was not aware of any issues compliant related to turning					
	her bedroom, seated have a pressure red underneath the but this time R42 was a the wheelchair ever been since she had seated in the wheel up in the wheelchai	tocks to minimize pressure. At asked how long she sat up in ry day and how long it had d a cushion to sit on while lchair and R42 stated she sat ir 3-4 times a day for over an l had not had a cushion in her					
	(NA)-F stated she bed bath and assist NA-F stated that sh up in the wheelchai because she did no getting worse. NA-F independently chan aware R42 being no	5 a.m. nursing assistant had just finished giving R42 a ted her into her wheelchair. he had not allowed R42 to sit ir longer than 30-60 minutes bt want R42's pressure sore stated R42 would hge position and was not oncompliant with pressure positioning assistance.					

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY IPLETED
		245535	B. WING	i			R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	ige 49	{F 3	14}	}		
	R42's care plan sho measurements and including the press have been impleme verified the last doo pressure ulcer asse were completed on On 10/15/14, at 10: to provide the press Upon completion of measured the wour surveyor and the fo 2.1 cm x 1.8 cm wit measured 0.6 cm. V	<ul> <li>15 a.m. the DON confirmed ould have been followed and I pressure ulcer interventions ure reducing cushion should ented as directed. The DON cumentation regarding a essment and measurements 8/13/14, (63 days ago).</li> <li>26 a.m. LPN-B was observed sure ulcer dressing change. If the dressing change, LPN-B hd at the request of the ullowing was revealed: 5.0 cm x th a tunnel at 6:00 o'clock that When the measurements were easurements obtained by the 6/14, it was evident the wound ze and depth.</li> </ul>					
	was non-compliant times. The DON als R42's non-complian R42 nor documente medical record. The pressure ulcer had the wound had not and monitored at le indicated by R42's of the ulcer was not re interventions implet was unaware the pr size and depth. The pressure redistribut	35 p.m. the DON stated R42 with repositioning needs at so stated the risks related to nee had not been explained to ed and care planned in R42's e DON confirmed R42's sacral increased in size/depth and been consistently measured east every two weeks as care plan. The DON verified eassessed nor were further mented because the facility ressure ulcer had increased in e DON stated she had found a ting cushion and placed it in ntil one could be ordered and					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
			A. BUILDI	ING			R
		245535	B. WING			10/	17/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	Continued From pa implemented for R4	12.	(F 31	14}			
	responsible for the stated he was not s comprehensive pre completed. RN-B s position of completi assessments and p completed on 1/6/1 following "Braden for skin breakdown coccyx with dressin is extensive AO1-2 bed mobility and ab repositioning using rails. LN [licensed r assessment after b Nursing assistance report concerns to weight-loss, infection ulcers, dehydration R62 had two stage dermis) pressure ut identify and assess ulcers upon admiss interventions could also failed to compl ordered by the phys	ssure ulcer assessment tated that he was new to the ng comprehensive provided a CAA summary 4, which identified the score is 15 which is mild risk .[R42] has stage 4 ulcer to g changes as ordered. [R42] [extensive assist of 1-2] for le to assist with turning and bilateral upper 1/2 length side nurse] does weekly skin ath and nail care as needed. monitor skin with cares and nurse. Her risk factors are ons, worsening of pressure , and discomfort." two (partial thickness loss of cers and the facility failed to a the presence of pressure sion to the facility so be implemented. The facility ete wound care treatment as					
	a sore on the right l	m the bed to the chair and had hip. dated 10/1/14, indicated R62					

If continuation sheet Page 51 of 79

		AND HUMAN SERVICES				FORM	APPROVED	
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:					IPLETED	
							R	
		245535	B. WING			10/	17/2014	
NAME OF F	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE			
				ŀ	REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 314}	ulcer over the right	ge 51 ct and had a small pressure ischial (back lower portion of	{F 31	14}				
		Sign Record nursing note						
	section indicated R on 10/2/14, and had hip. R62's Discharg indicated R62's diag chronic kidney dise treatments and ane	62 was admitted to the facility d an open area on the right le Summary dated 10/2/14, gnoses included diabetes, ase, renal failure with dialysis mia. The summary also two small ulcers on the right						
	R62's Admission/Re was undated and b	eadmission Care Plan form lank.						
	R62's Care Plan Fo and blank.	or Skin Integrity was undated						
		t of Skin Risk Factors & was undated and blank.						
	indicated R62 requi mobility and directe R62 every two hour indication R62 had	g assistant (NA) "cheat sheet" red staff assistance for bed d staff to turn and reposition rs. However, the sheet lacked current pressure ulcers and levelopment of pressure						
		dated 10/2/14, indicated R62 ent on staff for bed mobility,						

If continuation sheet Page 52 of 79

		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILL	יסוד	LE CONSTRUCTION		<u>0938-0391</u> E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					IPLETED
						R	
		245535	B. WING			10/17/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE		
				h	REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	ge 52	{F 31	14}			
		cal lift for transfers, had not					
		ar, had not stood for six					
		range of motion on both eft shoulder frozen and					
	strength in all extre						
	The Nurses Admiss	sion Assessment dated					
		one 1.8 cm by 1.0 cm open					
	area on the right bu	ittock.					
	right hip dressing cl light, green drainag	ated 10/5/14, indicated R62's hange was completed with e noted. No further ted to wound drainage could					
	indicated R62 could	arting Note dated 10/6/14, assist with repositioning and assistance when she wanted					
	Pressure, Arterial, V Ulcers) dated 10/8/ and old scars on bo identified "small sor the measurement of	nditions Form (Not For Venous, or Neuropathic 14, indicated small open areas ody. The picture diagram res" on right upper buttock with of 1.4 cm X 1.0 cm written n summary related to this und.					
	Observation form d had an open area o	epositioning (tissue tolerance) ated 10/8/14, indicated R62 on the right hip and was to be g and repositioning every two					

If continuation sheet Page 53 of 79

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				<u>MB NO. 0938-0391</u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED	
			A. BUILD	ING		r	R	
		245535	B. WING				、 17/2014	
NAME OF F	PROVIDER OR SUPPLIER		·	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	IN PERPICH EXT CAI	RE FAC		2	24856 HOSPITAL DRIVE			
UCONDA				F	REDLAKE, MN 56671			
(X4) ID		TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL	ID	v	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE	
					DEFICIENCY)			
( <b>T a</b> ( ))	_		1					
{F 314}	Continued From pa	ge 53	{F 3 <sup>·</sup>	14}	}			
	hours.							
	R62's physician ord	ler's dated 10/8/14, indicated						
		open area and directed staff						
		n normal saline, apply Mupricin						
		cover with Allevyn. The orders						
	directed stall to cha	ange the dressing every other						
	uay.							
		dated 10/10/14, indicated R62						
		t fibrinous tissue over two						
	small ulcer areas of	ver the right ischium.						
		on Therapy Notes dated						
	10/13/14, indicated	R62 had a right ischial ulcer.						
	The Braden Scale-I	For Predicting Pressure Sore						
		4, indicated R62 was at risk for						
	pressure ulcers.							
	R62's October 2014	4, Treatment Sheets directed						
		lete a skin integrity check						
		bath, however, the nurse						
	signature sections v	were blank. The sheets also						
		anse the right hip open area						
		apply Muprocin and cover with						
		day. However, the nurse f the form indicated the						
	0	ged on 10/5/14, 10/8/14, (three						
		sing changes). On 10/10/14,						
		/14, (five days between						
	dressing changes).	There was no documentation						
		iption of wound such as the						
	i size, drainage or nu	umber of wounds present.						

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	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		E SURVEY PLETED
AND FLAN C	FORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING	3		
						F	R
		245535	B. WING			10/	17/2014
NAME OF F	PROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	24856 HOSPITAL DRIVE		
JOURDA	IN PERPICH EXT CAI			I	REDLAKE, MN 56671		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	٩	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	Х	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	₹IATE	DATE
					DEFICIENCY)		
{F 314}	Continued From pa	ge 54	{F 31	14)	}		
		9 a.m. R62 was observed					
		to her room from a bath via a					
		staff assist. Both staff assisted					
		n bed R62 was observed					
		ght side. At this time R62					
		admitted to the facility with a					
		does not know if it was					
		stated she was currently					
		y to regain strength. R62					
		sist her with repositioning and					
		f the need for pressure relief,					
		e did not feel staff assisted her					
		s often as they should. R62					
		ned about four times a day					
		as up in the wheelchair from					
	noon until about 3:0	00 p.m. daily.					
	On 10/15/11 at 0.1	Fam. DN Cantered DCOIa					
		5 a.m. RN-C entered R62's					
		he wound treatment. R62 was					
		her left side with use of the					
		nd. An Allevyn dressing was					
		right buttock with the date					
		it. RN-C removed the led an approximate quarter					
		area with white fibrinous type					
		center of the wound on the					
		o the left of the wound another					
		e open area was observed.					
		oted. RN-C stated R62's					
		ne wound was from a past					
		ind not pressure related.					
		ng the treatment, RN-C					
		d dressing was dated					
		ied the date indicated the day					
		st changed. RN-C stated the					
		ould have been completed					
		s ordered. RN-C added, "When					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				२ 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	we work with one n it was difficult to ge pressure related wo complete first." RN- should have been of stated this was "not On 10/15/14, at 10 observed to transfe wheelchair via a me redistribution cushin wheelchair. On 10/15/14, at 1:0 aide (TMA)-A stated admitted to the faci skin condition then (skin, clothing broug they had dentures) then passed onto the a residents needs. considered the adm stated the facility di temporary/admission On 10/15/14, at 1:0 wound documentat descriptive and veri documentation cou confirmed a tempor not developed and identify the presend stated R62's wound outbreak of shingle them. LPN-A stated dressing change to it was expected tha	urse and two medication aids t everything done and stated bunds were the priority to C confirmed R62's treatment completed as ordered and good." :01 p.m. two NAs were r R62 from bed into a echanical lift. A pressure on was observed in R62's 3 p.m. the trained medication d when a resident was lity the nurses assessed their completed a questionnaire ght in, if they wore glasses, if which this information was ne NAs so they were aware of TMA-A stated this was nission care information and d not utilize a formal	{F 3	14}			

Facility ID: 00355

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		pleted R
		245535	B. WING				、 17/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	ge 56	{F 3	14}			
	hour nurse admissi description of a resi given to LPN-A in o the NA cheat sheet. treatments must be was "not acceptable five days with an or On 10/15/14, at 2:3 resident's admissio to be completed as admitted to the facil admission care plan stated if completed, wound identified an had not seen R62's one on her hip and from shingles. RN-F also possibly be a c wound and had req staff unknown) to c see if the wound wa determine if it was a RN-B stated the sta wound was "not squ could not find any ir indicate if the woun RN-B went on to sta information on R62 not personally obse rather refers to a nu wound information. On 10/15/14, at 3:0 occasionally provide	<ul> <li>9 p.m. LPN-B stated the 24 on sheet provided a brief dents care needs which was rder to add the information to LPN-B stated wound completed as ordered and it e" to leave a dressing on for der to change every two days.</li> <li>9 p.m. RN-B stated a n/readmission care plan was soon as a resident was ity. RN-B verified R62's n was not completed and he would expect to see the d on it. RN-B also stated he wounds but believed she had stated it could possibly be 3 stated R62's wound could leep tissue pressure related uested staff (qualifications of theck the wound yesterday to as "squishy" in order to a deep tissue wound or not. If had reported to him the uishy." RN-B also stated he formation in R62's chart to d was pressure related or not. At there was not a lot of . RN-B stated he usually did rve the resident's wounds used stated it wounds use it wounds use it here was not a lot of . RN-B stated he usually did rve the resident's wounds used stated it wounds used a lot of . RN-B stated he usually did rve the resident's wounds used a lot of . RN-B stated he usually did rve the resident's wounds used a wound on her backside re.</li> </ul>					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	9		PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	ge 57	{F 3	14}	•		
	providing wound tre measure 1.0 cm X second wound mea no drainage visible.	5 a.m. RN-C was observed eatment. The larger wound 1.0 cm with no drainage. The asured 0.5 cm X 0.5 cm with Both wounds had white throughout the center with					
	nurse completed th changes. TMA-A st	8 a.m. TMA-A stated the e wound treatments/dressing ated R62 was admitted to the e" small wound on her right					
	not seen nor was a	2 a.m. NA-C stated she had aware of any sore on R62's e nurse would manage it.					
	both wounds on adding admission assessment on admission assessment on admission and thought she had mere verified the admission identification of the location and size. R dressing she removes the the admission and size additional the the admissional the admissional the the admissional the the admissional the admissional the admissional the admissional the the the admissional the the the admissional the the admissional the the admissional the the admissional the the the admissional the the admissional the the admissional the the the admissional the the the admissional the the the the admissional the the the admissional the the the admissional the the the the admissional the	5 a.m. RN-C stated R62 had mission. When reviewed the nent form which identified only ission, RN-C stated she easured both of them. RN-C ion assessment lacked second wound, its description, RN-C also stated the wound ved yesterday was the same d on 10/5/14, when the ed at it.					
		4 a.m. the DON stated she did rounds were related to					
	R62's wound dress R62 had two open a	DN was observed to complete ing change and confirmed areas. The DON again stated a not pressure related rather					

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245535	B. WING	;			R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	were wounds from asked if she would identification, descr determine the caus stated "yes." The D to see complete wo included wound ass identification and m R62's medical reco On 10/16/14, at 9:5 surveyor with R62's Checklist For Skin M which were all bland presence of skin wo should have been of admitted and were On 10/16/14, at 10: (MD)-A along with t observed R62's wo progress notes and wounds were press related wounds. Wh disagreed with the of the wounds. MD- they were pressure ulcers and "I stand went on to state R6 hospitalizations whi development of pre confirmed knowleds R62's pressure ulcer The facility's Pressure and document the of The policy also dire	a history of shingles. When expect staff to document the ription and assessment to be of the wound the DON PON stated she would expect bund documentation which sessments, descriptions, nonitoring documented in rd. 1 a.m. RN-B provided the s Care Plan For Skin Integrity, Risk Factors and Interventions k. RN-B stated due to the bunds, the assessments completed when R62 was not. 16 a.m. R62's medical doctor the DON and surveyor unds as well as recent 1 MD-A confirmed R62's sure related ulcers not shingle hen informed the DON pressure ulcer determination -A responded saying if I said ulcers then they are pressure by my documentation." MD-A 52 had recent long term ich put her at high risk for the essure ulcers. The DON ge of the MD-A's diagnoses of	{F 3	14}			

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	to document in the resident's skin to in red or tender areas The facility's Presso [undated] directed s resident's record all included color, size inspecting the wour The facility's Using indicated the care p meet the resident's	the Care Plan policy [undated] blan would be developed to daily care needs and that st be consistent with the	{F 3	14}			
F 353 SS=F	PER CÀŔE PLANS The facility must ha provide nursing and maintain the highes and psychosocial w determined by resid individual plans of c The facility must pro-	ave sufficient nursing staff to d related services to attain or st practicable physical, mental, vell-being of each resident, as dent assessments and care. ovide services by sufficient	F3	353			11/18/14
	numpers of each of	f the following types of					

Facility ID: 00355

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED	
		245535				२ 1 <b>7/2014</b>	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COE 24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETIO DATE	
F 353	care to all residen care plans: Except when waiv section, licensed r personnel. Except when waiv section, the facility nurse to serve as duty. This REQUIREME by: Based on observa review, the facility	-hour basis to provide nursing ts in accordance with resident red under paragraph (c) of this nurses and other nursing red under paragraph (c) of this y must designate a licensed a charge nurse on each tour of ENT is not met as evidenced ation, interview and document failed to ensure adequate offing was provided for all 37	F 35	the facility will have sufficient staffing to provide nursing and services to attain or maintain to practicable physical, mental a psychosocial well-being of eac	d related the highest nd		
	Nurse (LPN)-D sta were working extr. LPN-D stated the licensed nurses w also stated reside was no time to con changes and docu the director of nur- notified by LPN-D	17 p.m. Licensed Practical ated that most all of the LPN's a shifts and double shifts. evening shift had not had two ork in over two weeks. LPN-D nt care suffered because there mplete scheduled dressing umentation. LPN-D stated both sing and the administrator were on many occasions within the e lack of staffing but the		as determined by resident ass and individual plans of care or basis. The prior staffing model was e as a sign-up methodology. Th held two mandatory clinical st on November 3. The 2567's of reviewed with the team and ex for attendance and performant standards anticipated in the fu- team agreed to 1:1 meetings DON (held 11/7 - 11/12) to rev routine schedules and to estal staff members preferred two v and to establish that schedule	sessments in a 24 hour established he new DON aff meetings were xpectations ice uture. The with the view their blish each week period		

Facility ID: 00355

		& MEDICAID SERVICES	1		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245535	B WING			2
		245555	D. WING _	STREET ADDRESS, CITY, STATE, ZIP C		17/2014
NAIVIE OF I	PROVIDER OR SUPPLIER				JODE	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 353	Continued From pa	000 61	Ба			
1 333	Continued From pa	-	F 3		ine plane a pto d	
	currently employed	se they could not handle		A bonus program has been to assist with an incentive p		
		ard care to the residents.		encourage attendance.	acrage to help	
		rding the details related to this		Two external staffing agence	ies were	
	complaint.			contacted to provide additio	nal staff.	
				Zellner Senior Health Cons		
				engaged to provide clinical		
				MDS assistance.	0	
	On 10/17/14, at 8:5	5 a.m. the director of nursing		The DON will provide daily	monitoring of	
	stated the normal s	staffing pattern was the		staffing hours to ensure ade		
	following:			professional nurse and nurse		
		was two licensed nurses and		staff are available to provide		
	seven nursing assi			care and services to the res	sidents of the	
		shift was two licensed nurses		facility.	4	
	and five NAs.	and licensed wires and three		ADDENDUM F353 11/10/14		
	NAs.	one licensed nurse and three		Staffing per shift is determin		
		he had not noticed a lack of		resident need and acuity lev is responsible for oversight		
		aff for the evening shift.		management of all clinical s		
		an for the evening shift.		call-ins will be managed by		
				coordinator (HUC) during th		
	The DON was agai	n interviewed on 10/17/14, at		and the charge nurse on ev		
		actual staffing for the evening		night shifts and weekends.		
		from 10/2/14-10/14/14. The		required to follow mandating		
	DON confirmed that	at the census was between 37		care. The DON is contacte	d to assist with	
		uring this time period and		problem solving staffing iss		
		PN was scheduled for the		is a new practice for this fac		
		ose days. The DON confirmed		Attendance will be tracked		
		s notified her that they had not		educated on November 3, 2		
		ete all the care required by the		expectations on attendance		
		N confirmed that licensed mployment with the facility as		A total of 23 separate staffir were contacted to attempt t		
		e poor working conditions and		traveling nurses and CNAs.		
		e DON stated she had entered		is providing three licensed s	• •	
		a licensed pool staff agency		extended contracts.		
		weeks, however the pool staff		Of the existing staff, six CN	As/TMAs have	
		le to provide the facility with		been moved to floor to serv		
		ed staffing needs. The DON		positions. Other staff has b		
	confirmed she had	not sought out any other		reassigned to provide direct	t ooro to	

Facility ID: 00355

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245535	B. WING _			२ । <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	P CODE	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 353	Continued From pa	ge 62	F 35	53		
	licensed pool staff a facility's need for lic the administrator w another contract wi agency. The DON o licensed nurse staff	agency's to try and meet the ensed nurse staffing because ould not allow her to sign th a licensed pool staff confirmed that evening fing had not been adequate for er but that she was actively		provide better coverage to needs. Clinical staff members has 1:1 with the DON to parti a structured staffing sche rotate in an every two we a new format as recently up for desired shifts, som assistant and licensed st assigned to weekends.	ave been meeting cipate in creating edule that will eek cycle. This is staff only signed ne nursing	
of lack of staffing was disc the DON and administrator the DON and administrator the staff relief from the sho of months now but the relie LPN-A stated the common voiced concern of lack of s working on it." LPN-A state had been working with a la approximately six months a her breaking point. LPN-A complain to her about lack care about once a week ar reported to LPN-A that the been changed or they had	ack of staff was "we are -A stated the licensed staff with a lack of staff for nonths and stated she was at LPN-A stated residents out lack of getting appropriate week and residents have that their dressings had not ley had not receive a nt. Refer to F314 regarding the		The nursing assistant ide being on the registry is re- now back working her as the floor. Refer to F496. A pick up bonus incentive approved by the Tribal H November7, 2014 to add and weekday shifts for a for clinical staff. The ince- will be evaluated by the I effectiveness and need u more fully stabilized. Advertising will be update permanent staffing by No 2014. The NHA and DO respond to job applicatio The attendance policy ha and a new tracking progr initiated to impact the con- communication and atter	esolved and is signed shifts on e plan has been ealth Director on ress weekend set period of time entive program DON and NHA for until staffing is ed to impact ovember 17, N promptly ns. as been reviewed am will be nsistent ndance for staff.		
	registered nurse (R responsible for com comprehensive res stated the 13 of 13	11:59 a.m. until 12:23 p.m. N)-B stated he was pleting the required ident assessments. RN-B required comprehensive vere significantly late was		The office Manager will t the data and the NHA wil monitoring and oversight starting November 17, 20	l provide of the process	

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245535	B. WING	i			R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	comprehensive ass received no hours t stated when he arri would be notified th patient care instead assessments. RN-E and the Administrat were past due and made to get them of stated he had little t time to complete th that approximately interview the licens administrator and e to their feeling of la leadership. The DC the staff things wo action plan was not issue. Additionally, licensed pool staff a licensed nurse staff stated the administ bringing in a pool st meeting. Please re details related to th assessments not be The facility's Reside 10/30/13, through 8 revealed the followi * The minutes date residents were able shortage of workers to be addressed by was also a comment	sessments on 9/30/14, he had o complete them. RN-B ved to work each day he is the had to provide direct d of doing the comprehensive 3 stated he notified the DON for that 13 of the assessments was told a plan would be saught up, however, RN-B faith he would be afforded the e assessments. RN-B stated two weeks previous to this ed staff met with the DON and expressed their concern related ck of staff and lack of DN and administrator promised uld "get better" but a written e developed to address the RN-B researched and found a agency that would provide fing for the facility. RN-B rator dismissed the idea of taff agency at the time of this offer to F272 and F276 for e comprehensive eing completed timely.	F	353			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IN PERPICH EXT CA			2	24856 HOSPITAL DRIVE		
JOORDA		NET AC		F	REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 64	F3	353			
		d 3/25/14, indicated that not responded to the action					
	had complained of times when only on floor. The resident facility should look is determine how to fi were paying money responsible for prov- the minutes reflected explained the facilit that workers were of that the facility need (licensed practical r nurses (RN)s) and tribal human resour * The minutes dated residents were awa hour shifts. The residents wh they were the ones Another comment r an unidentified resid the resident who sp meeting stated they to help. This resided look out after each reflected in the min regarding the nursin overtime, sometime assistants working	d 7/30/14, indicated residents short staffing, how there were e nursing assistant was on the council members felt the nto their concern and x it. The residents stated they and the facility was viding them care. In addition, ed that the administrator had y was not short staffed, but calling in. He acknowledged ded licensed nursing staff nurses (LPN)s and registered that he had contacted the re that staff were working 16 sidents felt it was pretty bad no lived at the facility and that which have been affected. noted in the minutes, indicated dent was having problems and ooke up at the resident council y were unable to find someone ent commented "a lot of us other or yell." In addition, utes were comments ng assistants working es there were only two nursing on a shift and that the d the nursing assistants would					

Facility ID: 00355

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER RUDPULERCUA DENTIFICATION NUMBER: 245535       (X2) MULTIPLE CONSTRUCTION A. BUILDING 245535       (X2) MULTIPLE CONSTRUCTION A. BUILDING 245536       (X2) MULTIPLE CONSTRUCTION A. BUILDING 245536       (X2) MULTIPLE CONSTRUCTION A. BUILDING 24550 HOSPITAL DRIVE REDLAKE, MN 56671       (X2) MULTIPLE CONSTRUCTION REDLAKE, MN 56671         Image: Margin and M			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
VAME         245535         B. WING         10/17/2014           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         24556 H0SPTAL DRIVE         24556 H0SPTAL DRIVE         24556 H0SPTAL DRIVE         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         24557         245577         245577         2455777         2457777 </td <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>· · /</td> <td>PLE CONSTRUCTION</td> <td colspan="2">(X3) DATE SURVEY</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY	
JOURDAIN PERPICH EXT CARE FAC         24856 HOSPITAL DRIVE REDAKE, MN 56671           Image: Colspan="2">SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         D PREFIX TAG         PROVIDERS FUNA OF CORRECTION (EACH ORDERTOR TOT MA APROPRIATE DEFICIENCY)         Continued FACH ORDERTOR TOT MA APROPRIATE DEFICIENCY)         Continued FACH ORDERTOR TOT MARKET CONCERNS and Stated the DON and the administrator were well informed by staff of the staffing concerns and nothing was done about it.         F 356         F 356         11/18/14           F 356         483.30(e) POSTED NURSE STAFFING SS=C         F 356         F 356         11/18/14           F acility must post the following information on a daily basis: o Facility name. o The total number and the actual hours worked by the following categories of licensed vocational nurses (as defined under State law). . Certified nurses of licensed vocational nurses (as defined under State law). . Certified nurse aides. o Clear and readable format.         F 361         Contified nurse aides. o Clear and readable format.			245535	B. WING _			
DOURDAIN PERPICH EXT CARE FAC           Image: Colspan="2">REDLAKE, MN 56671           Image: Colspan="2">Continued From page 65         preserve	NAME OF F	PROVIDER OR SUPPLIER					
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)       CONFLETE DEFICIENCY)         F 353       Continued From page 65 On 10/17/14, at approximately 11:00 a.m. the social worker verified the above resident council concerns and stated approximately three times a week a resident had verbally voiced their concerns related to staffing to her. The social worker also stated the DON and the administrator were well informed by staff of the staffing concerns and nothing was done about it.       F 356       F 356       11/18/14         F 3653       The facility must post the following information on a daily basis: o Facility name. 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 (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.       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.       Image: Staff 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.       Image: 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.       Image: Staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follow	JOURDA	IN PERPICH EXT CAI	RE FAC				
On 10/17/14, at approximately 11:00 a.m. the social worker verified the above resident council concerns and stated approximately three times a week a resident had verbally voiced their concerns related to staffing to her. The social worker also stated the DON and the administrator were well informed by staff of the staffing concerns and nothing was done about it. F 356 483.30(e) POSTED NURSE STAFFING F 356 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 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.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
<ul> <li>o In a prominent place readily accessible to residents and visitors.</li> <li>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</li> <li>The facility must maintain the posted daily nurse</li> </ul>	F 356	On 10/17/14, at app social worker verifie concerns and stated week a resident had concerns related to worker also stated to worker also stated to were well informed concerns and nothin 483.30(e) POSTED INFORMATION The facility must po a daily basis: o Facility name. o The facility must po a daily basis: o Facility name. o The current date. o The total number by the following cate unlicensed nursing resident care per sh - Registered nur- by the following cate unlicensed pract vocational nurses (a - Certified nurses o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla- residents and visito The facility must, up make nurse staffing for review at a cost standard.	broximately 11:00 a.m. the ed the above resident council d approximately three times a d verbally voiced their staffing to her. The social the DON and the administrator by staff of the staffing ing was done about it. NURSE STAFFING est the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. est the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to rs. pon oral or written request, g data available to the public not to exceed the community				11/18/14

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				२ 1 <b>7/2014</b>
NAME OF PROVIDER OR SUPP	IER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDAIN PERPICH EXT	~ ^			2	4856 HOSPITAL DRIVE		
	CA			R	REDLAKE, MN 56671		
PREFIX (EACH DEFICI	ENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
required by Sta This REQUIRE by: Based on inter facility failed to information was potential to affer visitors to the fa Findings includ The posted hours schedule was r during which it not reconciled to shifts. The follow the hours postion On 10/3/14, the hours were inactioned the nours postion On 10/3/14, the hours were inactioned There was no p 10/5/13. On 10/6/14, the posted hours ic 6:00 p.m6:00 schedule identii for this shift. On 10/7/14, the one RN that worked 6:00 the worked 6:00 the tworked 6:00 the two the two the two	A rate la vieve por citate vieve vieve por citate vieve	An inimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced and document review, the ure the posted nurse staffing sted accurately. This had the Il current residents (37) and y. and the actual working noiled from 10/3/14-10/10/14 noted the posted hours were flect the actual staffing for all g issues were identified with sted nursing assistant (NA) ate. The posted hours sing assistants worked from ., however, the schedule assistants actually worked the		356	The facility will post on a daily basi beginning of each shift the daily sta per regulation in a format that is cle readable and in a prominent place accessible to resident and visitors. The form for daily posting of staffing been revised to meet the regulation Form will be posted at the beginnin each day and updated daily to mate working schedule. The staffing coordinator has been t on the procedure on November 13, The DON will be responsible for au of the daily staffing posting daily for weeks and then weekly for 2 month Audit result will be reported to the C committee and action plans develon needed to ensure compliance.	iffing ear and readily g has h. g of ch the rained 2014. diting 2014. diting 2014. diting	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING	R	
		245535	B. WING		10/17/2	2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
JOURDAI	N PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COM TO THE APPROPRIATE	(X5) MPLETIC DATE
	p.m., one LPN wor worked 8:00 a.m4 6:00 p.m6:00 a.m p.m10:00 p.m. On 10/8/14, the po was one RN that worke LPN worked 6:00 a worked 8:00 a.m2 worked 6:00 a.m6 schedule identified a.m2:30 p.m., one a.m., one LPN wor LPN worked 6:00 a worked 6:00 p.m1 worked 8:00 a.m. t On 10/9/14, the po was one RN that worke LPN that worked 8 LPN that worked 8 LPN that worked 8 LPN that worked 6 working schedule i 8:00 a.m4:30 p.m p.m. and one LPN On 10/10/14, the p was one RN that worke LPN that worked 6 that worked 10:00 worked 2:00 p.m1	e LPN worked 6:00 a.m2:30 ked 2:30-10:30 p.m., one LPN 4:30 p.m., one LPN worked b. and one LPN worked 6:00 sted hours identified there worked 6:00 a.m2:30 p.m., d 6:00 p.m6:00 a.m., one a.m2:30 p.m., one LPN that 2:30 p.m. and one LPN that 2:30 p.m. The working that one RN worked 6:00 e RN worked 6:00 p.m6:00 ked 6:00 a.m2:30 p.m., one a.m6:00 p.m., one LPN 10:00 p.m. and one LPN 0 6:00 p.m. sted hours identified there worked 6:00 a.m2:30 p.m., d 6:00 p.m6:00 a.m., one :00 a.m4:30 p.m. and one :00 a.m4:30 p.m. and one :00 a.m6:00 p.m. The dentified that 1 RN worked b., one RN worked 6:00 e LPN worked 8:00 a.m4:30 worked 6:00 a.m2:30 p.m., d 8:00 a.m2:30 p.m., one :00 a.m2:30 p.m. one :00 a.m2:30 p.m. one :00 a.m2:30 p.m. one :00 a.m2:30 p.m. one :00 a.m. b.m. b.m. b.m. b.m. b.m. b.m. b.m.	F 3	956		

Facility ID: 00355

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	( - )	E SURVEY PLETED
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		245535	B. WING _	_		10/	17/2014
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
0(0)15		TEMENT OF DEFICIENCIES	15		PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	ĸ	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIFE	DATE
			1				
F 356	Continued From pa	ge 68	F 3	56			
	working during the	evening shift.					
	The director of nursing (DON) was interviewed on						
	The director of nurs	ing (DON) was interviewed on					
	10/17/14, at 10:23 a	a.m. and confirmed that both					
		ng and the working schedule The DON stated that when					
		t it wasn't consistently					
		on the working schedule. The					
		alth unit coordinator (HUC)					
		keeping the posted hours I was asked how she would					
		ensed nursing staff worked					
		he DON stated she would look					
		dministration record for the ify which staff signed off the					
		ermine who was working that					
	shift.	-					
	The health unit coo	rdinator was interviewed on					
		a.m. and confirmed that the					
	posted hours did no any of the days from	ot reflect the actual staffing on					
	any of the days non	11 10/3/14-10/10/14.					
		ed to daily posting of staff					
F 490	hours was requeste 483.75 EFFECTIVE		F 4	90			11/3/14
SS=F		- /RESIDENT WELL-BEING					, .,
	A fooility must be a	Iminiatorod in a marson that					
		dministered in a manner that resources effectively and					
	efficiently to attain o	or maintain the highest					
		l, mental, and psychosocial					
	well-being of each r	esident.					

Facility ID: 00355

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	Сом	E SURVEY PLETED
		245535	B. WING _			२ 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 490	This REQUIREMEI by: Based on interview facility administration were provided appr comprehensive ass systemic problems assessment timely could be implement oversee care to ensign were provided to pr development which deficiencies; failed staff resources were which resulted in a staffing; and failed plans for identified These administration	Ige 69 NT is not met as evidenced y and document review, the on failed to ensure residents opriate care based on a sessment. The facility had with failure to conduct resident so appropriate interventions ted; failed to adequately sure treatment and services revent pressure and skin ulcer resulted in a harm level to ensure appropriate licensed e available for the residents deficiency at sufficient to develop corrective action quality of care/life deficiencies. // failures had the potential to its residing in the facility.	F 4	Both the DON and nursing home administrator were replaced by h skilled and seasoned interim lead professionals and both started or full-time on November 3, 2014. addition, both leaders are on-call establish operational oversight at planning. ADDENDUM F490 11/10/14 The Tribal Health Director will red weekly report from the NHA prov operational updates and progres improvement focus areas in prog The Tribal Health Director will rod facility weekly for direct access a oversight of the operation. The T Health Director will audit the NHA performance monthly. Weekly reports from the interim I DON have been completed since 31, 2014. The reports are an exe	ighly dership nsite n to nd ceive a iding s on key gress. und the nd Fribal A's NHA and e October	
	had knowledge of p staffing, improper n ulcers, and untimel assessment for ove appropriate action t Refer to F272 and ensure a comprehe (MDS) for 3 of 3 res comprehensive MD residents (R38, R22 R31, R21 and R25) successfully submit	and director of nursing(DON) problems with insufficient nanagement of pressure y Minimum Data Set (MDS) er a year, yet did not take to address these issues. F276: The facility failed to ensive Minimum Data Set sidents (R2, R24, R59) and a DS reassessment for 10 of 10 2, R46, R44, R42, R4, R14, had been completed and tted in a timely manner.		summary of the weekly actions, I topics, progress of QA factors be addressed, and other care updat A senior care health consulting c has been contracted through Oc 2015 to provide clinical and man expertise to the skilled care facili In addition, this consulting compa provided a professional interim D interim NHA for the operation. T consulting company will be partic on-boarding the future permaner and NHA, provide mock surveys throughout the year, provide clini standards of practice expertise a systems.	key es. ompany tober agement ty weekly. any DON and he cipating in at DON	

Facility ID: 00355

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			E SURVEY PLETED
		245535			F	
	PROVIDER OR SUPPLIER	240000	D. WING _	STREET ADDRESS, CITY, STATE, Z		7/2014
	NN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIC DATE
F 490	wounds were assess resident (R4) who h been assessed and fluid intake had not 3 of 4 residents (R6 receiving dialysis the fluid restrictions. Refer to F314: The consistent assessment interventions to ensign were healing. R42, actual harm due to worsening of an exit Refer to F353: The sufficient staff to en- care and services a care plans and/or the had been identified on the residents' care Refer to F520: The corrective action pla quality of care and/or On 10/17/14, at 3:3 administrator prese aware of the followin MDSs not being co and the breakdown program. The DON able to provide a win noted areas of conto- had been aware of past several month MDSs not being do	<ul> <li>assed and monitored for 1 of 3 had skin ulcers that had not d monitored. In addition, daily been totaled or monitored for 51,R46, R59) who were eatment and on prescribed</li> <li>a facility failed to provide hent, monitoring and/or provide sure current pressure ulcers, R59 and R62 experienced the development and/or isting pressure ulcer.</li> <li>a facility failed to provide heat the needs of the residents to appropriately be reflected are plans.</li> <li>facility failed to develop ans to address identified</li> </ul>	F 49	Meetings with the Tribal and Tribal Chairman wer November 10, 2014 to a planned overview, comm expectation, audits, and new leadership. The Tribal Council will be monthly summary report facility monthly with a mo presentation from the NH for the 12 months. The f presentation will occur of 2014.	e conducted on ddress the nunication, reporting with the e provided a from the skilled onthly HA or a designee first Tribal Council	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490 F 496 SS=F	current administrato the full functions of Extended Care Cer supervisory role over 483.75(e)(5)-(7) NL VERIFICATION, RE Before allowing an aide, a facility must that the individual h requirements unles employee in a traini evaluation program individual can prove successfully comple competency evalua evaluation program has not yet been ind Facilities must follor individual actually b Before allowing an aide, a facility must State registry estab (2)(A) or 1919(e)(2) believes will include If, since an individu a training and comp there has been a co consecutive months individual provided services for moneta individual must com	in dated 1/3/13, indicated the or was authorized to carry out the Jourdain/Perpich ther including assuming the er all staff effective 1/4/13. JRSE AIDE REGISTRY ETRAINING individual to serve as a nurse receive registry verification as met competency evaluation is the individual is a full-time ing and competency approved by the State; or the e that he or she has recently eted a training and tion program or competency approved by the State and cluded in the registry. w up to ensure that such an ecomes registered. individual to serve as a nurse seek information from every lished under sections 1819(e) i(A) of the Act the facility e information on the individual. al's most recent completion of betency evaluation program, ontinuous period of 24 is during none of which the nursing or nursing-related ary compensation, the inplete a new training and tion program or a new	F 4		DEFICIENCY)		11/18/14

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING _			२ 1 <b>7/2014</b>
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOUF	DAIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4)   PREF TAG	IX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 4	96 Continued From pa	ge 72	F 49	6		
	This REQUIREMENE by: Based on interview facility failed to ens (NA-G) employed b State's nursing ass This had the potent residing in the facilit care for. Findings include: On 10/17/14, a revi registration with the hired on 9/12/07, w Verbal information agency on 10/17/1 removed from the r facility informed the date of employment On 10/17/14, the di she had called the NA-G was not listed The DON also state nurse registry report on the registry. The facility's semitative report dated 6/2/14 identified on the nut	AT is not met as evidenced and document review, the ure 1 of 26 nursing assistants by the facility was listed on the istant registry as required. ial to affect 37 residents ty in which NA-G provided ew of nursing assistant e State agency revealed NA-G, as not listed on the registry. received from the State 4, indicated NA-G was egistry 3/11/13, after the e State agency NA-G's end t at the facility was 3/11/13. rector of nursing (DON) stated State agency which confirmed d on the registry as required. ed the facility ran semi annual rts to ensure all staff remained annual nurse aide registry , revealed NA-G was not		There had been 2 employees with same first name that had been mis internally regarding the NA registry update. The employee NA-G has taken off the schedule until she ha and completion of the proper regis approval. A secondary review was completed NHA to assure all other employees properly registered. No other emp are out of compliance. The administrator will provide over this area of compliance ongoing. ADDENDUM F496 11/10/14 The personnel files will be audited quarter by the Office Manager repor the results to the Administrator for follow-up action if any employee de have a current registry documenta	sfiled been s clarity try d by the s are loyees sight of every orting bes not	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION		COM	E SURVEY PLETED
		245535	B. WING				२ 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY		-	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIN REDLAKE, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 496 F 497 SS=F	the DON both verifit the most recent ser report and stated the both verified NA-G facility without a bree facility employee m end date of employ on one of the semi Both the administration continued to work a medication aide app pay period through DON stated the fact related to the nurse requirements. On 10/17/14, at 3:4 secretary stated NA facility approximate and worked through residents. 483.75(e)(8) NURS REVIEW-12 HR/YF The facility must co of every nurse aide months, and must p education based or reviews. The in-set sufficient to ensure nurse aides, but mu per year; address a determined in nurse and may address th as determined by th aides providing service.	ed NA-G was not identified on mi annual nurse aide registry hey had missed that. However, remained an employee at the eak in service and stated a ust have entered the 3/11/13, ment for the wrong employee annual submission reports. tor and DON verified NA-G is an NA and trained proximately 40-60 hours per but the facility. At this time the ility did not have a policy aide registry employment 5 p.m. the administrative A-G continued to work at the ly 40-60 hours per pay period, nout the building care for all E AIDE PERFORM CINSERVICE mplete a performance review at least once every 12 provide regular in-service the outcome of these rvice training must be the continuing competence of ust be no less than 12 hours reas of weakness as a aides' performance reviews a special needs of residents be facility staff; and for nurse vices to individuals with nts, also address the care of	F 4				11/18/14

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245535	B. WING		F <b>10/</b> 1	२ । <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE		
				REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497	Continued From pa	ge 74	F 49	7		
	by: Based on interview nursing assistant (N reviewed did not ha evaluation complete NA-B, NA-D, NA-E, not receive 12 hour education training a potential to affect al residing in the facili Findings include: EVALUATIONS Nursing assistant (N performance evalua NA-D was hired on lacked documentati evaluation. NA-D w throughout the build INSERVICE EDUCA NA-A, NA-B, NA-D, worked in the facilit their personnel files they had received th in-service training p NAs work througho NA-A was hired on indicated she had re education units (CE	NA)-D did not have an annual ation. 3/1/13. His personnel file fon of any annual performance as assigned to work ding. ATION NA-E and NA-F had all y greater than 12 months and b lacked documentation that he required 12 hours of the required 12 hours of		Personnel evaluations. Employee NA-D presently has a completed annual evaluation in play addition, a completed review of all evaluations was completed and all employees have updated and comp evaluations. Inservice education: Employees NA-A, NA-B, NA-D, NA NA-F have completed their online t from the contracted Educare softwa The facility has an established com for access to complete the training. The Educare online Learning policy been reviewed by the new DON an and approved. Staff members wer contacted individually by the admin to establish the needed 2014 modu that need to be completed online. Monitoring will be completed by the or designee going forward for the education sessions oversight, staff communication, and scheduling of modules on a monthly basis. ADDENDUM F497 11/10/14 All personnel reviews for the past calendar year will be completed prin November 18, 2014. Going forward Office Manager will provide a list of employees due for evaluation one r prior to the needed date to the depa supervisors. The Administrator will the process to assure compliance p policy and timeliness.	other pleted -E and raining are. puter / has d NHA e istrator iles > NHA the or to d, the the month artment audit	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u> </u>	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 497	Continued From pa	-	F 4	97			
	training program N/ far for 2014.	A-A had received 5.5 CEUs so					
	indicated she had r	7/22/1993. Her personnel file eceived 9.5 CEUs for 2013, entation for CEUs which had 014.					
	indicated he had re and based on the H	3/1/2013. His personnel file ceived two CEUs for 2013, lierarchy Credit Hours report ining program NA-D had so far for 2014.					
	indicated she had r and based on the H from the on-line trai	1/4/2011. Her personnel file eceived seven CEUs for 2013, lierarchy Credit Hours report ining program and her had received 4.75 CEUs so					
	indicated she had read and based on the H	4/7/2008. Her personnel file eceived ten CEUs for 2013, lierarchy Credit Hours report ining program NA-F had so far for 2014.					
	secretary confirmed the on-line training She stated staff me certificates for all of attended and these staff members pers secretary confirmed was responsible for received the require	7 a.m. the administrative d the facility had implemented program in March of this year. There is a service of the system of their in-services they had certificates would be in each connel file. The administrative d the director of nursing (DON) overseeing that the NAs ed number of CEUs per year.					
	On 10/17/14, at 1:5	5 p.m. the DON stated she					

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		AND HUMAN SERVICES			FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497 {F 520} SS=F	was behind on doin DON verified the re a calendar year. The facility's Emplo policy [undated and employee following days) would receive annually. The facility's Educa [undated and unsig the policy was to as the required CEUs addition, the policy modules would be a every quarter and th DON. 483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAN A facility must main assurance committ nursing services; a facility; and at least facility's staff. The quality assess committee meets a issues with respect and assurance activ develops and imple action to correct ide A State or the Secr	ag performance reviews. The quired 12 CEUs are based on eyee Performance Evaluation (unsigned] specified every their probation period (90 e a performance evaluation are Online Learning policy ned] indicated the purpose of ssist the staff in maintaining to maintain their licensure. In indicated three training assigned to each staff person his would be monitored by the IBERS/MEET	F 49			11/18/14

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		& MEDICAID SERVICES				0938-039		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	Сом	E SURVEY PLETED		
		245535	B. WING			R 1 <b>7/2014</b>		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE			
JOURD	AIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETIO DATE		
{F 520}	except insofar as s compliance of such requirements of this Good faith attempts and correct quality a basis for sanction This REQUIREMEN by: Based on interview facility failed to ens had been develope concerns. This had residents residing in Findings include: On 10/17/14, at 3:2 and assurance (QA the director of nurs administrator. The committee met mon structured around a the plan of correction revisit (PCR) exit do presented to the QA confirmed the facility	<ul> <li>uch disclosure is related to the a committee with the s section.</li> <li>s by the committee to identify deficiencies will not be used as as.</li> <li>NT is not met as evidenced</li> <li>v and document review, the ure quality assurance plans ad for identified quality d the potential to affect all 37 n the facility.</li> <li>P.1 p.m. the quality assessment A) program was reviewed with ing (DON) and the DON stated the QAA nthly and their meeting was a standing agenda. She stated on from the post certification ate 8/12/14, had been AA committee. The DON ty had focused specifically on</li> </ul>	{F 52	The new DON and NHA h comprehensive action plar areas of pressure ulcers, f staffing concerns as initial improvement. In addition, quality initiatives have bee quality improvement. The will meet on November 12 action plans, revise the pla plans were initiated. The work of the QA comm communicated to all staff s aware of action plans bein quality improvement. The NHA is responsible fo and monitoring of the QA p Inclusion of other departm line staff will continue. ADDENDUM F520 11/10/ Policy review of the comm	have completed hs reflecting the MDS, and focus areas for two other key in initiated for QA Committee , 2014 to review ans, and the littee will be so they are ig worked on for ir the oversight program. ent leaders and 14 littee structure is			
	Findings include: On 10/17/14, at 3:2 and assurance (QA the director of nurs administrator. The committee met mon structured around a the plan of correction revisit (PCR) exit do presented to the QA confirmed the facili the portion of the do her expectation that compliance with the DON further stated system in place to b	21 p.m. the quality assessment (A) program was reviewed with ing (DON) and the DON stated the QAA nthly and their meeting was a standing agenda. She stated on from the post certification ate 8/12/14, had been AA committee. The DON ty had focused specifically on eficiency cited, however, it was at the facility would be in e regulation in its entirety. The the facility did not have a identify or solicit suggestions om staff, residents or family		quality initiatives have bee quality improvement. The will meet on November 12 action plans, revise the pla plans were initiated. The work of the QA comm communicated to all staffs aware of action plans bein quality improvement. The NHA is responsible fo and monitoring of the QA p Inclusion of other departm line staff will continue. ADDENDUM F520 11/10/2	n initiated for QA Committee , 2014 to review ans, and the ittee will be so they are g worked on for r the oversight orogram. ent leaders and 14 ittee structure is da created by NHA. e education was on and updates a staff ucted. The			

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TATEMEN	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT COM	. 0938-039 E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
{F 520}	administrator prese aware of the follow Minimum Data Set a timely manner, a overall pressure ul DON verified that a	age 78 ent, confirmed they had been ing concerns: short staffing, (MDS) not being completed in nd the breakdown in the cer prevention program. The a written plan of action had not r the above noted areas.	{F 52(	0} ulcers have been initiated for the November 12, 2014 meeting. Th committee members will particip revisions and full implementation improvements. The committee meeting cycle wi monthly until determined that the planning areas are established. committee members are the Me Director, NHA, DON, Maintenam Director, Social Services, and th pharmacist. Other employees a as topics and projects further de Education and communication w managed with written memo upo postings, action plans, and audit The Administrator will be respon oversight and management of th process. Please refer to F314, F353, and related initial quality assurance to action area details.	ne ate in ate in core Routine dical ce e re invited velop. ill be lates, results. sible for is F272 to	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			'		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	CON	E SURVEY IPLETED
		245535	B. WING	;			R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			{	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	17/2014
	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE		
JOONDA					REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 0	00}			
F 157 SS=D	of this department of 10/15/14, 10/16/14, compliance with Fe during a FMS resur this revisit the follow determined to be no 483.10(b)(11) NOT (INJURY/DECLINE A facility must imme consult with the res known, notify the re- or an interested fan accident involving t injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of trea consequences, or t treatment); or a deo the resident from th §483.12(a). The facility must als and, if known, the r or interested family change in room or specified in §483.1 resident rights under	IFY OF CHANGES	F1	157			11/18/14
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						11/07/2014

**Electronically Signed** 

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

PRINTED: 11/13/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (	COM	E SURVEY PLETED	
		245535	B. WING	i		R 10/17/2014		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	the address and ph legal representative This REQUIREMEN by: Based on observat review, the facility fi was notified of a ch wound developmen sample who had a great toe and third f reported to the phys treatment was prov Findings include: R4's cumulative Dis 2/12/14, indicated F diabetes, anemia, b persisting amnesic disease, edema an with medical treatm to his health. R4's quarterly Minir 7/4/14, indicated R4 physical and verbal significantly interfer also indicated R4 h quarterly MDS shou 10/4/14, however, if data was not availa Review of R4's media	cord and periodically update one number of the resident's a or interested family member. NT is not met as evidenced tion, interview and document ailed to ensure the physician ange in condition related to at for 1 of 1 resident (R4) in the wound develop on the right toe that was not identified and sician to ensure appropriate ided. Seases Index Report dated R4's diagnoses included blindness, alcohol induced disorder, chronic kidney d a history of non-compliance tent which presented hazards num Data Set (MDS), dated 4 had impaired cognition and behavioral symptoms that red with his cares. The MDS ad diabetic foot ulcers. (A uld have been completed by t was not completed and the	F	157	R4 has had family and physician notifications completed related to we on right great toe. The quarterly MDS that was due on 10/04/14 has been completed and submitted. A policy and procedure for Resident Change of Condition Notifications ha been reviewed by the Medical Direct Staff have had training on the Policy Procedure for Resident Change of Condition Notifications. The DON or designee will be respor for audits for compliance conducted x 2 weeks, weekly x 4 weeks and m x 2 months. Audit results will be reviewed by the Committee and action plans develop needed to maintain compliance. ADDENDUM F157 MD will be notified via phone or fax 24 hours of any pressure or non-pre related skin condition as stated in th policy for timely notifications will be documented in the medical record. have been educated on 11/13/14 of policy and procedure. Daily audits will be completed during stand-up during the week and the ch	as tor. and nsible daily onthly QA ped as within essure ege in n 24 Staff this g daily		

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		& MEDICAID SERVICES			OMB NO. (			
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		LETED		
		245535	B. WING		R 10/1	7/2014		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COL	DE			
JOURDA	NIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE		
F 157		-	F 15					
	indicated R4 had a	gress notes on 8/14/14, new ulcer on the dorsum of which was to be treated with dressings daily.		nurse will review on weekends provide oversight for those re- have new or changing pressu non-pressure related wounds.	sidents that re or			
	not mentioned any wounds. The round dermatitis on bilate	nding note dated 9/22/14, had issues related to open skin ding note identified stasis eral lower extremities with tin from stasis dermatitis.						
	R4's physician order the following orders needed for swelling lower extremities to apply Bactroban, co change BID (twice	ers dated 9/22/14, identified s: Una boot to right leg as g. A&D ointment to bilateral wice a day. Left second toe over with gauze dressing and a day) until resolved. Wash y moisturizing cream BID.						
	documentation from the following: -on 9/20/14, licens documented R4 has and one wound on nurse (RN) to asse A&D ointment, gau left plantar toe has (cm) in length and A&D ointment, gau Koban. -on 9/24/14, RN do wound dressing was	as notes and wound m 9/1/14-10/14/14, revealed and practical nurse (LPN)-C ad two new wounds on toes right big toe. The registered ass. Wounds cleansed and tize applied and Koban. R4's a skin tear 3.0 centimeters 3.0 cm in width, area cleansed, tize applied and wrapped with ocumentation indicated R4's as changed, however, the note ch dressing was changed or						
	physician was notif	d lacked indication the ied of the wound on the right ion of a management plan						

If continuation sheet Page 3 of 33

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			IPLETED R
		245535	B. WING				17/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From pa	ae 3	F 1	57			
1 107	•	d which had developed.		57			
	The wound book do	cumontation from					
	9/1/14-10/14/14 wa	s reviewed and there was no					
		ted to R4 having open wounds r of any treatment being					
	implemented.						
		proximately 10:50 a.m. RN-B					
		a history of foot wounds, was unsure if he had any new					
	or current ones.						
	(NA)-C stated on th on his right toe and	53 a.m. nursing assistant is past Monday R4 had a sore the scab had fallen off during					
	and had started to b	ed the wound appeared red bleed "a little bit." NA-C notified a nurse regarding the					
	-	03 a.m. RN-C stated as of two					
	RN-C stated she wa	n was intact, free from sores. as totally unaware R4 had a oot or a scab had fallen off					
	during his bath.						
	not have any press	44 a.m. RN-C stated R4 did ure sores and had a history of					
		RN-C also stated R4's skin , free of any sores. RN-C					
	stated staff continue	ed to monitored the tip of R4's					
		areas and were directed to should they open up.					
	On 10/16/14, at 1:4	6 p.m. the director of nursing					
		vas not sure when R4's right toe wounds had occurred					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245535	B. WING _	-			२ 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RF FAC			4856 HOSPITAL DRIVE		
				R	EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157 {F 279} SS=E	because R4's medi any feet related skin the physician was n wounds so approprinitiated. The DON expected the licens physician of the wo to the physician was was not provided. On 10/16/14, at app facility provided a p dated 10/16/14, wh approximate size of of the right great to On 10/17/14, at 9:3 seated on the edge interviewed. During toe was observed to and the third toe of and bloody. It was r apparent circulation extremity as the leg was no dressing on 3rd toe wound. 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an	cal record had not identified in issues. The DON confirmed not notified of R4's right foot iate treatment could be stated she would have ed nurses to notify the unds. A policy for notification is requested from the DON but proximately 2:00 p.m. the icture of R4's right great toe ich revealed an open ulcer the f a pea on the dorsal surface e. 3 a.m. R4 was observed of the bed and was the interview R4's right great to have a pea size open ulcer the right foot was macerated noted that there was an in problem with the right lower was purple in color. There the right great toe or right foot (1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 1				11/18/14

Facility ID: 00355

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			()(0) 1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BOILDII			R
		245535	B. WING _			17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
	IN PERPICH EXT CA			24856 HOSPITAL DRIVE		
JUUKDA		RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 279}	Continued From pa assessment.	ige 5	{F 27	'9}		
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment the.				
	by: Based on observat review, the facility f written care plan in- interventions for mo for 3 of 3 residents dialysis. In addition a behavior care pla behaviors for 1 of 3 antipsychotic medic Findings include: R59 was on a 1500 prescribed fluid res comprehensive car daily total and moni R59's care plan dat diagnoses as conge in heart function to	onitoring 24 hour fluid intake (R59, R46, R61) receiving n, the facility failed to develop n which included target b residents (R38) reviewed for cations.		The facility will use the rest assessment to develop, ret the resident's comprehens include measurable goals a to meet the resident's med and mental and psychosod have been identified in the assessment. Residents R59, R46 and R their care plans updated to appropriate interventions fo 24 hour fluid intake. Resid had their care plan updated target behaviors for the use antipsychotic medications. All other resident affected B have had their care plans r updated to reflect monitorin fluid intake and those curre orders for antipsychotic medications	view and revise ive care plan to and timetables ical, nursing ial needs that comprehensive 61 have had include or monitoring of ent R38 has d to include e of by this practice eviewed and ng of 24 hour ently having edications will	

Facility ID: 00355

	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUUT	TIDI			0938-039 SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			ECONSTRUCTION		PLETED	
						F	ર	
		245535	B. WING			10/1	17/2014	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
{F 279}	approaches identifia and output monitori restriction with delir for 60 ml to be give with each meal. Ho direction for staff to what approaches to 1500 ml/day restrict R59's Physician Or 9/12/14, indicated F hour fluid restriction monitor intake and On 10/16/14, at 10: her expectations we the individual care p were needed the ca and updated to mea resident.	otential for fluid overload. The ed on 9/3/14, included intake ing and a 1500 ml fluid heation of the fluid distribution n with medications and 420 ml wever, the care plan lacked total the fluid intake daily and o do if R59 should exceed the tion. ders & Progress Notes dated R59 was on a 1500 (ml)/24 h and staff were directed to output (I&O). 35 a.m. the DON confirmed ere that the staff would follow plan for R59 and as changes are plan should be reassessed et the needs of the be	{F 27	79}	care plan updating to reflect resider current assessed needs per the comprehensive assessment. The DON or designee will be respon for auditing 3 care plans per week f weeks then 2 monthly for 3 months ensure care plan is current for 24 ho fluid monitoring and target behavior Audit results will be reported to the Committee and action plans develo needed to ensure compliance.	nsible or 4 to our s. QA		
	restriction and the f plan interventions w R46's daily fluid inta R46's Admission Fa	cribed 1500 ml daily fluid acility had not developed care which addressed monitoring of ake. ace Sheet indicated R46 was I stage renal disease (ESRD)						
	secondary to chron diabetes mellitus, ir cerebrovascular dis	ic kidney disease, type II htercerebral hemorrhage and sease.						
	a 1500 ml fluid rest centimeter (cc) fluid cc with each med p	t revised on 9/23/14, indicated riction with 420 cubic d allowed with each meal, 80 pass, was to have no water and fluid with meals and						

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA		RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 279}	physician ordered a restriction due to ch need for hemodialy R46's Treatment Ac from 10/3-10/13, re was not calculated The revealed R46's been calculated on 10/8, 10/11, and 10 intake was noted to over the fluid restrict that action was take intake on 10/14/14. On 10/15/14, at 10: R46's care plan did fluid intake was goi R61 was on a prese in which staff did no daily fluid intake. R61's Admission Fa diagnosed with ESF R61's physician ordered a restriction due to ch need for hemodialy R61's TAR 10/3-10/ fluid intake had not monitored consistent	Arrictions allowed. Hers revealed on 12/18/13, the a 1500 ml per day fluid arronic kidney disease and sis. dministration Records (TAR) vealed daily total fluid intake and monitored consistently. a total daily fluid intake had not 10/3, 10/4, 10/5, 10/6, 10/7, /12/14. On 10/14/14, R46's b have been 1620 cc (120 cc ction). There was no evidence en related to the excess fluid 30 a.m. the DON confirmed not identify how the daily total ng to be monitored. cribed 1500 ml fluid restriction of monitor or calculate total ace Sheet indicated R61 was RD. Hers revealed on 8/5/14, the a 1500 cc per day fluid been calculated and ntly. R61's total daily fluid	{F 2	79}	DEFICIENCY)		
		ulated on 10/3, 10/4, 10/5,					

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		AND HUMAN SERVICES				FORM	APPROVED	
			(X2) MU	חוד		MB NO. 0938-0391 (X3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		IPLETED	
			A. BOILD				R	
		245535	B. WING				17/2014	
NAME OF F	PROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	IN PERPICH EXT CAI			2	24856 HOSPITAL DRIVE			
				I	REDLAKE, MN 56671			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION	
PREFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE	
					DEFICIENCY)			
{F 279}	Continued From pa	-	{F 27	79)	}			
	10/6, 10/7, 10/8, 10	/9, 10/10,10/11, and 10/13/14.						
	R61's care plan dat	ed 8/19/14, revealed R61 was						
		estriction. However, the care						
		ated how much fluid each						
		ovide R61 (i.e., dietary,						
		nor who would be responsible						
	for monitoring the 2	4 hour total fluid intake.						
	On 10/15/14 at 12:5	53 p.m. the DON confirmed						
		ot delineated how much fluid						
		Ild provide nor who would be						
	intake.	nitoring the 24 hour total fluid						
	intake.							
		ring and Recording policy						
		as its purpose to accurately						
	determine the amou consumed in a 24 h	unt of liquid a resident						
	consumed in a 24 f							
	The Using the Care	Plan policy [undated]						
		plan would be developed to						
	meet the resident's	daily care needs.						
	R38 had observable	e behaviors and the facility						
		care plan to include						
	identification of targ							
		dated 2/2/14, identified R38 an intracranial injury,						
		ry and a subarachnoid						
	hemorrhage.							
	-							
	R38's nurse notes f	for 9/14, (none for October)						
		behaviors which consisted of						
		n head board, yelling and						
	swearing at the stat	ff, kicking and biting the staff,						

If continuation sheet Page 9 of 33

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			२ 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 279}	throwing objects in voiding in inappropri revealed R38 had p changes 9/14 and v professional. R38's care plan dat moved self from his laid next to his bed checks. The care p crawl out into the ha The head board of an injury hazard du The care plan direc behaviors and inter target behaviors we On 10/15/14, at 10: a low bed anxiously the side rails and sl On 10/15/14, at 1:5 bed restlessly movi R38's head board v wallpaper and deep plaster. On 10/16/14, at 8:3 bed watching TV. W communicate with F verbally communicat floor and quickly sc mattress which laid	the dining room, disrobing and riate places. The notes also psychotropic medication vas followed by a psych ed 12/20/14, indicated R38 s bed onto the mattress that and required hourly safety lan also indicated R38 would allway and call out for help. the bed was removed due to e to R38 kicking and hitting. ted staff to document ventions as they occur. No	{F 279}			

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		AND HUMAN SERVICES		FORM	APPROVED		
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT	TIDI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
							R
		245535	B. WING			10/	17/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC					
				R	EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 279}	Continued From pa	ge 10	{F 27	79}			
	bed with no incontir R38's penis was ex touching himself an f" The door to R3	6 a.m. R38 was observed in nent product / underwear on. posed and he was openly d periodically saying "f, f, 38's room was open and R38 no passed by his room.					
	(RN)-C confirmed F injury. When asked R38 displayed RN-0 stating " f, f, f" RN-0 physically abusive to scratch at the walls	20 a.m. registered nurse R38 had a traumatic brain what inappropriate behavior C stated he would swear C stated R38 was not but would pull at his bed and and also would remove his and throw it about his room.					
	had behaviors whic throwing objects an without appropriate confirmed R38's tar	05 a.m. the DON verified R38 h consisted of hitting, biting, d scooting self out in the hall clothing on. The DON get behaviors were not are plan and they should have					
{F 282} SS=D	Review policy dated comprehensive car tool, changing with status and these ch and addressed in th	RVICES BY QUALIFIED	{F 28	32}			11/18/14

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If continuation sheet Page 11 of 33
	H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONST		(X3) DATE SURVEY COMPLETED R		
	245535	B. WING	i			≺ 17/2014	
NAME OF PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CO	ODE		
JOURDAIN PERPICH EXT C	ARE FAC			SPITAL DRIVE (E, MN 56671			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
<ul> <li>must be provided accordance with e care.</li> <li>This REQUIREME by: Based on observereview, the facility plan related to wo measurement for had a pressure under the findings include:</li> <li>R59 had a stage a thickness loss of t tendon or muscle and was not monit to her care plan.</li> <li>R59's care plan d diagnoses as con in heart function to wound on buttock area of chronic kie was added. R59's impaired skin inter coccyx wound to o the next 90 days. photograph and m two weeks and do On 10/14/14, at 11 request, the direct and confirmed R50</li> </ul>	<ul> <li>and or arranged by the facility by qualified persons in each resident's written plan of</li> <li>ENT is not met as evidenced</li> <li>ation, interview and document failed to follow the written care und assessment and 2 of 2 residents (R59, R42) who cer.</li> <li>A pressure ulcer (ulcer with full issue with exposed bone, which had increased in size tored and measured according</li> <li>ated 6/24/14, identified R59's gested heart failure (decrease o pump blood), diabetes, open and on 9/3/14, a new problem dney disease with renal dialysis care plan also identified grity with a goal for R59's decrease in size by 1.0 cm in R59's care plan directed staff to beasure the coccyx wound every curment this information.</li> <li>1:10 a.m. upon the surveyors for of nursing (DON) measured</li> </ul>	{F 2	The s facility perso reside Resid care p current care a assig neede All off areas and u assig current plan of updat Profe assis Nove for fo relate ulcers The D auditi relate treatm	services provided or ar y will be provided by qu ons in accordance with ent's written plan of car dent R59 and R42 have plans reviewed and upo nt status of pressure ul and treatment Nursin inment sheets have bee ed to reflect current car her resident with currer s have had their care pl updated as needed and inment sheets updated nt care needs. policy and procedure fo of care has been review ted as needed. essional nursing staff ar tants have been educa ember 13 on the policy a llow-through on the pla ed to care and treatmer s. DON or designee is res ing that care plans are ed to pressure ulcer car ment per policy and pro ugh direct observation a pleted on 5 residents wi	ualified each e. e had their dated with lcers and their og assistant en updated as re needs. In pressure ans reviewed I nursing to reflect or following the wed and and nursing ted on and procedure in of care of pressure sponsible for being followed re and ocedure. audits will be		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	MB NO. (X3) DATE	50938-039
AND PLAN (	OF CORRECTION	DENTIFICATION NUMBER:		G		PLETED
		245535	B WING			2
NAME OF	PROVIDER OR SUPPLIER	243333	D: Willo _	STREET ADDRESS, CITY, STATE, ZIP CODE	10/1	17/2014
				24856 HOSPITAL DRIVE		
JOURDA	AIN PERPICH EXT CA	RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIO DATE
{F 282}	<ul> <li>Continued From page 12</li> <li>0.5 cm of undermining (separation of tissue from the surface on the edge of a wound) at the eleven o'clock through 1 o'clock area of the wound. The wound had a moderate amount of exudate (drainage) and slough (dead tissue). The DON stated the wounds were to be measured weekly by facility staff.</li> <li>The Photographic Wound Documentation Form dated 8/13/14, identified R59 as having a stage 4 wound which measured 4.1 cm in length, 3.4 cm in width and a depth of 1.5 cm. with undermining of 1.5 cm at 12 o'clock, 1.2 cm at 3 o'clock and 0.9 cm at 9 o'clock. The DON confirmed an assessment, measurements and photo of R59's wound was last completed on 8/13/14 (63 days ago).</li> <li>R59's nursing notes (NN) reviewed from 8/13/14, until 10/15/14, lacked consistent documentation</li> </ul>		{F 282	interventions are being followed w for 2 months and monthly for 3 monthly Audit results will be reported to the committee and action plans develous needed to ensure compliance. ADDENDUM F282 11/10/2014 At least two observational audits w conducted daily on rotating shifts f month to observe for care being p per the plan of care with a special on pressure ulcer prevention and treatment. Audit schedule will the stated above unless otherwise direct the QA Committee. The DON will review audits and re-educates, coaches, and discipli clinical staff as needed.	will be or one rovided focus n be as ected by	
	of the coccyx woun - on 9/3/14, NN ind measured and dete 5.4 cm in width, an -on 9/11/14, NN inc dressing was chang to have some light On 10/14/14, at 1:3 she didn't know wh documentation with measurement and between 8/13/14, w wound was taken, f measured the woun was taken. The DC increased in size fr	icated the wound was ermined to be 5.6 cm length,				

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'				E SURVEY	
			A. BUILD	NING	3		R	
		245535	B. WING				17/2014	
NAME OF F	PROVIDER OR SUPPLIER		-	;	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
	IN PERPICH EXT CAI	RE FAC		:	24856 HOSPITAL DRIVE			
JOORDA					REDLAKE, MN 56671			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE	
					DEFICIENCY)			
			l					
{F 282}	Continued From pa	ge 13	{F 28	82]	}			
		35 a.m. DON confirmed her						
		hat the staff would follow the						
	individual plan of ca	are for R59.						
		pressure ulcer and staff failed						
		ess, monitor and implement						
	as directed by the c	ist with pressure ulcer healing						
	R42's Admission Fa	ace Sheet dated 5/28/14,						
		gnoses included a stage 4						
		cer, type II diabetes mellitus,						
	sepsis and chronic	anemia.						
	R42's care plan dat	ed 7/3/14, identified R42 had						
		integrity related to a coccyx						
		e area on right ankle.						
		ed the following: medication						
		ordered to coccyx and right						
		igns and symptoms of						
	ordered. Photo doc	kin checks, wound clinic as						
		east every 2 weeks. Air						
		d pressure relief cushion on						
		(specialized splint devices for						
	the lower extremitie	es) bilaterally. The care plan						
	did not address R42	2's repositioning plan.						
	P42's wound alinia	documentation dated 0/26/14						
		documentation dated 9/26/14, und healing was complicated						
		ire, and stool incontinence with						
		ceration. The wound on the						
		4.0 cm x 1.3 cm x 0.6 cm with						
		ermining. There is a 1.7 cm						
	tunnel at 5:00 o'cloo	ck. The wound clinic						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 11/13/2014 APPROVED D. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245535	B. WING			10	R / <b>17/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
{F 282}	documentation ider Hydrofera blue for t bioburden. Heavy S sacrum and interglu Continue pressure bottom. General su patient is interested this visit on 9/26/14 Roho cushion [a sp optimizes weight re soon as possible]." A comprehensive p R42 was requested facility. Registered I responsible for the was interviewed on that he was not sur comprehensive pre RN-B provided a Ca summary complete R42 was at mild ris stage 4 ulcer to coc ordered and a licen skin assessment af assistants were to r report concerns to t The Photographic V dated 8/13/14, indic 4 pressure ulcer wh cm x 1.1 cm. The p the wound bed, wou tissue / skin was no monitoring, assess facility could be fou since 8/13/14.	ntified the following plan: the next month to help with SensiCare application to uteal cleft for skin barrier. alleviation efforts to her urgery consult for colostomy if d. The written clinic referral for 4, identified "Patient needs becialized cushion that edistribution] ordered ASAP [as becialized cushion that edistribution] ordered ASAP [as becialized cushion that edistribution] ordered by the Nurse (RN)-B who was comprehensive assessments in 10/15/14, at 2:55 p.m. stated re that R42 had a essure ulcer assessment. are Area Assessment ed on 1/6/14, which identified sk for skin breakdown, had a ccyx with dressing changes as insed nurse was to do a weekly fter baths and nursing monitor skin with cares and	{F 24	82}			

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		AND HUMAN SERVICES				FORM	: 11/13/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282} {F 309} SS=G	her room, seated in have a pressure req underneath the butt R42 was interviewed how long she sat up and how long it had cushion to sit on wh R42 stated she sat times a day for ove not had a cushion in time." On 10/14/14, at 11: R42's care plan sho measurements and including the press have been implement also confirmed the facility staff regardin assessment and m on 8/13/14, (63 day) The Using the Care indicated the care p meet the resident's documentation must residents' plan of ca 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necessa or maintain the high mental, and psycho	<ul> <li>a wheelchair. R42 did not distribution cushion tooks to minimize pressure.</li> <li>ad at this time and was asked p in the wheelchair every day d been since she had a nile seated in the wheelchair.</li> <li>t up in the wheelchair 3-4 r an hour each time and had n her wheelchair "for a long</li> <li>15 a.m. the DON confirmed ould have been followed and d pressure ulcer interventions ure reducing cushion should ented as directed. The DON last documentation from ng R42's pressure ulcer easurements was completed <i>xs</i> ago).</li> <li>e Plan policy [undated] bean would be developed to a daily care needs and that st be consistent with the are.</li> <li>CARE/SERVICES FOR</li> </ul>	{F 2				11/18/14

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY PLETED
		245535	B. WING _		F 10/1	२ 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IN PERPICH EXT CAI			24856 HOSPITAL DRIVE		
JUURDA				REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	by:	NT is not met as evidenced	{F 30			
	Based on observat review, the facility fa related wound was monitored or treated the sample reviewe skin issues. This d harm for R4. In add consistently monito residents (R46, R67 kidney disease, rec prescribed fluid rest of 1 resident (R62) nor develop a care related to the monit the access site. Findings include: R4 had identified w and 3rd toe that had assessed, monitore R4's Cumulative Dis 2/12/14, indicated F diabetes, anemia, r	ion, interview and document ailed to ensure a non pressure appropriately assessed, d for 1 of 3 residents (R4) in d for non pressure related eficient practice caused actual dition, the facility failed to r daily fluid intake for 3 of 3 1, R59) who had chronic eived dialysis and were on a triction; and failed to monitor 1 dialysis access catheter site plan to include interventions oring and emergency care of ounds on the right great toe d not been appropriately ed and treated. seases Index Report dated R4's diagnoses included non-compliance with medical s, alcohol induced persisting		Each resident will receive the nece care and services to attain the high practicable physical, mental and psychosocial well-being, in accorda with the comprehensive assessmen care plan. Resident R4 has been reassessed skin risk and all wounds have been assessed and treatment plan have care planned per the assessment. Weekly wound measurements have completed and the treatment and ca plan have been adjusted as directed the physician. Residents R46, R59 and R61 will ha daily I&O monitored per policy and procedure. Care plans have been updated to reflect monitoring of fluid intake. Resident R62 has had the dialysis a catheter monitored per policy and th plan has been updated to include monitoring and emergency care for access site. All other residents that may be affect these practices have had their care	est nce nt and for been e been are d by ave d access ne care the cted by	
	amnesic disorder, c and a personal hist medical treatment v health. R4's quarterly Minir 7/4/14, indicated R4 physical and verbal interfered with the r	chronic kidney disease, edema ory of non-compliance with which presented hazards to num Data Set (MDS) dated 4 had impaired cognition, behaviors that significantly esident's care. The MDS also abetic foot ulcers. (A quarterly		reviewed and updated to reflect cur status. the policy and procedure for I&O monitoring for resident on fluid restr has been reviewed and revised as r to include updating of care plan. The policy and procedure for monitor dialysis access sites has been revie and revised as needed to include up of care plans.	rictions needed oring ewed	

Facility ID: 00355

		& MEDICAID SERVICES	()(0)			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
			A. BUILDI			R
		245535	B. WING			17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	
	IN PERPICH EXT CA			24856 HOSPITAL DRIVE		
JOORDA				REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 309}	Continued From pa	ao 17	(E 20			
(i 505)		been completed by 10/4/14,	{F 30		staff have been	
		been completed and the data		All professional nursing seducated on the policy a		
	was not available).			I&O monitoring, wound r		
				dialysis catheter site car		
		ress notes on 8/14/14, new ulcer on the dorsum of		on November 13. This w		
		to be treated with Bactroban		updating of care plans a change of condition.	s needed with	
	and dry dressings of			the DON or designee wil	l be responsible	
				for auditing 5 residents v	vith one or more	
		ding note dated 9/22/14, had		of these care issues we		
		issues related to open skin ing note identified stasis		then monthly for 3 month be reported to the QA Co		
		ral lower extremities with		further action plans deve		
		in from stasis dermatitis.		to ensure compliance.		
	Review of R4's phy	sician orders dated 9/22/14,		ADDENDUM F309 11/10	)/2014	
	identified the follow	ing: Una boot to right leg as		MDs have been contacted		
		. A&D ointment to bilateral		needed fluid restriction if		
		vice a day. Left second toe		plans have been update		
		over with gauze dressing, a day) until resolved. Wash		added to NAR care shee Daily audits of intake and		
		isturizing cream BID.		documentation for all fou		
	R4's nurse progres	s notes and wound		currently on dialysis, R46		
		n 9/1/14-10/14/14, revealed		andR62 will be conducte		
	the following:	d practical pures (LDN) C		nurses on varying shifts		
		ed practical nurse (LPN)-C ad two new wounds on toes		restriction is being monit each day. Audits will be		
		right big toe. The registered		daily for needed follow-u		
	nurse (RN) to asse	ss. Wounds cleansed and		intervention based on ob		
		ze applied and Koban. R4's		record review.	1 10 10 1	
		a skin tear 3.0 centimeters 3.0 cm in width, area cleansed,		At least two observations		
		ze applied and wrapped with		conducted by licensed n rotating shifts for one mo		
	Koban.			for care being provided p		
				care with a special focus	on pressure	
		cumentation indicated R4's		ulcer prevention and trea		
		s changed, however, the note th dressing was changed or		schedule will then be as unless otherwise directe		
	where it had been.	an uressing was changed of		Committee.		

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		& MEDICAID SERVICES	0.00			. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	PLE CONSTRUCTION G		E SURVEY
			A. BUILDIN	G		R
		245535	B. WING			/17/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 309}	Continued From pa	age 18	{F 309	13		
	the foot wounds for was there an RN as found in the medica 9/20/14-10/14/14. I lacked indication the wound on the right management plan which had develop Review R4's Treatr (TAR) from 10/1/14 was directed to per assessment and per charting showed th	R4's medical record also he physician was notified of the great toe or indication of a related to related to this wound		Please refer to F314 for revised skin/pressure ulcer protocols. The DON will review audits and re-education, coaching and disc staff as needed.	ipline of	
	documentation rela wound on any toes	as reviewed and there was no ated to R4 having an open , nor any treatment provided.				
	responsible for the a foot ulcer on the could not identify w the wound. At 3:04 was mistaken, that on either foot and s	2 p.m. LPN-B who was care of R4 stated R4 still had left foot second toe, however, what treatment was provided for p.m. LPN-B then stated she R4 did not have any wounds stated all of R4's wounds were ind nursing staff continued to				
	monitor R4's right of the physician would stated at this point, wounds. At 3:06 p. observation of his f became upset and	great too and if it opened up d be notified. LPN-B again R4 did not have any open foot m. R4 was asked if an feet could be made in which R4 yelled for the surveyor and room. R4's request was				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	DELE CONSTRUCTION		E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	. ,		G		PLETED
		245535	B. WING				R 1 <b>7/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Continued From pa	-	{F 3(	09]	}		
	confirmed R4 had a	proximately 10:50 a.m. RN-B a history of foot wounds, was unsure if he had any new					
	(NA)-C stated on th on his right toe and his bath. NA-C state and had started to b	53 a.m. nursing assistant is past Monday R4 had a sore the scab had fallen off during ed the wound appeared red bleed "a little bit." NA-C notified a nurse regarding the					
	weeks ago R4's ski RN-C stated she wa new wound on his f during his bath. On 10/16/14, at 1:4 (DON) stated she w great toe and third to because R4's medi any feet related skin the physician was n wounds so appropr initiated. The DON expected the licens physician of the wo On 10/16/14, at app facility provided a p dated 10/16/14, wh	proximately 2:00 p.m. the icture of R4's right great toe ich revealed an open ulcer the					
	of the right great to On 10/17/14, at 9:3	f a pea on the dorsal surface e. 3 a.m. R4 was observed of the bed and was					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED		
							R		
	PROVIDER OR SUPPLIER	245535	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	10/17/2014			
					24856 HOSPITAL DRIVE				
JOURDA	AIN PERPICH EXT CA	RE FAC			REDLAKE, MN 56671				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
{F 309}	interviewed. During toe was observed to and the third toe of and bloody. It was r apparent circulation extremity as the leg was no dressing on 3rd toe wound. DIALYSIS: R46 was on a prese (cc) fluid restriction not monitored. R46's Admission Fa diagnoses included (ESRD) secondary type II diabetes met hemorrhage and ce R46's physician orce physician ordered a restriction due to ch need for hemodialy R46's care plan las R46's was on a 150 to have 420 cc fluid each med pass, no fluids with meals ar allowed. R46's TAR from 10, daily total fluid intak monitored consister intake was not calc 10/6, 10/7, 10/8, 10	the interview R4's right great o have a pea size open ulcer the right foot was macerated noted that there was an o problem with the right lower g was purple in color. There the right great toe or right foot cribed 1500 cubic centimeter and his daily fluid intake was ace Sheet indicated R46's lend stage renal disease to chronic kidney disease, llitus, intercerebral erebrovascular disease. ders indicated on 12/18/13, the a 1500 cc per day fluid pronic kidney disease and	{F 3	09}					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245535	B. WING	i			R 1 <b>7/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	over the fluid restrict that action was take intake on 10/14/14. On 10/15/14, at 10: R46's total fluid inta monitored consister R61 was on a prese which was not cons and a plan for delin each department hat R61's Admission Fa diagnosed with ESF R61's physician orc order for a 1500 cc chronic kidney dise hemodialysis. R61's care plan dat a 1500 cc daily fluid plan had not delines discipline would pro- nursing, activities) a for monitoring the 2 R61's TAR records that daily total fluid and monitored cons- intake had not beer 10/5, 10/6, 10/7, 10 10/13/14. On 10/15/14, at 12: R61's daily total fluid	ction). There was no evidence en related to the excess fluid :30 a.m. the DON confirmed ake was not totaled and intly. cribed 1500 cc fluid restriction sistently totaled and monitored heation of fluid provided by ad not been developed. ace Sheet indicated R61 was RD. ders revealed on 8/5/14, an c per day fluid restriction due to	{F 3	09}			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING	i			R 1 <b>7/2014</b>
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 309}	provide or who wou monitoring the 24 h R59 was on a prese hour fluid restriction not consistently tota R59's care plan dat diagnoses included (decrease in heart f diabetes, hypertens open wound on but infarction (heart atta problem area of chi dialysis was added. R59 had a problem for fluid overload. T 9/3/14, included inta a 1500 ml fluid rest fluid distribution for medications and 42 R59's medical reco review, however, R Assessment (CAA) which indicated R59 impairment and wa tray set-up assistan R59's Physician Or dated 9/12/14, indic /24 hour fluid restric monitor intake and dialysis three days and Friday). R59's October 2014	Id be responsible for our total fluid intake. cribed 1500 milliliter (ml) 24 and her 24 hour intake was aled or monitored. red 6/24/14, indicated R59's congested heart failure function to pump blood), sion (high blood pressure), tock, a history of myocardial ack) and on 9/3/14, a new ronic kidney disease with renal . The care plan also indicated with nutrition and a potential The approaches identified on ake and output monitoring and riction with delineation of the 60 ml to be given with 20 ml with each meal. rd lacked a completed MDS N-B provided a Care Area summary dated 6/23/14, 9 had moderate cognitive s independent with eating after ice. ders and Progress Notes cated R59 was on a 1500 ml ction and directed staff to output. In addition, R59 had a week (Monday, Wednesday	{F 3	09}			

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES	1			MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
						R		
		245535	B. WING			10/	17/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE			
				r	REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309}	Continued From pa 10/1/14 - lacked amount of fluid cons the 24 hour total wa total for the shifts de exceeding the fluid ml). 10/2/14 - lacked amount of fluid cons 24 hour total was no 10/3 & 4/14 - lacked amount of fluid intake 10/6/14 - reside 10/6/14 - lacked amount of fluid cons the 24 hour fluid intake 10/7-9/14 - lacked amount of fluid cons the 24 hour total. 10/7-9/14 - lacked amount of fluid cons the 24 hour total. 10/7-9/14 - lacked amount of fluid cons the 24 hour total. 10/7-9/14 - lacked hour fluid intake total documented on 10/ exceeding the fluid ml). 10/10/14 - 24 h and totaled (1060 m 10/11-12/14 - la 24 hour fluid intake 10/13/14 - 24 h and totaled (1320 m 10/14/14 - 24 h and totaled (1640 m restriction for the da The registered dieti Therapy Notes date on a 1500 ml fluid r Nutrition Therapy N it was difficult for he from the medication On 10/15/14, at 1:5	ge 23 d documentation for the sumed during the night and as not completed (the fluid ocumented equaled 1540 ml - restriction for the day by 40 d documentation for the sumed in the evening and the ot completed. acked documentation for the sumed in the evening and the ot completed. acked documentation for the sumed on the day shift and ded documentation for the 24 al (the fluid total for the shifts 9/14, equaled 1520- restriction for the day by 20 our fluid intake documented nl) ocked documentation for the total. our fluid intake documented nl) our fluid intake documented nl) our fluid intake documented nl) our fluid intake documented nl) cian's (RD) Medical Nutrition ed 9/4/14, indicated R59 was estriction. The RD's Medical otes dated 9/30/14, indicated er to ascertain actual intake n administration record. 2 p.m. trained medication aide	{F 30	09}	DEFICIENCY)			
		2 p.m. trained medication aide any resident on dialysis						

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245535	B. WING				R 1 <b>7/2014</b>	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 309}	should have a 24 hd daily. TMA-A confir of the night staff to and that this total sh treatment record. T month of October 2 had only been tallie 10/14/14. The total 1640 ml, which excr restriction by 140 m On 10/15/14, at 1:5 confirmed she was care. The dialysis F R59 had come in for treatment at 70 kilo kilograms over her body weight without nurse confirmed R5 kilograms and R59 dialysis treatments dialysis RN confirm been monitoring R5 within her 1500 ml/d dialysis RN stresses monitor R59's total never be over four F was on 10/13/14). T exceeding the 24 hd 1500 ml would plac complications such heart attack or resp On 10/15/14, at 2:1 hour total fluid intak incomplete and that	our total fluid intake recorded rmed it was the responsibility total R59's 24 hour total intake hould be documented on her TMA-A confirmed for the 2014, R59's total fluid intake ed on 10/10/14, 10/13/14, and I fluid intake on 10/14/14, was beeded the 24 hour fluid al for the day. 22 p.m. the dialysis unit RN familiar with R59 and her RN verified that on 10/13/14, or her scheduled dialysis grams which was 5.5 dry weight (the amount of t extra fluid). The dialysis 59's dry weight goal was 64.5 had routinely come in for her around 66 kilograms. The ed the facility should have 59's fluid intake and staying day fluid restriction. The d it was very important to fluid intake and she should kilograms on fluid (which she This lack of monitoring and our fluid intake restrictions of the R59 at risk for clinical as congested heart failure,	{F 3	09}				

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		AND HUMAN SERVICES				FORM	11/13/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			R 10/17/2014	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	NIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	On 10/16/14, at 10: her expectations we the individual care p The facility's Intake policy [undated], sp accurately determin resident consumed R62 received dialys (a small medical ap beneath the skin in port to a vein) and t site and develop a c site nor the emerge provided should dis occur. R62's History and F indicated R62 was post renal failure or R62's 24 Hour-Vital was admitted to the Discharge Summar R62's diagnoses in kidney disease with portacath. R62's Admission/Re	<ul> <li>35 a.m. the DON confirmed ere that the staff would follow plan for R59.</li> <li>a. Measuring and Recording becified as its purpose to the the amount of liquid a 1 in a 24 hour period.</li> <li>a. Sis via a right chest portacath opliance that is installed which a catheter connects the the facility failed to monitor the care plan to identify the access ency care procedures to be slodgment and/or bleeding</li> <li>Physical dated 10/1/14, recently started on dialysis the facility on 10/2/14. R62's ry dated 10/2/14, indicated R62 e facility on 10/2/14, indicated cluded diabetes and chronic in dialysis treatments via a</li> <li>e dated 10/2/14, indicated R62</li> </ul>	{F 3(	)9}			

If continuation sheet Page 26 of 33

		AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUUT	וחוד	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						COMPLETED		
						R		
		245535	B. WING			10/17/2014		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE			
				F	REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 309}	Continued From pa	ge 26	{F 30	)9}				
	indicated following a at 2:30 p.m. for dial indicated R62 return p.m., however, the regarding the appea dressing or how R6	Sign Record dated 10/2/14, admission R62 left the facility ysis. The record further ned from dialysis at 10:00 record lacked notation arance of the catheter site i2 tolerated the dialysis.						
		sion Assessment dated R62 had a central line inserted						
	lacked identification	ng assistant (NA) cheat sheet n of R62's dialysis catheter n of the catheter site.						
		ers dated 10/8/14, indicated dialysis every three times a						
	the right chest porta directed staff to cha soiled. The staff sig Treatment Sheets la	4, Treatment Sheets identified acath for dialysis access and ange the dressing as needed if nature section was blank. The acked indication of monitoring or emergency care.						
		<ol> <li>Medication Administration ked indication of monitoring of</li> </ol>						
		7 p.m. LPN-A confirmed R62 porary care plan developed.						
		9 p.m. RN-B stated an sion care plan was to be						

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				OMB NO. 0938-0391		
						(X3) DATE SURVEY COMPLETED		
			A. DOILDI		·	R		
		245535	B. WING			10/17/2014		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE			
					REDLAKE, MN 56671	<u></u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 309}	Continued From pa	ge 27	{F 30	09}	}			
		as a resident was admitted to ated R62 received dialysis,						
	had a left arm acce	ss site and was not to have						
		ken from the left arm. ted he wasn't sure if the NAs						
	were aware of that	or not. RN-B verified he was						
		plete the care plans, however,						
		ave "a lot" of information on ed R62's admission care plan						
	was blank and state	ed it should have been						
		le dialysis access site, the site as well as any						
		no blood pressures on the left						
	arm.	-						
	On 10/15/14 at 3:0	0 p.m. R62 was observed in						
	the dialysis unit of th	he adjoining hospital receiving						
		ath insertion site was with a clean, white dressing.						
		stated the dressing was						
	changed weekly du	ring dialysis services.						
	On 10/15/14. at 3:0	1 p.m. the dialysis unit RN						
	confirmed dialysis s	staff changed R62's portacath						
		d stated there was no nursing onitor the access site.						
		tated staff should have been						
	monitoring the cath	eter site for dislodgment						
		e RN stated if bleeding uld apply pressure and if						
	unable to control the	e bleeding, R62 would need						
	to be seen in the en	mergency department.						
		4 a.m. R62 stated no one at ed at her dialysis access site.						
		9 p.m. NA-B verified she diversified she was						
	not sure where R62							

If continuation sheet Page 28 of 33

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
			A. BUILD	ING		R	
		245535	B. WING			10/ <sup>-</sup>	17/2014
NAME OF I	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Continued From pa	ge 28	{F 30	09}			
	had a right chest dia which the dialysis u dressing. TMA-A st catheter site for ble	8 a.m. TMA-A confirmed R62 alysis catheter in place in nit staff took care of the ated she monitored R62's eding three times a day, ere was no documentation					
	have a policy and p	ON stated the facility did not rocedure related to the porary admission care plans.					
	and procedure date must be kept clean never pull or tug on also indicated the g each shift in the res follows: 1. location of documented in the take blood pressure placed. 2. The cond interventions, if nee during shift. 4. Any	dialysis Access Care policy d 5/13, indicated the catheter and dry at all times and to catheter tubing. The policy eneral nurse should document ident's medical record as of the catheter will be MAR with the notation not to es in the arm, if a shunt is lition of the dressing and any ded. 3. If dialysis was done part of a report the dialysis ovided post-dialysis. 5. ialysis.					
F 465 SS=D	indicated the care p meet the resident's documentation mus residents' plan of c 483.70(h) SAFE/FUNCTIONA E ENVIRON	the Care Plan policy [undated] lan would be developed to daily care needs and that it be consistent with the are. L/SANITARY/COMFORTABL	F 4	465			11/11/14

Facility ID: 00355

If continuation sheet Page 29 of 33

	-	AND HUMAN SERVICES & MEDICAID SERVICES		FORM	APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245535	B. WING	) 	F	२ 1 <b>7/2014</b>			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
	IN PERPICH EXT CA			24856 HOSPITAL DRIVE					
JOORDA				REDLAKE, MN 56671					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 465	Continued From pa sanitary, and comfo residents, staff and	ortable environment for	F 465	5					
	by: Based on observat failed to maintain w resident room (#W <sup>2</sup> observed to have la plaster. Findings include: On 10/15/14, at 1:5 was observed in his R38's head board w approximately two f was wall paper was gouges with plaster On 10/16/14, at 12: stated the wallpape had been in disrepa the maintenance m repair the damaged	00 p.m. the director of nursing r and plaster in room #W165 air for at least two weeks and an was working on a plan to I wall.		Resident R38 has placed hard par at the head wall of the resident bed address the gouges. A comprehen room review was completed on Nor 5th with a completion date to impro wallpaper issues in other resident r by November 11, 2014. The administrator will establish wee rounds with the Maintenance Direc address any resident or common a wall repair needed with time action planning for improvement.	to sive vember ve all ooms ekly tor to				
{F 520} SS=F	maintenance stated was in disrepair and paneling to cover the plaster. The maintee room #W165 had b or more weeks and the room properly. 483.75(o)(1) QAA		{F 520			11/18/14			

Facility ID: 00355

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED
		245535	B. WING _		R 10/1	7/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE		
				REDLAKE, MN 56671		0.(=)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 520}	Continued From pa	ge 30	{F 52	0}		
	assurance committe nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the				
	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 develops and implements appropriate plans of action to correct identified quality deficiencies.					
	disclosure of the re- except insofar as su	retary may not require cords of such committee uch disclosure is related to the committee with the s section.				
		s by the committee to identify deficiencies will not be used as s.				
	by: Based on interview facility failed to ensu- had been developed concerns. This had residents residing in Findings include:	NT is not met as evidenced y and document review, the ure quality assurance plans d for identified quality the potential to affect all 37 in the facility.		The new DON and NHA have com comprehensive action plans reflect areas of pressure ulcers, MDS and staffing concerns as initial focus an improvement. In addition, two othe quality initiatives have been initiate quality improvement. The QA Com met on November 12th to review an plans, revise the plans, and the plan were initiated. The work of the QA Committee will	ing the leas for er key d for mittee ction ns	

Facility ID: 00355

If continuation sheet Page 31 of 33

		AND HUMAN SERVICES			FORM	11/13/201 APPROVEI 0938-039			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED			
		245535	B. WING			R 1 <b>7/2014</b>			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	-				
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE			
{F 520}	the director of nursi administrator. The l committee met mor structured around a the plan of correctio revisit (PCR) exit da presented to the Q/ confirmed the facilit the portion of the da her expectation tha compliance with the DON further stated system in place to i for improvement from members, besides resident council me administrator prese aware of the followi Minimum Data Set a timely manner, ar overall pressure ulo	A) program was reviewed with	{F 52	20} communicated to all st aware of action plans b quality improvement. The NHA is responsibl and monitoring of the O Inclusion of other depa line staff will continue. ADDENDUM F520 11/ Policy review of the co complete with a new a the interim DON and ir The staff quality assura initiated with Staff Edua on November 3, 2014 mandatory meetings co initial three action plan MDS assessment proc ulcers have been initia November 12, 2014 m committee members w revisions and full imple improvements. The committee meetin monthly until determine planning areas are est committee members a Director, NHA, DON, N Director, Social Service pharmacist. Other em as topics and projects Education and commu managed with written r postings, action plans, The Administrator will I oversight and manage process. Please refer to F314, F related initial quality as action area details.	being worked on for e for the oversight QA Program. Intment leaders and 10/2014 mmittee structure is genda created by iterim NHA. ance education was cation and updates with staff onducted. The s regarding staffing, cess, and pressure ted for the eeting. The vill participate in ementation g cycle will be ed that the core ablished. Routine re the Medical Maintenance es , an d the ployees are invited further develop. nication will be nemo updates, and audit results. be responsible for ment of this F353, and F272 to				

Facility ID: 00355

If continuation sheet Page 32 of 33

DEPART	FORM	APPROVED					
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP	LE CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	IDENTIFICATION NUMBER:	A. BUILD		COMPLETED			
			-				R
		245535	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	17/2014
	PROVIDER OR SUPPLIER				24856 HOSPITAL DRIVE		
JOURDA	JOURDAIN PERPICH EXT CARE FAC				REDLAKE, MN 56671		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE
_		·			DEFICIENCY)		
			1				

Facility ID: 00355

If continuation sheet Page 33 of 33

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 245535	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 10/17/2014
Name of Facility			Street Address, City, State, Zip Code	
JOURDAIN PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE	
			REDLAKE, MN 56671	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem	(	Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0155		10/17/2014		ID Prefix	F0159		10/17/2014		ID Prefix	F0323		10/17/2014
Reg. #	483.10(b)(4)				•	483.10(c)(2)-(5)				Reg. #	483.25(h)		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Drofiv	F0225		Completed		ID Drofiv	50444		Completed		ID Drofiv			Completed
ID Prefix			10/17/2014		ID Prefix			10/17/2014					
-	483.25(i)					483.65				Reg. #			_
LSC				<u> </u>	LSC					LSC			_
			<b>o</b> "					<b>o</b> "					<b>a</b> "
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
			-					-					_
Reg. # LSC					Reg. #					Reg. #			_
													_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #	. <u></u>				Reg. #					Reg. #			_
LSC				<u> </u>	LSC					LSC			_
Reviewed By	r Review	ved E	Зу	Da	te:	Signature o	f Surve	yor:	1			Date:	
State Agency	/												
Reviewed By	Review	ved E	Зу	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on	:				Check	for anv	Uncorrected D	efici	encies. Was	a Summary of	L	
	5/22/2014						-				to the Facility?	YES	NO

Form Approved

OMB NO. 0938-0390

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245535	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/17/2014			
Name of Facility			Street Address, City, State, Zip Code				
JOURDAIN PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE				
			REDLAKE, MN 56671				

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5) I	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0329		10/17/2014		ID Prefix	F0428		10/17/2014		ID Prefix	F0441		10/17/2014
Reg. #	483.25(I)				•	483.60(c)				Reg. #	483.65		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Drofiv	50544		Completed		D Drofiv			Completed		ID Drofiv			Completed
ID Prefix			10/17/2014	'									_
	483.75(I)(1)				Reg. #					Reg. #			_
LSC					LSC					LSC			_
			•					<b>0</b> //					<b>a</b> "
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
													_
Reg. # LSC					Reg. #					Reg. #			_
													_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix				1	ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			-
			Correction					Correction					Correction
			Completed	.				Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			-
Reviewed By	r Rev	viewed B	у	Date	<b>:</b>	Signature of	Surve	yor:				Date:	
State Agency	, L	.B/mm	1	10/	29/201	4		32601				10/17	7/2014
Reviewed By	/ Rev	viewed B	у	Date	<b>:</b> :	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	on:				Check f	or anv	Uncorrected D	eficie	ncies. Was	a Summary of	<u> </u>	
	6/27/201	4					-				to the Facility?	YES	NO
				1									

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

					ND TRANSMITTAL 'E SURVEY AGENCY	ID: ISKC Facility ID: 00355				
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245535           2.STATE VENDOR OR MEDICAID NO.         (L2)           833840000         333840000		3. NAME AND ADI (L3) JOURDAIN ( (L4) 24856 HOSP (L5) REDLAKE, 1	PERPICH EXT C ITAL DRIVE MN	CARE FAC	(L6) <b>56671</b>	4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other				
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint				
6. DATE OF SURVEY 08/12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	3 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			FISCAL YEAR ENDING DATE: (L35) 12/31				
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         47         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK         See Attached Remarks         17. SURVEYOR SIGNATURE	47 (L18) 47 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Com Requirement ICF (L42)	ace With equirements e Based On: acceptable POC pliance with Program ents and/or Applied V IID (L43)		And/Or Approved Waivers Of The         2. Technical Personnel        3. 24 Hour RN        4. 7-Day RN (Rural SNF)        5. Life Safety Code         * Code:       B*         15. FACILITY MEETS         1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12) (L15)				
Theresa Gullingsrud,			09/10/2014 D BY HCFA RE	(L19) CGIONAI	Enforcement Specialist 09/23/2014 (L20)					
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Part          2. Facility is not Eligible		20. COM	IPLIANCE WITH CI		<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>					
22. ORIGINAL DATE OF PARTICIPATION 12/30/1991 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI A. Suspension of	DATE E SANCTIONS	24. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION:         VOLUNTARY       0!         01-Merger, Closure         02-Dissatisfaction W/ Reimburseme         03-Risk of Involuntary Termination         04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ont 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change				
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)			00-Active				
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 00400	ARRIER NO.	(L31)	30. REMARKS					
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION ( 07/15/2014	OF APPROVAL DAT	те (L33)	DETERMINATION APPRO	WAL				

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

ID. ISKC

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

	PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00355
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

#### CCN: 24-5535

On August 12, 2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on May 22, 2014 and an FMS completed June 27, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 22, 2014.

The deficiencies not corrected are as follows:

F0155 -- S/S: D -- 483.10(b)(4) -- Right To Refuse; Formulate Advance Directives F0159 -- S/S: E -- 483.10(c)(2)-(5) -- Facility Management Of Personal Funds F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

At the time of the revisit the following deficiency related to the standard survey was identified:

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, our revisit to follow up on the deficiencies issued pursuant to the FMS survey determined the following deficiencies were not corrected:

F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being F0329 -- S/S: D -- 483.25(1) -- Drug Regimen Is Free From Unnecessary Drugs F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

F0514 -- S/S: D -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible

Furthermore, at the time of the revisit the following deficiencies related to the FMS survey were identified:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility pursuant to the standard survey and the FMS survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that the cility continues to not be in substantial compliance, this Department imposed the following category 1 remedy:

- State Monitoring effective September 2, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of July 8, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Jourdain/Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 22, 2014. Post Certificatoin Revisit (PCR) to follow.

Refer to the CMS 2567 along with the facility's plan of corrections for the results of this visit.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 28, 2014

Mr. William Eckblad, Administrator Jourdain/Perpich Extended Care Facility 24856 Hospital Drive Redlake, Minnesota 56671

RE: Project Number S5535025, S5535027

Dear Mr. Eckblad:

On June 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 22, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 27, 2014, a survey team representing the Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found the most serious deficiency to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)

On July 8, 2014 CMS notified you of the results of the FMS and informed you they were imposing the following remedy:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014. (42 CFR 488.417 (b))

Furthermore, CMS notified you in their letter of July 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 22, 2014.

On August 12, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on May 22, 2014 and an FMS completed June 27, 2014.

Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 22, 2014. The deficiencies not corrected are as follows:

F0155 -- S/S: D -- 483.10(b)(4) -- Right To Refuse; Formulate Advance Directives F0159 -- S/S: E -- 483.10(c)(2)-(5) -- Facility Management Of Personal Funds F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

At the time of the revisit the following deficiency related to the standard survey was identified:

F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, our revisit to follow up on the deficiencies issued pursuant to the FMS survey determined the following deficiencies were not corrected:

F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens F0514 -- S/S: D -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible

Furthermore, at the time of the revisit the following deficiencies related to the FMS survey were identified:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility pursuant to the standard survey and the FMS survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility continues to not be in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective September 2, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of July 8, 2014:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 22, 2014, remain in effect. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Jourdain/Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 22, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

# APPEAL RIGHTS

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

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

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

### **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:

Lyla Burkman, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 allegation of compliance and/or 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 November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

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

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

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

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

Sincerely,

Mark Meath

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

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

5535r1\_14lc&fms

#### **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 245535	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 8/12/2014			
Name of Facility			Street Address, City, State, Zip Code				
JOURDAIN/PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE				
			REDLAKE, MN 56671				

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem	(	Y5) I	Date
			Correction					Correction					Correction
ID Prefix	F0160		Completed 08/12/2014		ID Prefix	F0332		Completed 08/12/2014		ID Prefix	F0334		Completed 08/12/2014
	483.10(c)(6)		00,12,2014			483.25(m)(1)		00,12,2014			483.25(n)		
•	403.10(0)(0)					465.25(11)(1)				LSC	405.25(11)		_
									+-				
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			_
LSC					LSC								_
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			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			_
LSC													_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #								
LSC					LSC					LSC			_
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ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC				⊢_	LSC			_
Reviewed B	y Revi	ewed B	Зу	Da	te:	Signature of S	Surve	yor:				Date:	
State Agenc	y L	B/m	m	08/	/28/201	4	3	3562				08/	12/2014
Reviewed B	y Revie	ewed B	By	Da	te:	Signature of S	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o	on:		Check for any Uncorrected Deficiencies. Was a Summary of									
6/27/2014		Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						YES	NO				

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245535	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 8/12/2014			
Name of Facility			Street Address, City, State, Zip Code				
JOURDAIN/PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE				
			REDLAKE, MN 56671				

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)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date	(Y4)	ltem	(Y	5)	Date
				Correction					Correction					Correction
ID	Prefix	F0160		Completed 08/12/2014		ID Prefix	F0170		Completed 08/12/2014		ID Prefix	F0280		Completed 08/12/2014
I	•	483.10(c)(6)				•	483.10(i)(1)				-	483.20(d)(3), 483.	10(k)(2)	_
	LSC					LSC					LSC			_
				Correction					Correction					Correction
חו	Drofiv	50244		Completed		ID Drofiv	F0345		Completed		ID Drofiv	E0240		Completed
		F0311		08/12/2014		ID Prefix			08/12/2014		ID Prefix			08/12/2014
1	LSC	483.25(a)(2)					483.25(d)				•	483.25(e)(2)		_
				Correction					Correction					Correction
ID	Prefix	F0334		Completed 08/12/2014		ID Prefix	F0356		Completed 08/12/2014		ID Prefix			Completed
	Rea. #	483.25(n)		-		Rea. #	483.30(e)		-		Reg. #			_
	LSC			•		LSC								_
				Correction Completed					Correction Completed					Correction Completed
ID	Prefix			-		ID Prefix					ID Prefix			
I	Reg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			_
				Correction					Correction					Correction
				Completed					Completed					Completed
				-										_
I	Reg. # LSC					Reg. # LSC					Reg. # LSC			_
Revie	wed By	,	Reviewed I	Зу	Da	te:	Signature of	f Surve	yor:			I	Date:	
State	Agency	/	LB/m	m	08	/28/20	14		335	562			08/	12/2014
	wed By		Reviewed B	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
CMS F														
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?					-							
5/22/2014					Unco	JIICOLE	a Denciencies		-2007 3011	to the raciity :	YES	NO		

		AND HUMAN SERVICES			FO	RM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		245535	B. WING _			R <b>08/12/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		00/12/2014
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
						(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 000	)}		
{F 279} SS=D	of this department of determine compliar issued during a Feo on June 27,2014. I regulations were de 483.20(d), 483.20(k)		{F 275	)}		10/3/14
	A facility must use t to develop, review a comprehensive pla	he results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment .).				
	by: Based on interview facility failed to dev	NT is not met as evidenced and document review the elop a comprehensive care 1 of 1 resident (R59) identified ficile (C-diff).		Jourdain Perpich Extende performs comprehensive with an interdisciplinary te A. R59's status is stable, s	care planning am. (IDT)	s
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	00/0	(X6) DATE
Electron	ically Signed				09/0	5/2014

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

# PRINTED: 09/10/2014

		AND HUMAN SERVICES & MEDICAID SERVICES			I	FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245535	B. WING			R 08/12/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
{F 279}	Continued From pa	ge 1	{F 2	79}			
	Findings include:				currently symptom free. Care plan updated to reflect history of c-diff. B. All residents were audited regardir	na	
	indicated R59 was	harge Summary dated 8/6/14, diagnosed with Clostridium e of infectious diarrhea) and a cral pressure ulcer.			bowel status. Care plans on those residents that have a history of c-diff been updated. C. Staff education will be provided or	<sup>i</sup> have	
	indicated an order f milligrams (an antib	Fransfer Orders dated 8/6/14, or metronidazole 500 piotic medication used to treat mouth 3 times a day until			importance of unusual bowel status incidents on Sept 8th, 2014. Audit completed on every resident for bow symptoms. DON or designee will mo new admissions or readmissions with diagnosis of c-diff to ensure that care	onitor h	
	infection, control pr	ked identification of the otocols to minimize the risk of liff and interventions to direct fection.			include interventions and symptom monitoring. D. The plan of correction will be mon by the DON or designee, then reporte QAPI committee at least quarterly.		
	(DON) confirmed th on R59's care plan. expected intervention	p.m. director of nursing hat C-diff was not addressed She stated she would have ons specific to R59's C-diff sed on the care plan.					
F 282 SS=D	October 2010, indic planning/interdiscip for the review and u the resident had be from a hospital stay	linary team was responsible updating of care plans when en readmitted to the facility v. RVICES BY QUALIFIED	F 2	282			10/3/14
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of					

Facility ID: 00355

If continuation sheet Page 2 of 23
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMI	E SURVEY PLETED
		245535	B. WING			F 08/1	२ 1 <b>2/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 2	F 2	282			
	by: Based on interview facility failed to adm for 1 of 1 resident ( care. R46's physician orc R46 was diagnosed dialysis treatments. order for Renvela (a phosphorous in die phosphorous levels disease) 800 milligr day and 2 tabs with Review of R46's ca indicated R46 recei to administer three with snacks. R46's Medication A for August 2014, re R46's Renvela med PM, AM snack, PM five times per day. 2014 revealed that Renvela during sna August 2, 3, 4, 6, 7, not administered du August 2, 3 and 8 a refused on August 4 include supporting of the medication was orders.	NT is not met as evidenced v and document review, the inister prescribed medication R46) as directed by the plan of lers signed 6/30/14, indicated d with diabetes with routine The order's also indicated an a medication used to bind tary intake and normalize in patients who have renal ams (mg) 2 tablets 3 times a snacks. re plan dated 6/19/14, ved Renvela and directed staff times a day with meals and dministration Record (MAR) evealed the times to administer dication were at "7AM, 11AM, 5 snack." This was a total of Review of the MAR for August R46 had not received the ck times in the morning on , 8 and 11. The Renvela was uring the afternoon snack on and it was documented as 4, 5 and 6. The MAR did not documentation to indicate why not administered per the viewed on 8/12/14, at 9:09			Jourdain Perpich will provide servic accordance with each resident's wri plan of care. A. R46's medication administration schedule has been reviewed and re current. B. All residents on dialysis will be au to assure that medications are not n and administered per MD orders. C. Audits will be conducted daily x 7 then 2 times a week for 2 weeks, th weekly x 2 weeks or until 100% compliance is achieved. Staff educa will be provided on Sept 8th, 2014 regarding resident dialysis regimens how to utilize care plans. D. The plan of correction will be mo by DON or designee. Results will be reported to QAPI at least quarterly.	itten emains udited missed 7day, ien ation ation s and onitored	

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIU	TIPLE CONSTRUCTION		<u>0938-039</u> E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		E SURVEY IPLETED
						R
		245535	B. WING		08/	12/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 282		ge 3 R46's Renvela medication ccording to the written care	F 2	82		
{F 309} SS=D	dated 10/2010, indi- plan would be deve medical, mental and The Care Plans - C October 2012, did r utilize the care plan	ARE/SERVICES FOR	{F 30	99}		10/3/14
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment				
	by: Based on interview facility failed to ensu- kidney dialysis was according to physic (R46) in the sample kidney disease (ES Findings include: R46's physician offi	NT is not met as evidenced and document review, the ure medication related to consistently provided ian's orders for 1 of 1 resident e reviewed for end stage RD). ce visit form dated 8/5/14, diagnosed with end stage		Jourdain Perpich will provide th necessary care and services to maintain the highest practicable mental and psychosocial well be accordance with the compreher assessment and plan of care. A. R46's medication administrat schedule has been reviewed an current. B. All residents currently on dial audited to ensure that all medic	attain or physical, sing in sive ion d remains ysis will be	

Facility ID: 00355

If continuation sheet Page 4 of 23

		& MEDICAID SERVICES	()(0) I		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING			२
		245535	B. WING			12/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 309}	Continued From pa	age 4	{F 309	}		
		RD) and type II diabetes		not missed and administered order.		
	Renvela (a medica in dietary intake an levels in patients w	ders included an order for tion used to bind phosphorous d normalize phosphorous ho have ESRD) 800 milligrams nes a day and 2 tabs with		<ul> <li>C. Audits will be conducted day by DON or designee, then 2x 2 weeks, then, weekly x 2 weet 100% compliance achieved.</li> <li>D. Plan of correction will be m DON or designee. Results will to QAPI at least quarterly.</li> </ul>	per week x eks or until ionitored by	
	received dialysis tra and was prescribed times a day with m	ted 6/19/14, indicated R46 eatments three times per week d Renvela to be given three eals and with snacks. The care R46 could self administer the et up by staff.				
	for August 2014, re R46's Renvela mea PM, AM snack, PM Review of the MAR that R46 had not re snacks on August 2 Renvela was not a snacks on August 2 R46 refused Renve MAR did not includ identified the reaso	Administration Record (MAR) evealed the times to administer dication were at "7AM, 11AM, 5 I snack," five times per day. I for August 2014, revealed eceived Renvela with morning 2, 3, 4, 6, 7, 8 and 11. The dministered with afternoon 2, 3 and 8. The MAR indicated ela on August 4, 5 and 6. The e documentation which on the medication had not been by the resident had refused the				
{F 329} SS=D	8/12/14, at 9:09 a.r lacked documentat not administered.	sing (DON) was interviewed on n. and confirmed the MAR ion of why the medication was EGIMEN IS FREE FROM	{F 329	}		10/3/14

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMI	E SURVEY PLETED
		245535	B. WING			F 08/1	२  2/2014
NAME OF F	PROVIDER OR SUPPLIER		ſ	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 329}	Continued From pa	ge 5	{F 32	29}			
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on interview failed to provide me use of psychoactive dosage reductions antianxiety medicat failed to monitor the used to modify und	NT is not met as evidenced y and record review, the facility edical justification for continued e medications or attempt of antipsychotic and ions. In addition, the facility e effectiveness of medications esirable behaviors for 1 of 5 iewed for unnecessary			Jourdain Perpich Extended Care w ensure that will be free from unnece drugs, including antipsychotic drugs A. R18's medication regimen will be reviewed by the consulting pharmat recommendations made to mental provider. B. All residents that receive psycho medications will have their medicat reviewed to ensure that they have p	essary s. e cy and health tropic ions	

Facility ID: 00355

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	CS FOR MEDICARE	E & MEDICAID SERVICES	(X2) MULT	IPLF			0938-039
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						F	२
		245535	B. WING _			08/	12/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 329}	Continued From pa	age 6	{F 32	9}			
	Findings include:				diagnosis, behavior monitoring and	l risk	
	Review of R18's pl	nysician's orders revealed R18			vs. benefit and effectiveness of medication.		
		ing psychotropic medications:			C. Audits will be done weekly x4 to	ensure	
	Zyprexa (antipsych	notic) 5 mg twice daily (BID),			that behaviors are being document		
		ant) 100 mg daily (qd) and ) 0.5 mg three times daily (tid).			that GDR are being recommended Consultant pharmacists to acquire		
		et behaviors included the			target behaviors of each resident of		
	following: refusal o	f cares, verbal abuse,			psychotropic medication and attack	n to	
		ing, and throwing. The			their MRR sheet. Consultant pharn		
		splayed psychotic behavior tions and delusions.			to ensure that target behaviors are appropriate for medications. Sprea		
					will be updated by consultant pharr		
		he resident drug regimen was			on a monthly basis during review.		
		re was no way to confirm the rst started taking the			D. Plan of correction will be monito the DON or designee. Results will		
		0.5 mg tid. It was noted that the			reported at QAPI at least quarterly.		
	Ativan had been in	creased last on 1/11/14, from					
		ree times a day, Zyprexa 5 mg					
		ted on 10/27/10, and last 1, and the Zoloft 100 mg qd					
		on 4/27/11. There was no					
	record that an atte	mpted dose reduction had					
		any point since the Ativan,					
	started.	t medications had first been					
	Review of the phar	macist monthly drug regimen					
	review reports for .	June and July 2014, revealed					
	that no recommend R18's medication r	dations were made regarding egimen.					
	on 8/12/14, at 11:2 not had any recom	ith the consultant pharmacist 3 a.m. she stated that she has mendations in the last 6 he consultant pharmacist					
	stated she was not R18 had the correct	t aware that she had to ensure t indication for the use of behavioral monitoring was to be					

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 329}	reviewed to ensure dementia with psyc diagnoses for the u medication. The co that R18 did not har identified in his reco The facility consulta interviewed on 8/12 she confirmed that indication for the ar confirmed there has reduction since all o medications had be was not a progress which identified ade use of the medication Zoloft. Review of the Care Summary dated 5/2 Zyprexa and Zoloft of depression, dem factors identified for medications was lis medication side effective weight changes." T target behaviors inco testing, verbal abus throwing/knocking to staff when they app Summary noted that the lowest effective Ativan for managing medication was not determine the medi-	proper target symptoms, and thosis was not an adequate use of an antipsychotic insultant pharmacist confirmed ve psychotic behavior ord. ant pharmacist was again 2/14, at 1:39 p.m. during which there was not an adequate intipsychotic medication. She is not been an attempted dose of the aforementioned een implemented, and there note written by a physician equate justification for ongoing ons Ativan, Zyprexa, and Area Assessment (CAA) 28/14, noted that Ativan, were used "for management ientia and anxiety." Risk r the use of the three sted as "behavioral changes, ects, falls, pressure ulcers and he CAA Summary indicated cluded "refusal of cares or se/swearing/demeaning, things on floor and yelling at proach to help." The CAA at R18 was "currently receiving of dose of Zoloft, Zyprexa and g symptoms." However, each t assessed individually to ical justification, analysis of of that medication for R18 or cts of the medication in	{F 32	29}			

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						ł	R
		245535	B. WING			08/	12/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
TAG	REGULATORTOR	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
{F 329}	Continued From pa	ge 8	{F 32	29}			
		al health note dated 6/29/13, long/short term memory					
		ity, poor comprehension,					
	frustration, poor tole	erance, mood swings,					
		n span, distractibility, difficulty pulse control and anger					
		ehaviors stable - no					
		ors include refusal or cares or					
		e, swearing, demeaning,					
		on. At this time he is on se of Zoloft, Ativan and					
		oms are managed "					
	<b>.</b>						
		h registered nurse (RN)-A on m. she stated that she does					
		chotic symptoms that R18					
	displays, and RN-A	could not locate any					
		rogress notes written related					
	to the resident's bei	havior since April 2014.					
	During interview wit	h the director of nursing					
		at 3:01 she confirmed that					
		psychotic behavior, and R18 ge reduction of the Zyprexa					
		ring of the dosage for the					
	Zoloft. In addition, t	he clinical record had not					
		in justification for the reasons					
		mpt a dosage reduction and ementioned medications.					
F 428		EGIMEN REVIEW, REPORT	F 4	128			10/3/14
SS=D	IRREGULAR, ACT						
	The drug regimen o	of each resident must be					
	5 5	nce a month by a licensed					
	pharmacist.	-					
	The pharmacist mu	st report any irregularities to					

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PRINTED: 09/10/2014

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED	
		245535	B. WING			R 08/12/2014		
NAME OF F	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		,	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	nursing, and these This REQUIREME by: Based on interview facility failed to ensidentified drug irreg provide medical jus psychotropic medic of the effectiveness modify undesirable residents reviewed Findings include: Review of R18's phr received the follow Zyprexa (antipsych Zoloft (antidepress Ativan (antianxiety) The resident's targ following: refusal or	Age 9 cian, and the director of reports must be acted upon. NT is not met as evidenced wand document review, the sure the consultant pharmacist gularities related to failure to stification for continued use of cations, and lack of monitoring s of medications used to behaviors for 1 of (R18) 5 for unnecessary medications. hysician's orders revealed R18 ing psychotropic medications: otic) 5 mg twice daily (BID), ant) 100 mg daily (qd) and 0.5 mg three times daily (tid). et behaviors included the f cares, verbal abuse, ng, and throwing. The	F 4	.28	The drug regimen for all residents a reviewed by a licensed pharmacist. A. R18's medication regimen will be reviewed and revised by the consult pharmacist B. The drug regimen for all the othe residents will be reviewed with a foc antipsychotic medications and any irregularities. Consultant pharmacist review all behavior monitoring. C. Education will be provided Sept 8 2014 to nursing staff to train on parameters for use of psychoactive medications and specific behavior c for use. D. Plan of correction will be monitore the DON and reported to QAPI at le quarterly.	ant r us on ts will 8th, riteria ed by		
	resident had not dis including hallucinat	splayed psychotic behavior ions and delusions. ne resident drug regimen was						
	date the resident fi medication Ativan ( Ativan had been in twice per day to thr BID had been start	re was no way to confirm the rst started taking the 0.5 mg tid. It was noted that the creased last on 1/11/14, from ree times a day, Zyprexa 5 mg ed on 10/27/10, and last 1, and the Zoloft 100 mg qd						

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	had been started or record that an atter been attempted at a Zyprexa, and Zoloft started. Review of the phan review reports for J that no recommend R18's medication re During interview wit on 8/12/14, at 11:23 not had any recommend months for R18. The stated she was not R18 had the correc medications, that bo reviewed to ensure dementia with psyc diagnoses for the u medication. The co that R18 did not had identified in his reco The facility consulta interviewed on 8/12 she confirmed that indication for the ar confirmed there had reduction since all of medications had be was not a progress which identified ade use of the medicati Zoloft. Review of the ment	n 4/27/11. There was no mpted dose reduction had any point since the Ativan, t medications had first been macist monthly drug regimen lune and July 2014, revealed dations were made regarding egimen. th the consultant pharmacist 3 a.m. she stated that she has mendations in the last 6 he consultant pharmacist aware that she had to ensure et indication for the use of ehavioral monitoring was to be proper target symptoms, and thosis was not an adequate use of an antipsychotic insultant pharmacist confirmed ve psychotic behavior	F 4	28			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		COM	E SURVEY PLETED
		245535	B. WING					R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, Z	ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 428	frustration, poor tole decreased attention planning ahead, im outburstsTarget b worsening. Behavin testing, verbal abus change in depressin lowest effective dos Zyprexa and sympt During interview wit 8/12/14, at 10:37 a. not know of any psy displays, and RN-A documentation or p to the resident's bel During interview wit (DON) on 8/12/14, R 18 did not display had not had a dosa and Ativan nor tape Zoloft. In addition, t identified a physicia R18 should not atter	ity, poor comprehension, erance, mood swings, a span, distractibility, difficulty pulse control and anger ehaviors stable - no ors include refusal or cares or se, swearing, demeaning, on. At this time he is on se of Zoloft, Ativan and oms are managed " th registered nurse (RN)-A on m. she stated that she does ychotic symptoms that R18 could not locate any rogress notes written related havior since April 2014. th the director of nursing at 3:01 she confirmed that psychotic behavior, and R18 ge reduction of the Zyprexa ring of the dosage for the he clinical record had not in justification for the reasons empt a dosage reduction and	F 4	128				
{F 441} SS=F		ementioned medications. I CONTROL, PREVENT	{F 4	41}				10/3/14
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.						
	(a) Infection Contro The facility must es	l Program tablish an Infection Control						

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	OF DEFICIENCIES	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
		245535	B. WING _			R 1 <b>2/2014</b>
	PROVIDER OR SUPPLIER	RE FAC		STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
{F 441}	in the facility; (2) Decides what p should be applied t (3) Maintains a rec actions related to in (b) Preventing Spre (1) When the Infec determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is in professional practic (c) Linens Personnel must ha	ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to of infection, the facility must t. est prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. est require staff to wash their irect resident contact for which dicated by accepted	{F 44	.1}		
	by: Based on observa review the facility fa resident (R59) roor to prevent the spre difficile(infectious of potential to affect 2 same room. The factors	NT is not met as evidenced tion, interview and document ailed to properly disinfect 1 of 1 m and care equipment in order ad of clostridium diarrhea) which had the 2 of 2 residents residing in the acility failed to ensure a blood properly disinfected prior to use		Jourdain Perpich will establish a maintain an infection control pro- provide a safe, sanitary and com environment and to help prevent development and transmission o and infection. A. Resident infection and staff ill be investigated, controlled and th	gram to fortable the f disease ness will	

Facility ID: 00355

	-	AND HUMAN SERVICES			F	FORM /	09/10/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMF	SURVEY PLETED
		245535	B. WING _			٦ 08/1	2/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/1	2/2014
JOURDA	IN PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
{F 441}	practice had the por residents who utiliz facility failed to trace infections which ha residents residing i Findings include: Clostridium difficile R59's Hospital Disc indicated R59 was difficile colitis (C-Di thickness tissue los or muscle) sacral p R59's Interagency indicated an order f milligrams (an antilit tablet by mouth three R59's care plan dat was continent of boo R59 to the common up/down pants and elimination. R59's co of the C-Diff diagno interventions and in order to minimize th C-Diff. During the survey, a leave.	R58) observation. This obtential to affect 28 of 40 red the cuff. In addition, the ek, trend and analyze resident ad the potential to affect all 40 in the facility. (C-diff): charge Summary dated 8/6/14, diagnosed with clostridium iff) and a chronic stage 4 (full ss with exposed bone, tendon	{F 44	+1}	of infection prevented. R59 was asymptomatic of c-diff at time of readmission. The infection control log completed to include location of infect the type of organism if available and in reculture was obtained. An analysis of staff and resident infection will be compiled on a monthly basis to detern any similarities or patterns of contamination. Updated policy and procedure will include appropriate cleansing solutions to be used on resident contamination concerns. B. An infection control policy and procedure has been developed and implemented. All resident and staff ill will be monitored and tracked, approprime asures will be taken to prevent the spread of illness and infection. C. Policy and procedures will be revise and updated on a yearly basis. The infection control nurse or DON will tra and log all illnesses and implement the necessary measures to prevent the spread if infection and illness. The infection control nurse shall attempt the spread if infection and illness. The infection control nurse shall attempt the spread if shall be educated on the infection control policy and procedure and specifically how it related to cleaning care of resident care equipment and cleansing resident units such as whe c-diff is diagnosed. Staff will be provide	ction, if a of rmine sident iec of lness priate e ewed ack he to s. on and en	
	(NA)-G stated she	had cared for R59 once since			education on September 10th, 2014. D. Infection control logs and tracking		

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · · ·	IPLETED	
						R	
		245535	B. WING _		08/	/12/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
{F 441}	Continued From pa	age 14	{F 44	1}			
	was instructed to u precautions when a R59 used a facility were instructed to special solution. R bathroom with an in use the shared bath R59 had not used the surveyor to R50 cleaner, however, in the shared bathrood was kept in the hold further stated R59 she cared for her. On 8/12/14, at 2:57 worked with R59 o R59 utilizing the sh shift of 8/11/14, hold had a stool at that (tuberculosis) spra commode / equipm brought the survey and identified the si	se gown and glove caring for R59. NA-G stated bedside commode and staff clean the commode with a 59 shared a room and independent resident who did hroom. However, NA-G stated the bathroom. NA-G brought 9's room to retrieve the none was stored in the room or om. NA-G stated the solution usekeeping closet. NA-G did have loose stools when 7 p.m. NA-D verified she had nce and state she observed hared bathroom on the evening wever, she denied that R59 time. NA-D stated she used TB y or Sani-wipes to clean the nent used by R59. NA-D or to the housekeeping closet spay used was TB Disinfectant Jse. NA-D also stated she had iter based training program		be monitored by DON. The control nurse in collaborati DON shall review all docur infections of staff and resid similarities. QAPI continue monthly by the infection co the DON.	ion with the mented dents to analyze to be updated		
	that a 10:1 bleach equipment with pol NA-D indicated the to use and had bee disinfectant spray of On 8/12/14, at 3:05 bedside commode housekeeping clos commode. NA-E a	solution could be used to clean tential C-Diff contamination. by had not had bleach solution on directed to use the TB					

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING	i			२ 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 441}	R59 refused to use upon using the shar she had helped R59 wiped the toilet dow use. On 8/12/14, at 6:11 (DON) confirmed R room should have to bleach solution and cleaner Ready To U were effective again confirmed C-diff wa care plan and state 8/13/14, at 10:44 a. he cleaned the roor facility and had clea indicated TB Disinfe was used to wipe d H-A indicated the fle water and stated he gallon bucket (a 1:1 gallons). H-A state responsible to clear H-A stated the TB D used to clean the to bathroom and the b to mop the bathroon received training re use bleach water to The undated Clostrr staff to routinely cle resident surfaces a disinfection of items	the commode and insisted red bathroom. NA-F stated 9 in the shared bathroom and on with Sani-wipes after R59's p.m. director of nursing 59's care equipment and been cleaned with a 10:1 I that neither TB disinfectant Jse nor Sani-Cloth Plus wipes nst C-diff. The DON also as not addressed on R59's d it should have been. m. housekeeper (H)-A stated ms on each of the halls in the aned R59's room. He ectant Cleaner Ready to Use own the bed and furniture. oor was mopped with bleach e used a cupful of bleach in a 5 IO solution equals 2 quarts to 5 d the nursing staff was in R59's bedside commode. Disinfectant Cleaner was also bilet and sink in the shared oleach water solution was used m floor. H-A stated he had garding C- diff and was told to	{F 4	41}			

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		AND HUMAN SERVICES			FORM	: 09/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
		245535	B. WING _			R /12/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE
	Continued From pa Blood pressure cuff On 8/12/14, at 8:23 aide (TMA)-A was of electronic blood pre- central nursing area R58's room. The b the attached baske TMA-A proceeded to pressure machine i blood pressure cuff TMA-A was observe size of Aloe Vesta s shampoo cleansing cloth and proceede pressure cuff and p arm. However, TM/ accurate blood press removed and place On 8/12/14, at 12:2 the blood pressure was drug behind the was wheeled into R Aloe Vesta cleansin most appropriate so pressure cuff and s alcohol wipe or som On 8/12/14, at 3:59 Aloe Vesta cleansin appropriate disinfed used for skin care. Sani-Cloth wipe (a	age 16 f: a.m. the trained medication observed to wheel an essure machine from the a down the hall 25 feet to blood pressure cuff fell out of it and landed on the floor. to wheel the electronic blood into R58's room, dragging the f on the floorAt 8:24 a.m. ed to squirt a 50 cent piece solution (a body wash and g foam) on a dry disposable ed to wipe off the blood blace the cuff around R58's left A-A was unable to obtain an ssure reading the cuff was ed on R58's right arm. 29 p.m.TMA-A acknowledged cuff had fallen to the floor and e blood pressure machine as it R58's room. TMA-A stated the ng foam was probably not the olution to clean the dirty blood she should have used an	TAG {F 44 <sup>:</sup>	CROSS-REFERENCED TO THE APPRI DEFICIENCY)		DATE
	placing the cuff on t	lood pressure cuff before the patient. Disinfection of Resident-Care				

	AB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R 08/12/2014
<b>245535</b> B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
JOURDAIN PERPICH EXT CARE FAC 24856 HOSPITAL DRIVE REDLAKE, MN 56671	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLÉTION
{F 441}       Continued From page 17 Items and Equipment policy revised on 10/2009, directed staff to follow current Center of Disease Control and Prevention (CDC) recommendations for cleaning and disinfecting resident care equipment including reusable items and durable medical equipment.       [F 441]         Infection Control Logs:       Review of the facility's infection control logs for July and August of 2014, revealed the logs lacked data which determined if the infection was cultured, the type of organism the infection was caused by and if the infection was re-cultured following antibiotic treatment was not completed. Additionally, the facility surveillance including where each infection had occurred in the building so that pattern and trends of the spread of infection could be reviewed was not completed.       [F 514]         During interview on 8/12/14, at 3:39 p.m. the Director of Nursing (DON) confirmed the findings and verified the lack of appropriate tracking, trending and surveillance of infections.       [F 514]         SS=D       RECORDS-COMPLETE/ACCURATE/ACCESSIB LE       [F 514]         The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.       [F 514]	10/3/14

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		AND HUMAN SERVICES			FORM	09/10/201 APPROVE 0938-039
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245535	B. WING			R 1.2/2014
NAME OF	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODE	08/1	2/2014
	AIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIOI DATE
{F 514}	services provided; t preadmission scree and progress notes This REQUIREMEN by: Based on interview facility failed to ens accurately documen administration reco R16, R18) in the sa Finding include: R11's undated Dise R11's undated Dise R11's diagnoses into candidiasis of skin R11's treatment she identified an order of cream 100,000 unit of candidiasis and of amount to the affect twice a day until res revealed the followi entries: 8/9, and 8/7 P.M. (evening) entr second treatment s order dated 7/20/14 monitor R11's hip e apply A&D ointmen A.M. entries were n 8/10, and under the were blank on 8/6, On 8/12/14, at 7:00	NT is not met as evidenced v and document review, the ure treatments were nted in the treatment rds for 3 of 3 residents (R11,	{F 51	<ul> <li>4}</li> <li>Jourdain Perpich Extended Care ( will maintain records on each resid accordance with accepted profess standards and practices that are complete, accurately documented, accessible and systemically organ that will contain sufficient informati identify the resident, a record of th resident's assessments, the plan of and services provided, the results preadmission screening conducted state and progress notes.</li> <li>A. R11, R16 and R18 will not have doses without reason.</li> <li>B. MAR and Treatment sheets will audited daily and missed documer of medications and treatment will b considered medication errors.</li> <li>C. Policy and Procedure for medic administration will be updated as r and yearly. Audits will be conducted the night shift and results submitte DON or designee. This will be ong Staff education regarding the impo- of complete documentation focusin the medication and treatment reco be provided on September 8th, 20 D. Plan of correction will be monitor the DON and results reported to Q least quarterly.</li> </ul>	lent in ional readily ized, on to e of care of any d by the missed be ntation be ation heeded d on d to the oing. ortance ng on rd will 14. ored by	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	4856 HOSPITAL DRIVE		
JOURDA	IN PERPICH EXT CA	RE FAC		F	REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 514}	Continued From pa	ge 19	{F 5	14}			
	R16 had diagnoses part of foot, pemph	eases Index Report indicated that included ulcer of other igoid bullous (skin disorder ge blisters), and diabetes					
	indicated: -"6/13/14 Wound & - 1) apply Santyl oir wrap with Kerlix and daily for decubitus of was discontinued 8 "Hour AM" from 8/8 entries on the follow -"3/18/14 Wound & bilateral legs - 1) cle apply bactroban oir cover with gauze - 1 change daily for bul review under "Hour on the following day 8/12. -"11/12/13 Wound & Calazinc to buttock review under "Hour on the following day blank entries were 1 8/5 and 8/6. -"4/17/14 Wound an hip open area - app on right hip daily. " AM" revealed blank 8/7 and 8/9. -"8/8/14 Apply A&D attention to healed	eets dated 8/1/14 to 8/31/14, Skin Care Orders - Right heel htment, 2) cover with gauze, 3) d secure with tape, 4) change ulcer of right heel." The order /8/14. Further review under 5/14 to 8/8/14 revealed blank ving days: 8/5 and 8/7. Skin Care Orders - Sores on eanse with soap and water, 2) htment to all open areas, 3) imit use of tape to skin, 4) llous pemphigoid. " Further s AM" revealed blank entries /s: 8/7, 8/9, 8/10, 8/11 and & Skin Nursing Order - Apply BID [twice a day]. Further AM" revealed blank entries /: 8/7. Under "Hours PM" noted on the following days: nd Skin Nursing Order - Right bly A&D and Telfa open areas Further review under "Hour entries on the following days: to bilateral feet daily - paying ulcer on right heel." Further AM" revealed blank entries on					

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	•	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			\$856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 514}	Continued From pa	ge 20	{F 5 <sup>-</sup>	4}			
		p.m. DON confirmed the reatments was not complete k entries.					
	facial treatment Tre consistently docum	ment sheet revealed that the etinoin 0.01% had not been ented and the reason for en documented on all 11 of 11 st 2014.					
	following treatment face q [every] HS [h	nt sheets identified the for R18: "Tretinoin 0.01% to nour of sleep]-may leave in e DX: [diagnosis] Facial cysts s."					
	indicated that the st offered on 6 of the the medicated skin days. There was not treatment administr the reason the treat or the reason R18 H skin treatment. Rev notes and nurses n revealed that the ph	eets dated 8/1/14 to 8/31/14, kin treatment had not been 11 days and R18 had refused treatment on the other 5 of 11 o documentation on the ration record which identified tment had not been provided had refused the medicated view of the physician progress otes from 8/1/14-8/11/14, hysician had not been notified een provided the Tretinoin kin treatment.					
	p.m. during which s documentation of tr and contained blan medication. The DC resident refused an	viewed on 8/12/14, at 3:31 she confirmed that the reatments was not complete k entries and refused DN further stated that if the by treatment the reason for the ocumented on the back of the					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	09/10/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		X3) DATE S COMPL	SURVEY
		245535	B. WING		R 08/12	2/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 514}	Continued From pa	ge 21	{F 514}			
F 520 SS=F	treatment record. 483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAN		F 520		1	0/3/14
	assurance committe nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the				
	committee meets a issues with respect and assurance activ develops and imple	nent and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of entified quality deficiencies.				
	disclosure of the re except insofar as si	retary may not require cords of such committee uch disclosure is related to the committee with the s section.				
		s by the committee to identify deficiencies will not be used as is.				
	by: Based on interview facility failed to ensi and Assurance (QA appropriate action p areas of concern du	NT is not met as evidenced and document review, the ure the Quality Assessment (&A) committee implemented plans for previously identified uring the recent recertification ring surveys in order to prevent		Jourdain Perpich Extended Care Ce will maintain a QAPI committee that consists of the DON, medical directo 3 other members of the facility staff. committee will meet at least quarter identify issues, with respect to which	or and This y to	

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	repeat quality deficiencies. This had the potential to affect all 40 residents residing in the facility. The Findings include: On 8/12/14, at 7:45 p.m. the facility plan of correction (POC) was reviewed with the director of nursing (DON). The POC indicated the DON		F 5	20	quality assurance activities are neo and develop and implement approp plans of action to correct the identii quality deficiencies. The QAPI com will address at a minimum incident accident reporting, infection control medication and pharmacy services A. All audits will be completed as s	oriate fied mittee and l and	
	or designee would a and identify those a rehabilitation servic thereafter to ensure indicated staff educ regarding the prope and audits would be designee weekly x thereafter. Addition would be conducted they had been vacc On 8/12/14, at 8:10 rehabilitation notes the proper administ resident immunizat as indicated. Refer to F155 relate benefit education p refuses treatment. Refer to F309 relate	audit the rehabilitation notes at risk or have refusals of es x 4 weeks and monthly e compliance. The POC also cation would be provided er administration of Renvela e conducted by the DON or 4 weeks and then monthly nally, the POC indicated audits d on all residents to ensure			<ul> <li>A. All audits will be completed as s</li> <li>B. A QAPI meeting will be held on September 10th, 2014 to discuss a audit formats and findings.</li> <li>C. All issues will be added to the Q agenda.</li> <li>D. Plan of correction will be monito the director of nursing and adminis QAPI will continue to meet on a mo basis, but minimally quarterly.</li> </ul>	ll tags, API red by trator,	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			I.		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTIO		COM	E SURVEY IPLETED
		245535	B. WING _				R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS	, CITY, STATE, ZIP CODE		
	IN PERPICH EXT CA			24856 HOSPITAL	DRIVE		
JOONDA				REDLAKE, MN	56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	DER'S PLAN OF CORRECTIO ORRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	S	{F 000	)}			
{F 155} SS=D	of this department of determine complian issued during a rec May 22, 2014. Dur regulations were de	was conducted by surveyors on August 11, 12, 2014, to nee with Federal deficiencies ertification survey exited on ring this visit the following etermined to be not corrected. T TO REFUSE; FORMULATE TVES	{F 15	;}			10/3/14
	refuse to participate and to formulate an	e right to refuse treatment, to a in experimental research, advance directive as aph (8) of this section.					
	specified in subpart related to maintaini procedures regardin requirements include provide written infor concerning the righ or surgical treatmen option, formulate an includes a written d	mply with the requirements I of part 489 of this chapter ng written policies and ng advance directives. These le provisions to inform and rmation to all adult residents t to accept or refuse medical at and, at the individual's n advance directive. This escription of the facility's nt advance directives and w.					
	by: Based on interview facility failed to doc risks and benefits of services for 1 of 3 r	NT is not met as evidenced and document review, the ument education regarding f refusing restorative therapy esidents (R23) reviewed for		wishes rega A. R23 will t	erpich honor all resider Irding refusal of care. De re-evaluated by ther document re-assessme	ару,	(X6) DATE
	ically Signed	LINGUFFLIER REFREGENTATIVE 5 5101	VALUKE			00/05	/2014
	ically cigited					U7/U3	12014

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

PRINTED: 09/10/2014

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				२ 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 155}	therapy. Findings include: R23's significant ch (MDS) dated 4/25/1 diagnoses that inclu hemiparesis, and P also indicated R23 impairment and req person for bed mob the corridor. The N one-sided upper ex participated in a res active range of mot R23's progress note the physical therapi aide continue strend and passive range extremity along with wheeled walker and tolerated 3-6 times R23's care plan dat required strengther left upper extremity and passive range extremity 3-6 times directed staff to am wheeled walker 3-6 Review of R23's Red dated 7/1/2014, to 7 refused rehabilitativ 7/8, 7/9, 7,11, 7/15, opportunities). It al	ange Minimum Data Set 14, indicated R23 had uded stroke, hemiplegia or varkinson's disease. The MDS had moderate cognitive guired extensive assist of 1 bility, transfer, and walking in 1DS further indicated R23 had tremity impairment and storative nursing program for ion and walking. e dated 2/10/14, and signed by ist recommended the rehab gthening to lower extremities of motion to right upper n ambulation with forward d the assistance of one staff as per week. ted 7/30/14, indicated R23 hing exercises as tolerated to and both lower extremities of motion to right upper per week. The care plan bulate R23 with forward	{F 15	55}	Nursing rehab aides will be re-educ on the importance of complete documentation. B. All records were reviewed for ref of care. Nursing rehab aids will doc all refusals of therapy and resident education regarding risk vs benefit. Documentation shall reflect attemp determine root cause of refusal and up per policy and procedure. C. Will review policy and procedure update as needed. Education will be provided to staff at the nursing mee September 8, 2014. DON or design audit the rehabilitation notes and id those that are at risk or have refusa rehabilitation services x 4 weeks ar monthly there after to ensure comp D. The plan of correction will be mo by the DON or designee and report QAPI Committee at least quarterly.	ts to d follow e and e entify als of d liance. onitored	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
()(4) (D	SUMMARY STA	TEMENT OF DEFICIENCIES		ĸ	PROVIDER'S PLAN OF CORRECTION	N	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 155}	Continued From pa	ge 2	{F 1	55}			
	dated 8/1/2014, to 8 refused rehabilitativ opportunities). It al the following days 8 8/12 (6 of 8 opportu On 8/12/14, at 4:26 stated R23 frequen services. NA-H ind bed most of the day able to get R23 to a room needed to be this no longer work ambulated to appoi had an appointmen Rehabilitation Treat August 2014, were confirmed R23 refu July and 1 of 8 oppo	p.m. nursing assistant (NA)-H tly refused rehabilitation licated R23 preferred to stay in y. She stated she used to be attend rehab by telling him his cleaned, however, indicated ed. NA-H stated R23 ntments so she told him he t with her and that worked. Imment Sheets for July and reviewed with NA-H who sed 10 of 23 opportunities in ortunities in August. NA-H ak entries on 4 of 23 days in					
		d documentation that g the risk of refusing therapy R23.					
	confirmed documer	m. director of nursing (DON) ntation regarding the risk and herapy was not available in					
{F 159} SS=E	was requested but	CILITY MANAGEMENT OF	{F 1!	59}			10/3/14
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: ISKC12	2	Fac	cility ID: 00355 If continua	tion sheet	t Page 3 of 36

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 159}	Upon written author facility must hold, s account for the pers deposited with the f paragraphs (c)(3)-(4) The facility must de funds in excess of S account (or accoun the facility's operatia all interest earned of account. (In pooled separate accountion The facility must material funds that do not ex- bearing account, in petty cash fund. The facility must est that assures a full a accounting, accordia accounting principle funds entrusted to the behalf. The system must p resident funds with of any person other The individual finan through quarterly st the resident or his of The facility must no Medicaid benefits w resident's account of	rization of a resident, the afeguard, manage, and sonal funds of the resident facility, as specified in		59}			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2014 APPROVED 0938-0391		
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED		
		245535	B. WING				२ 1 <b>2/2014</b>		
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
JOURDA	AIN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
{F 159}	section 1611(a)(3)(I amount in the acco the resident's other reaches the SSI res resident may lose e This REQUIREMEN by: Based on interview facility failed to ensu- trust fund accounts their money after bu- the weekends. This of 40 residents resi- personal trust funds Findings include: The administrator w 11:00 a.m. and stat arrangements for m medication room sc access to money af weekend the charg the residents reque administrator further resident could acce emergency purpose purchase candy or emergency and did accommodated. Review of the faciliti Fundi-Emergency of following: "Norma	B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, source limit for one person, the eligibility for Medicaid or SSI. NT is not met as evidenced and document review, the ure residents with personal with the facility, had access to usiness office hours and on a had the potential to affect 31 ding in the facility who had a accounts with the facility.	{F 1	59}	Resident Trust Funds are protecte available for resident use. A. The availability of money on wee and evenings will be maintained thr money bag locked on the nurses ca Nurses will have a listing of those residents with funds available. B. Funds are available for all reside with trust accounts. Business office provide nursing staff with an update of those residents with funds availa a weekly basis. C. Policy and procedure was review and updated on 8-22-14. Language changed to eliminate the word eme and allow for residents to use for ar reason. D. The plan of correction will be mo by the Administrator and the results reported to the QAPI Committee at quarterly.	ekends rough a art. ents e will ed list ible on ved e was ergency ny onitored s will be			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING _			२ 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
{F 159} {F 279} SS=D	Resident trust funds hours. Trust funds or emergencies on ev PROCEDURES 1. staff of the need for pop, bag of chips, of considered an eme exists, the nurse wi has funds available provided by the bus will be available in t Room" During further inter 8/12/14, at 11:00 a. that funds for the re holds in trust only n emergency basis. 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s	s are available during these will be available for enings and weekends. Resident will contact nursing emergency funds. A can of or pack of cigarettes is not rgency. 2. If an emergency Il check to see if the resident for withdrawal. The list will be siness office. If so the funds he lock box in the Medication wiew with the administrator on m. he stated that he thought esidents whom the facility eeded to be available on an ()(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	{F 15			10/3/14

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245535			R 08/12/2014	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	12/2014
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 279}	due to the resident' §483.10, including under §483.10(b)(4 This REQUIREMEI by: Based on interview facility failed to dev plan for the care of with Clostridium dif Findings include: R59's Hospital Disc indicated R59 was difficile colitis (a typ chronic stage IV sa R59's Interagency indicated an order f milligrams (an antik C-diff) one tablet by 8/14/14. R59's care plan lac infection, control pr transmission of C-o the care of R59's in On 8/12/14, at 6:11 (DON) confirmed th on R59's care plan expected interventi infection be addres	s exercise of rights under the right to refuse treatment ). NT is not met as evidenced v and document review the elop a comprehensive care 1 of 1 resident (R59) identified ficile (C-diff). charge Summary dated 8/6/14, diagnosed with Clostridium be of infectious diarrhea) and a cral pressure ulcer. Transfer Orders dated 8/6/14, for metronidazole 500 biotic medication used to treat v mouth 3 times a day until ked identification of the otocols to minimize the risk of diff and interventions to direct affection. p.m. director of nursing nat C-diff was not addressed . She stated she would have ons specific to R59's C-diff sed on the care plan. comprehensive policy dated	{F 279	<ul> <li>Jourdain Perpich performs comprehensive care planning wi interdisciplinary care team. (IDT A. R59's status is stable, she wa currently symptom free. Care pla updated to reflect history of C-di B. All residents were audited reg bowel status. Care plans on thos residents that have a history of C been updated.</li> <li>C. Staff education will be provide importance of reporting unusual status incidents on September 8 Audit completed on every reside bowel symptoms. DON or design monitor new admissions or read with diagnosis of C-diff to ensure plans include interventions.</li> <li>D. The plan of correction will be by the DON or designee and rep the QAPI committee at least quare</li> </ul>	s and is an ff. arding se C-diff have ed on the bowel th, 2014. nt for nee will missions that care monitored orted to	

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· /	E SURVEY
	of correction	IDENTIFICATION NOWDER.	A. BUILDII	NG		R
		245535	B. WING _			12/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
{F 279}	for the review and u	updating of care plans when en readmitted to the facility	{F 27	9}		
{F 282} SS=E	483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	{F 28	2}		10/3/14
	must be provided b	ded or arranged by the facility y qualified persons in ach resident's written plan of				
	by: Based on observat review, the facility f written care plan fo required incontinen interventions to mir 3 residents (R4) re weight loss who red for 1 of 3 residents repositioning to mir a pressure ulcer, an who required medic Findings include: R3 was at risk for fa implement a person the plan of care. R3's undated, Dise R3's diagnoses incl weakness affecting	alls and the facility failed to hall clip alarm as directed by asse Index Report indicated luded quadriplegia (muscle all four limbs), contracture of es and dysphagia pharyngeal		Jourdain Perpich will provide se accordance with each residents plan of care. A. R-3's care plan has been revie updated. The clip alarm has bee discontinued. Observation audits been implemented to assure time incontinence care. Addistionally, ongoing hourly visual checks to a safety.Staff have been educated need to follow residents care pla regarding incontinence care. A 3 bowel and bladder assessment r that there were no specific patter resident did not feel the need to communicate that need. R4 Plea to F325 for details. R30 please refe for details. B. All residents will be reviewed to that appropriate incontinence care provided as per the care plan wit focus being on incontinent reside residents will be reviewed to ens	written ewed and h have ely R3 has assure on the n day evealed on and void or lse refer efer to er to F309 to ensure re is h the ents. All	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		045505				२
		245535	B. WING _			2/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
{F 282}	Continued From pa	ige 8	{F 282	2}		
	risk for falls and dir clip alarm on when and when in bed. I falls/safety checks care plan also indic elimination for both directed staff to che hours, offering him these times. On 8/12/14, at 8:45 in a tilt back wheeld area. No personal alert staff when the attached to R3 or F On 8/12/14, at 9:00 wheeled R3 back to alarm was observe frame. NA-A and N R3 back to bed with mechanical lift. R3 was dry, however, I or a urinal. NA-A a to R3's right should placed in the low po the mattress on the on the floor by R3's -At 10:32 a.m. NA-, room and reposition confirmed the last to conducted on R3 w 23 minutes).	a.m. nursing assistant (NA)-A o his room. A personal clip d to be affixed to R3's bed IA-B were observed to transfer in the assistance of a 's brief was checked which R3 was not offered a bedpan ttached the personal clip alarm ler of his shirt. The bed was osition, a wedge placed under e right side and a mat placed a bed. A was observed to enter R3's ned a blanket. NA-A time a safety check had been vas at 9:09 a.m.(one hour and		they are receiving assist and food choices hono- be reviewed and updat residents receiving dial reviewed to ensure that the appropriate medical documentation comple C. Audits will be utilized compliance All house a completed of all other r care plans match care services provided. The 10% of all residents an remaining residents sho until 100% of resident of are being completed as the care plan. Staff edu provided on September all staff meeting. D. DON or designee wi and compliance daily x weekly x 2 weeks, then or until 100% complian report findings to QAPI	red, care plans will ed as needed. All ysis will be t they are receiving tions and te. d to ensure udits have been esidents to assure delivery guids and reafter every week, d 10% of the all be done weekly care interventions s documented in acation will be r 10th, 2014 during Il monitor audits 7, then twice weekly x 2 weeks ce achieved. Will	
	enter R3's room an his wheelchair they dry, however, neith	A and NA-C were observed to d prior to transferring him to checked his brief and he was er NA-A or NA-C offered R3 a al. Once in the chair, NA-A				

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		AND HUMAN SERVICES				FORM	: 09/10/2014 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	СОМ	E SURVEY IPLETED
		245535	B. WING	;			R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 282}	hallway. A clip alarn chair. - At 11:06 a.m. NA- about the missing p remained affixed to personal clip alarm and when up in the verified in the morn first been put back to personal clip alarm wheelchair. NA-A st had been left affixed should have been n he was transferred On 8/12/14, at 3:30 (DON) confirmed R place a personal cli seated in a wheelch every one hour, che hours and to offer a times. The DON ve staff to follow R3's ve R4 required assista facility failed to prov by the plan of care. R4's Face Sheet da diagnoses of diabet blindness of both ey R4's care plan, date	his room and ten feet down the m was not placed on R3 or his A was queried by the surveyor bersonal clip alarm which R3's bed. NA-A verified the should be on R3 when in bed wheelchair. NA-A also ing at 9:00 a.m. when R3 had to bed, R3 had not had a on when he was up in the tated the personal clip alarm d to R3's bed frame and it noved to the wheelchair when to the wheelchair. P.m. the director of nursing R3's care plan directed staff to ip alarm to R3 when he was hair, conduct safety/fall checks eck and change R3 every two a bedpan or a urinal at these erified her expectation was for written care plan.	{F 2	82}			
		aff to open and pour liquids,					

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		AND HUMAN SERVICES				FORM	: 09/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT CON	E SURVEY
		245535	B. WING	;			R / <b>12/2014</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 282}	explain food locatio and to guide R4's h Additionally, the pla feed him or offer as meal. The care plar alternative food as high protein foods ( increased portions desserts of pudding On 8/12/14, at 8:19 on the side of his be him and food debris not being assisted to cheerios and milk of stated he did not lik attempting to eat co On 8/12/14, at 11:3 seated on the side front of him. R4 was and stated he could consisted of bread potatoes, ice cream paper placemat. N entered the room a R4 stated he wante because they were not consume the ch did not like the chic No alternate food w	meat and butter bread) and in as on the face of a clock ands to the food locations. In indicated R4 refused staff to asistance with eating at each in also directed staff to offer needed, encourage intake of (offer eggs every AM), of meat and provide extra g/jello. a.m. R4 was observed seated ed with his meal tray in front of is lying on the floor. R4 was to eat breakfast and the carton were not opened. R4 the cold cereal and was bookies and crackers. 0 a.m., R4 was observed of the bed with his meal tray in is calling, "Help! Help! Help!" d not see his food. R4's lunch ed chicken pieces, mashed in and a brownie on a blue ursing assistant (NA)-A ind began assisting R4 to eat. ed to start with the desserts easiest for him to see. R4 did nicken, and NA-A stated R4 ken because it was too dry. vas offered to R4.	{F 2	82}			
		itioning assistance and the vide the service as directed by					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245535	B. WING				२ 1 <b>2/2014</b>
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From pa	ge 11	{F 28	82}			
	provide extensive a	ed 5/29/14, directed staff to ssist of one to turn and d every (relieve pressure) 2					
	her room seated in watching television. pressure ulcer to he -At 9:33 a.m. R30 v to the common area -At 10:19 a.m. R30 in the activity area. -At 10:50 a.m. R30 activity area. -At 11:19 a.m. R30 wheelchair while ea	was observed attending bingo continued to play bingo in the was observed to remain in her ting lunch in her room. remained seated in her					
		7 p.m. R30 stated she had r since she got up at around					
	long R30 was to sit repositioned but inc be in the nursing as	stated she wasn't sure how up before she was licated the information would ssistant book. NA-I also worked at the facility for 3					
	she wanted to be re R30 could sit up as until her hip got sor been up in her whe further stated she h	J stated R30 told staff when epositioned. NA-J also stated long as 4 hours at a time or e. NA-J confirmed R30 had elchair since 9:15 a.m. NA-J had not been told to encourage offload for her pressure					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245535	B. WING			R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 282}	Continued From pa ulcer.	ge 12	{F 282	}		
	observed to put R3	6 p.m. NA-I and NA-J were 0 back to bed after she had elchair for 3 hours and 21				
	should have been r	8 p.m. the DON stated R30 epositioned or offloaded every by the plan of care.				
	R46's medication a according to the write	dministration was not provided tten care plan.				
	R46 was diagnosed dialysis treatments. order for Renvela (a phosphorous in die phosphorous levels	ers signed 6/30/14, indicated with diabetes with routine The order's also indicated an a medication used to bind ary intake and normalize in patients who have renal ams (mg) 2 tablets 3 times a snacks.				
	indicated R46 recei	re plan dated 6/19/14, ved Renvela and directed staff times a day with meals and				
	for August 2014, re R46's Renvela med PM, AM snack, PM five times per day. 2014 revealed that Renvela during sna August 2, 3, 4, 6, 7, not administered du	dministration Record (MAR) evealed the times to administer lication were at "7AM, 11AM, 5 snack." This was a total of Review of the MAR for August R46 had not received the ck times in the morning on 8 and 11. The Renvela was uring the afternoon snack on nd it was documented as				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. (							
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245535	B. WING			R 1 <b>2/2014</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 282}	include supporting of the medication was orders. The DON was inter a.m. and confirmed was not provided ac plan for R46. The facility's Care F	ge 13 4, 5 and 6. The MAR did not documentation to indicate why not administered per the viewed on 8/12/14, at 9:09 R46's Renvela medication ccording to the written care	{F 28	32}			
{F 309} SS=D	plan would be deve medical, mental and The Care Plans - C October 2012, did r utilize the care plan 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high	loped to meet the resident's d psychological needs omprehensive policy dated not direct the staff how to CARE/SERVICES FOR	{F 30	09}		10/3/14	
	accordance with the and plan of care. This REQUIREMEN by: Based on interview facility failed to ensu- kidney dialysis was according to physic	NT is not met as evidenced and document review, the ure medication related to consistently provided ian's orders for 1 of 1 resident e reviewed for end stage		Jourdain Perpich will provide care/services to maintain or attain thighest well being. A. R46's medication administration schedule has been reviewed and reviewed			

Facility ID: 00355

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		AND HUMAN SERVICES			FORM	09/10/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COM	E SURVEY PLETED	
		245535	B. WING _			२ 1 <b>2/2014</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN PERPICH EXT CA	RE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309}	indicated R46 was or renal disease (ESR mellitus. R46's physician or Renvela (a medication in dietary intake and levels in patients will (mg) 2 tablets 3 times snacks. R46's care plan date received dialysis treat and was prescribed times a day with me plan also indicated medication after see R46's Medication A for August 2014, re R46's Renvela medic PM, AM snack, PM Review of the MAR that R46 had not re snacks on August 2 Renvela was not ac snacks on August 2 R46 refused Renvel MAR did not include identified the reaso	RD). Acce visit form dated 8/5/14, diagnosed with end stage (D) and type II diabetes ders included an order for tion used to bind phosphorous d normalize phosphorous ho have ESRD) 800 milligrams tes a day and 2 tabs with teed 6/19/14, indicated R46 eatments three times per week d Renvela to be given three eals and with snacks. The care R46 could self administer the	{F 30!	<ul> <li>(9)</li> <li>current. All medication refusals by F shall be documented for root cause refusal. If a resident refusals inhibit effectiveness of the medication, PC be notified for direction.</li> <li>B. The policy and procedure for medication administration will be re and updated as needed. All residen receiving dialysis will have medicati regimens reviewed and care plans updated as needed, and have miss doses addressed as per R46.</li> <li>C. Facility will provide ongoing educt on appropriate medication administ through designated online education program to the staff. Staff responsite medication of Renvela, will monitor resident as to the medical necessity Renvela and provide education to ra s needed. Additional staff educatic be conducted on September 10, 20 medication administration of nutrier binding medications. Audits will be conducted daily x7days, 2x week x2 weeks, then weekly x2 or until 1009 compliance achieved.</li> <li>D. The plan of correction will be mothy the DON or designee and the rest reported to QAPI at least quarterly.</li> </ul>	e of the P shall viewed ts on ed cation ration n ole for / of esident on will 14 on nt 2 %		
	The director of nurs	sing (DON) was interviewed on					

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	09/10/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(3) DATE COM	E SURVEY PLETED	
		245535	B. WING	i			२ 1 <b>2/2014</b>	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0/12/2014	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 309}	8/12/14, at 9:09 a.m. and confirmed the MAR lacked documentation of why the medication was not administered.		۲3 (F	2				
{F 314} SS=D	F 314) 483.25(c) TREATMENT/SVCS TO SS=D PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.		{F 3	14}			10/3/14	
	by: Based on observat review, the facility for offloading (pressure and prevention for t pressure ulcers as of 2 residents (R30	NT is not met as evidenced tion, interview and document ailed to provide repositioning / e relief) to promote healing the further development of directed by the care plan for 1 ) identified with a current stage in loss with exposed bone, pressure ulcer.			Jourdain Perpich has a plan in place address possible pressure sores and provide for the treatment of skin brea down. A. R30's care plan was reviewed and remains current. All staff were educat on the updated policy and procedure specifically, the need to off-load for a minimum of 2 minute while R30 is in chair as well as other residents as	k I ted and		
	Findings include: R30's undated Disease Index Report indicated R30's diagnoses included a pressure ulcer on the lower back, severe chronic kidney disease, diabetes and above knee amputation.				directed in the NA/R care book. B. All residents have been reviewed a those that are at risk have had their c plans reviewed and revised as neede Policy and procedure for pressure so reviewed and updated as needed. All NA/R care guides were audited to ass the guide corresponds to the individua offloading routines.	care ed. res l sure		

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STATEMENT	OF DEFICIENCIES F CORRECTION	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	` ´COM	E SURVEY PLETED
		245535	B. WING _				R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
{F 314}	Continued From page 16 R30's significant change Minimum Data Set (MDS) dated 5/23/14, indicated R30 had intact cognition, was non-ambulatory, required extensive assistance of two+ staff for bed mobility, extensive assistance of one staff member for toilet use, total staff assistance for transfers and had bilateral lower extremity limitation in functional range of motion. The MDS also indicated R30 had one stage 4 and one stage 3 (full thickness tissue loss with possible subcutaneous fat visible) pressure ulcers and also indicated R30 was on a turning and repositioning program.		{F 31	4}	<ul> <li>C. Staff education will be provide PUSH tool to monitor progress of pressure areas and wounds and repositioning as per the care plan September 8th, 2014 all nursing meeting.</li> <li>D. DON or designee shall do observational audits for offloadin residents with tissue tolerance of issues. Will complete audits daily days, then 3x week for 2 weeks, weekly x 2 weeks or until 100% compliance. Will report to QAPI a quarterly.</li> </ul>	f staff g on all <sup>r</sup> skin / x 5 then	
	to determine the le pressure without cl	ance Assessment (a tool used ength of time skin can withstand hange) dated 5/23/14, to be turned and repositioned e lying and sitting.					
	impaired skin integ required total staff mechanical lift, ha inability to transfer, independently. The reposition or offloa two hours, pressur	ated 5/29/14, indicated R30 had grity, was non ambulatory, assistance for transfer with d decreased mobility with , turn and reposition nor sit up e plan directed staff to turn and d (relieve pressure) R30 every re relieve air mattress on bed, a elchair cushion and right e in bed.					
	Healing discharge indicated R30 had ulcer and instructe	nidji Medical Center Wound summary signed 7/9/14, a coccyx and ankle pressure d staff to continue to limit the e and sitting on the coccyx and					

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	to continue to offloa ankle.	ge 17 ad any pressure on the right mission Assessment dated	{F 3	14}			
	7/23/14, indicated F which measured 3.	R30 had a coccyx wound 0 centimeters (cm) x 3.6 cm x ankle pressure ulcer which					
	Risk assessment d was at moderate ris attached Checklist Interventions dated	e for Predicting Pressure Sore ated 7/28/14, indicated R30 sk for pressure ulcers. The Of Skin Risk Factors & 7/28/14, indicated R30 was to sitioned every two hours.					
	bed, lying on her ba mattress was obser- At 9:15 a.m. R30 v seated in her electr has had the coccyx A pressure redistrib on R30's wheelchai -At 9:33 a.m. R30 v to the common area electric wheelchair. -At 10:19 a.m. R30 in the activity area. -At 10:50 a.m. R30 activity area. -At 11:19 a.m. R30 wheelchair while ea -At 11:59 a.m. R30 in the wheelchair.	vas observed in her own room, ic wheelchair. R30 stated she pressure ulcer for two years. oution cushion was observed ir seat. vas observed to wheel herself a by the nurses station in her					

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		AND HUMAN SERVICES				FORM	: 09/10/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245535	B. WING _				R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			6 HOSPITAL DRIVE DLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 314}	chair since about 9 stated sometimes h and said she tolera hours at a time. -At 12:10 p.m. nurs had worked at the f wasn't sure how lor often she was to be information would b information would b information book -At 12:24 p.m. NA- staff when she wan also stated R30 cou hours at a time with or until her hip got s been up in her whe had not been instru reposition or offload -At 12:36 p.m. NA-I assist R30 into bed remained seated in repositioning or offl minutes. On 8/12/14, at 12:3 (DON) confirmed R pressure ulcer to he care plan and skin required every two The DON stated R3 repositioned or offlo directed. The Prevention of F October 2010, indic usually formed whe	age 18 :15 a.m. that morning. R30 her bottom got sore from sitting te sitting up for a couple of sing assistant (NA)-I stated she facility for three weeks and hg R30 could sit up and how e repositioned but stated that be in the nursing assistant -J stated R30 would inform ted to be repositioned. NA-J uld sit up for as long as four hout repositioning or offloading, sore. NA-J confirmed R30 had belchair since 9:15 a.m. and ted to encourage R30 to d her pressure ulcer. I and NA-J were observed to I via a mechanical lift. R30 the wheelchair without loading for three hours and 21 88 p.m. the director of nursing R30 had a healing stage 4 er coccyx and verified R30's assessments indicated R30 hour repositioning / offloading. 30 should have been baded every 2 hours as Pressure Ulcers policy dated cated pressure ulcers were an a resident remained in the an extended period of time	{F 314	4}			

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY	
F CORRECTION	IDENTIFICATION NUMBER:				E SURVEY IPLETED	
					R	
	245535	B. WING _		08/	12/2014	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETIO DATE	
causing increased p circulation to that a destruction of tissue pressure ulcers we pressure. The polio the resident at leas and every two hour frequently when ne 483.25(h) FREE OF	oressure or decrease of rea and subsequent e. The policy also indicated re made worse by continuous cy directed staff to reposition t every hour when in a chair s when in bed or more eded. F ACCIDENT				10/3/14	
environment remain as is possible; and	ns as free of accident hazards each resident receives					
by: Based on observat review, the facility f implementation of f minimize the risk of (R3) identified at ris facility failed to ens for 1 of 3 residents who had a history of	tion, interview and document ailed to ensure consistent all interventions in order to further falls for 1 of 1 resident sk for falls. In addition, the ure side rails were removed (R12) reviewed for accidents of falls from bed and whose		ensure the safety of all residents A. R3's care plan has been upda reflect current alarm usage. Clip have been discontinued. Resider visual hourly checks on all shifts. had an assessment regarding his assistive devices, resident prefer sleep with his head at the bottom bed. He does utilize half siderails in self transferring and bed mobil B. All residents will be reviewed f assistive devices and care plans	ted to alarms at is on R12 has need for s to of the to assist ity. or		
	PROVIDER OR SUPPLIER IN PERPICH EXT CAL SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa causing increased p circulation to that a destruction of tissue pressure ulcers we pressure ulcers we pressure. The polid the resident at leas and every two hour frequently when ner 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and adequate supervision prevent accidents. This REQUIREMEN by: Based on observation review, the facility failed to ens for 1 of 3 residents who had a history of facility side rail asso unnecessary.	F CORRECTION IDENTIFICATION NUMBER: 245535 PROVIDER OR SUPPLIER IN PERPICH EXT CARE FAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 causing increased pressure or decrease of circulation to that area and subsequent destruction of tissue. The policy also indicated pressure ulcers were made worse by continuous pressure. The policy directed staff to reposition the resident at least every hour when in a chair and every two hours when in bed or more frequently when needed. 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 consistent implementation of fall interventions in order to minimize the risk of further falls for 1 of 1 resident (R3) identified at risk for falls. In addition, the facility failed to ensure side rails were removed for 1 of 3 residents (R12) reviewed for accidents who had a history of falls from bed and whose facility side rail assessment indicated they were unnecessary.	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDIN         245535       B. WING _         ROVIDER OR SUPPLIER       ID         IN PERPICH EXT CARE FAC       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 19 causing increased pressure or decrease of circulation to that area and subsequent destruction of tissue. The policy also indicated pressure ulcers were made worse by continuous pressure. The policy directed staff to reposition the resident at least every hour when in a chair and every two hours when in bed or more frequently when needed.       {F 323         483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES       {F 323         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         This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent implementation of fall interventions in order to minimize the risk of further falls for 1 of 1 resident (R3) identified at risk for falls. In addition, the facility failed to ensure side rails were removed for 1 of 3 residents (R12) reviewed for accidents who had a history of falls from bed and whose facility side rail assessment indicated they were unnecessary.	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245535       B. WING         IROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2455 HOSPITAL DRIVE       ZHEET ADDRESS, CITY, STATE, ZIP CODE         2456 HOSPITAL DRIVE       REDLAKE, MN 56671         SUMMARY STATEMENT OF DEFICIENCIES (REQUATORY OR LSC IDENTIFYING INFORMATION)       ID         PREFIX REDULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         Continued From page 19 causing increased pressure or decrease of circulation of that area and subsequent destruction of tissue. The policy also indicated pressure Ulcers were made worse by continuous pressure. The policy disco indicated pressure ulcers were made worse by continuous pressure. The policy disco indicated pressure Ulcers were made worse by continuous pressure. The policy Oracided Staff to reposition the resident at least every hour when in a chair and every two hours when in bed or more frequently when needed.       {F 323}         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.       Jourdain Perpich has a plan in p ensure the safety of all residents A. R3's care plan has been upda relicitly failed to ensure consistent implementation of fall interventions in order to minimize the risk of ralls. In addition, the facility faile to ensure cide rails were removed for 1 of 3 residents (R12) reviewed for accident who had a history of falls from bed and whose facility side real assessment indicated they were unnecessary.       Jourdain Perpich has a plan in p ensure the safe	F CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COW         A BUILDING       STREET ADDRESS, CITY, STATE, ZIP CODE       24856 HOSPITAL DRIVE       STREET ADDRESS, CITY, STATE, ZIP CODE         IN PERPICH EXT CARE FAC       STREET ADDRESS, CITY, STATE, ZIP CODE       24856 HOSPITAL DRIVE       REDULACE, IM S6671         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREVIDENCE NOT THE APPROPRIATE       COONDER CORRECTIVE ACTION POOR CORRECTION         REGULATORY OR LSC IDENTIFYING INFORMATION       PREFIX       TAG       PREFIX       CROSS-REFERENCED TO THE APPROPRIATE         Continued From page 19       causing increased pressure or decrease of circulation to that area and subsequent       (F 314)       CROSS-REFERENCED TO THE APPROPRIATE         Deressure Uncers were made worse by continuous pressure. The policy directed staff to reposition the resident teast every hour when in a chair and every two hours when in a chair and every two hours when in a chair and every two hours when in bed or more frequently when needed.       (F 323)         This REQUIREMENT is not met as evidenced by:       Seade on observation, interview and document review, the facility failed to ensure site and substance devices to prevent accidents.       Jourdain Perpich has a plan in place to ensure the safety of all residents. A R3's care plan has been updated to reflect current alarm usage. Clip alarms have been discontinued. Resident is on visual hourly checks on all shifts. R12 has had an assessment regidents in addition, the work of a history of falls frorm bed and whose facility side rail asseessment indicat	

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	IDENTIFICATION NUMBER: 245535 RE FAC		IG		PLETED
ERPICH EXT CAP		B. WING _			२
ERPICH EXT CAP	RE FAC				12/2014
SUMMARY STA	RE FAC		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
blement a person rt staff of attemp ated in the wheel 's undated, Disea s diagnosed with akness affecting ntracture of joints ase (difficulty with 's Fall Risk Evalu was at risk for fa 's quarterly Minin /14, indicated R3 bairment, require bility, total staff a bulatory and hac sessment. 's care plan date ( for falls and dire / safety visual ch R3 when seated e post scene inve icated R3 fell fro iries sustained. 8/12/14, at 8:45	al clip alarm (tab alarm) to ts to stand while he was chair. ase Index Report indicated R3 quadriplegia (muscle all four limbs), multiple and dysphagia pharyngeal in swallowing). attion dated 6/1/14, indicated alls. num Data Set (MDS) dated alls. num Data Set (MDS) dated assistance, was non a two or more falls since last d 6/5/14, indicated R3 was at extend staff to perform hourly necks and to clip a tab alarm in bed or the wheelchair. estigation report dated 7/3/14, m bed onto floor mat. No a.m. R3 was observed in the	{F 32:	<ul> <li>and updated. Side rail and fa assessments will be done at of admission, quarterly and y residents. Fall assessments completed after each fall. In alarms and incontinence car observation audits will be do x7days, bi-weekly x 2weeks thereafter until 100% compli achieved. Staff will be reedu procedures on completing at the September 8th, 2014.</li> <li>D. Plan of correction will be Director of nursing or design</li> </ul>	within 7 days yearly on all s will be reference to re-visual ine daily and weekly ance cated on ssessments monitored by iee and	
olination is solution is solution is solution in the solution is solution is solution in the solution in the solution in the solution is solution in the solution in the solution in the solution is solution in the solution in the solution in the solution is solution in the solution in the solution in the solution in the solution is solution in the solution in the solution in the solution is solution in the solutin the solution in the s	lement a person t staff of attemp ted in the wheel s undated, Disea diagnosed with kness affecting tracture of joints se (difficulty with s Fall Risk Evalu was at risk for fa s quarterly Minin 14, indicated R3 airment, require bility, total staff a bulatory and had essment. s care plan date for falls and dire (safety visual ch a when seated post scene inve- cated R3 fell fro- ries sustained. 8/12/14, at 8:45 n common area elchair without a 8/12/14, at 9:00 )-A was observe-	s care plan dated 6/5/14, indicated R3 was at for falls and directed staff to perform hourly safety visual checks and to clip a tab alarm R3 when seated in bed or the wheelchair. post scene investigation report dated 7/3/14, cated R3 fell from bed onto floor mat. No	<ul> <li>a undated, Disease Index Report indicated R3 diagnosed with quadriplegia (muscle kness affecting all four limbs), multiple tracture of joints and dysphagia pharyngeal se (difficulty with swallowing).</li> <li>a Fall Risk Evaluation dated 6/1/14, indicated was at risk for falls.</li> <li>a quarterly Minimum Data Set (MDS) dated 14, indicated R3 had severe cognitive airment, required extensive assist with bed bility, total staff assistance, was non bulatory and had two or more falls since last essment.</li> <li>a care plan dated 6/5/14, indicated R3 was at for falls and directed staff to perform hourly safety visual checks and to clip a tab alarm R3 when seated in bed or the wheelchair.</li> <li>post scene investigation report dated 7/3/14, cated R3 fell from bed onto floor mat. No ries sustained.</li> <li>B/12/14, at 8:45 a.m. R3 was observed in the n common area, seated in a tilt back elchair without a tab alarm in place.</li> <li>B/12/14, at 9:00 a.m. nursing assistant )-A was observed to wheel R3 back to his</li> </ul>	<ul> <li>and updated. Side rail and fa assessments will be done at of admission, quarterly and y residents. Fall assessments will be done at of admission, quarterly and y residents. Fall assessments will be done at of admission, quarterly and y residents. Fall assessment will be done at observation audits will be do x7days, bi-weekly x 2weeks thereafter until 100% compliance (difficulty with swallowing).</li> <li>a Fall Risk Evaluation dated 6/1/14, indicated was at risk for falls.</li> <li>a quarterly Minimum Data Set (MDS) dated 14, indicated R3 had severe cognitive airment, required extensive assist with bed bility, total staff assistance, was non vulatory and had two or more falls since last essment.</li> <li>a care plan dated 6/5/14, indicated R3 was at for falls and directed staff to perform hourly 'safety visual checks and to clip a tab alarm R3 when seated in bed on the wheelchair.</li> <li>post scene investigation report dated 7/3/14, cated R3 fell from bed onto floor mat. No ries sustained.</li> <li>B/12/14, at 8:45 a.m. R3 was observed in the ncommon area, seated in a tilt back elchair without a tab alarm in place.</li> <li>B/12/14, at 9:00 a.m. nursing assistant -A was observed to wheel R3 back to his</li> </ul>	<ul> <li>and updated. Side rail and fall assessments will be done at within 7 days of admission, quarterly and yearly on all residents. Fall assessments will be completed after each fall. In reference to alarms and incontinence care-visual observation audits will be monitored by 2 weeks and weekly thereafter until 100% completing assessments at the September 8th, 2014.</li> <li>b. Fall Risk Evaluation dated 6/1/14, indicated was at risk for falls.</li> <li>c. quarterly Minimum Data Set (MDS) dated 14, indicated R3 had severe cognitive airment, required extensive assist with bed bility, total staff assistance, was non sulatory and had two or more falls since last essment.</li> <li>c. care plan dated 6/5/14, indicated R3 was at for falls and directed staff to perform hourly safety visual checks and to clip a tab alarm R3 when seated in bed onto floor mat. No rise sustained.</li> <li>8/12/14, at 8:45 a.m. R3 was observed in the normon area, seated in a tilt back elchair without a tab alarm in place.</li> <li>8/12/14, at 9:00 a.m. nursing assistant - A was observed to wheel R3 back to his</li> </ul>

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			R 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 323}	bed frame. NA-A ar transfer R3 into bed attached the alarm shirt. The bed was wedge was placed right side and a ma to R3's bed. -At 10:32 a.m. NA-A room and reposition stated the last time conducted on R3 w 23 minutes earlier). At 10:58 a.m. NA-A enter R3's room, ch transfer him into the mechanical lift and A tab alarm was no On 8/12/14, at 11:0 not have an alarm i the wheelchair and have been moved t On 8/12/14, at 3:30 (DON) confirmed R place a tab alarm o wheelchair. R12 was observed side rails and the fa and failed to assess R12's care plan, da diagnoses included care plan also indic decreased mobility.	nd NA-B were observed to d via a mechanical lift. NA-A to R3's right shoulder of his s placed in the low position, a under the mattress on the at was placed on the floor next A was observed to enter R3's n a blanket. At this time, NA-A a visual safety check was vas at 9:09 a.m.(one hour and A and NA-C were observed to neck R3's incontinent brief and e tilt back wheelchair via the wheel R3 out into the hallway. of applied to R3. 16 a.m. NA-A verified R3 did in place when assisted into stated his bed alarm should to his wheelchair. 0 p.m. the director of nursing R3's care plan directed staff to on R3 when seated in the to utilize bilateral, lower bed acility was unaware of their use	{F 323}			

If continuation sheet Page 22 of 36

STATE MENT OF DEFICIENCES         IXI DESCRIPTION		-	AND HUMAN SERVICES			FORM	09/10/2014 APPROVED 0938-0391
245535         B. WING         08/12/2014           NAME OF PROVIDER OR SUPPLIER         JURDAIN PERPICH EXT CARE FAC         Street ADDREss, CITY, STATE, JP CODE           JOURDAIN PERPICH EXT CARE FAC         Z486 HOSPTIAL DRIVE REDLAKE, IMN 56671         Convertion           PREFIX         BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MS TB EPRECEDED BY FULL TAG         PREFIX REDLATORY OR LISC DENTIFYING INFORMATION)         Dr. D. PREFIX         PREFIX (EACH DEFICIENCY STATE - PROPRIATE DEFICIENCY)         COMMETS ILANOF CORRECTION (EACH DEFICIENCY BE PRECEDED BY FULL TAG         PREFIX (F 323)         Continued From page 22 (F 323)         D. PREFIX         PREFIX (EACH DEFICIENCY)         COMMETS ILANOF CORRECTION (EACH DEFICIENCY)	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
JOURDAIN PERPICH EXT CARE FAC         24856 HOSPITAL DRIVE REDLATOR ACK, INN 56671           (Y4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY FULL REDLATORY OR LISC IDENTIFYING INFORMATION)         ID PREFIX TAG         PREFIX (EACH DEFICIENCY MST BE PRECEDED BY FULL REDLATORY OR LISC IDENTIFYING INFORMATION)         ID PREFIX TAG         PREFIX (EACH DERIVER X EATON SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMMENTION (EACH DEFICIENCY TAG         PREFIX TAG           (F 323)         Continued From page 22 lacked indication of the use or need of side rails. R12's undated Side Rail Assessment form indicated R12 had weakness, orthostatic hypotension and a balance deficit. The conclusion of the assessment indicated side rails were not indicated. R12's Falls Risk Assessment dated 7/13/14, and 7/29/14, indicated R12 was at high risk for falls. Rview of R12's nursing progress notes revealed multiple recent falls: -7/29/14, R12 fell between bed and tweeknekar. -7/31/14, 9:00 a.m. R12 fell attempting to ambutate in the haliway, and at 12:20 p.m. R12 fell in room while saferifuransfer. -6/28/14, R12 was found lying on floor in front of bed.         Fill Sign Sign Sign Sign Sign Sign Sign Sign			245535	B. WING			
JOURDAIN PERPICIE KXT CARE FAC     REDLAKE, NN 56671       (Ma) ID PREFIX TAC     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PROVIDER'S INCORRECTIVE ACTION BIOLD BE CORDERCTIVE ACTION BIOLD BE CROBSREETED TO THE APPROPRIATE DEFICIENCY ON LISC DENTIFYING INFORMATION)     ID PREFIX TAS     PROVIDER'S NUM OF CORRECTION (EACH DEFICIENCY BENDER'S ACTION IEACH ORCENT'S ACTION BIOLD BE CROBSREETER BUT THE APPROPRIATE DEFICIENCY     COMMATION (COMMATION DEFICIENCY       (F 323)     Continued From page 22 lacked indication of the use or need of side rails. R12's undated Side Rail Assessment form indicated R12 requested side rails for repositioning, bed weakness, orthostatic hypotension and a balance deficit. The conclusion of the assessment indicated side rails were not indicated. R12's Falls Risk Assessment dated 7/13/14, and 7/29/14, Indicated R12 was a thigh risk for falls. Review of R12's nursing progress notes revealed multiple recent falls: -7.29/14, R12 fell between bed and wheelchair. -7.713/14, 900 a.m. R12 fell attempting to ambulate in the hallway, and at 12:20 p.m. R12 fell in room while attempting as elf-transfer. -6/28/14, R12 fell between bed and rtry table. -6/28/14, R12 was found lying on floor in front of bed.     On 8/12/14, R12 was found lying on floor in front of bed.       On 8/12/14, R12 was found lying on floor in front of bed.     Do 8/12/14, R12 was observed sated on the side of his bed dinking socia. R12 exhibited poor trunk control and was falling backward onto his bed. Bilateral quarter side rails were observed raised on the lower, foot ends of the bed.     At 11:02 a.m. R12 was observed histed side rails were observed to remain raised.	NAME OF	PROVIDER OR SUPPLIER					
PREFIX TAG       (EACH DEFRCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTURE ACTION SHOULD BE CROSS-REFERENCE TO THAT APPROPRIATE       COMMETTION SHOULD BE CROSS-REFERENCE TO THAT APPROPRIATE         (F 323)       Continued From page 22 lacked indication of the use or need of side rails.       (F 323)         R12's undated Side Rail Assessment form indicated R12 requested side rails for repositioning, bed mobility and independent bed control access as needed. The form also indicated R12 had weakness, orthostatic hypotension and a balance deficit. The conclusion of the assessment indicated side rails were not indicated.       R12's Falls Risk Assessment dated 7/13/14, and 7/29/14, indicated R12 was at high risk for falls.         Review of R12's nursing progress notes revealed multiple recent falls: -7/13/14, 9:00 a.m. R12 fell attempting to ambulate in the hallway, and at 12:20 p.m. R12 fell in room while attempting a self-transfer. - 6/21/14, R12 was found lying on the floor next to the bed.         On 8/12/14, at 10:10 a.m. R12 was observed seated on the side of his bed drinking soda. R12 exhibited poor trunk control and was falling backward onto his bed. Bilateral quarter side rails were observed raised on the lower, foot ends of the bed.         On 8/12/14, at 10:10 a.m. R12 was observed seated on the side of his bed drinking soda. R12 exhibited poor trunk control and was falling backward onto his bed. Bilateral quarter side rails were observed raised on the lower, foot ends of the bed.         At 11:02 a.m. R12 was observed lying in bed on his left side. The lower, bed side rails were observed to remain raised.	JOURD	AIN PERPICH EXT CA	RE FAC				
Iacked indication of the use or need of side rails.         R12's undated Side Rail Assessment form indicated R12 requested side rails for repositioning, bed mobility and independent bed control access as needed. The form also indicated R12 had weakness, orthostatic hypotension and a balance deficit. The conclusion of the assessment indicated side rails were not indicated.         R12's Falls Risk Assessment dated 7/13/14, and 7/29/14, indicated R12 was at high risk for falls.         Review of R12's nursing progress notes revealed multiple recent falls: -7/29/14, R12 fell between bed and wheelchair. -7/13/14, 9:00 a.m. R12 fell attempting to ambulate in the hallway, and at 12:20 p.m. R12 fell in room while attempting a self-transfer. - 6/28/14, R12 fell between bed and tray table. - 6/21/14, R12 was found lying on the floor next to the bed.         On 8/12/14, R12 was found lying on floor in front of bed.         On 8/12/14, at 10:10 a.m. R12 was observed seated on the side of his bed drinking soda. R12 exhibited poor trunk control and was falling backward onto his bed. Bilateral quarter side rails were observed raised on the lower, foot ends of the bed.         At 11:02 a.m. R12 was observed lying in bed on his left side. The lower, bed side rails were observed to remain raised.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
	{F 323}	lacked indication of R12's undated Side indicated R12 require positioning, bed r control access as m indicated R12 had hypotension and a conclusion of the as were not indicated. R12's Falls Risk As 7/29/14, indicated F Review of R12's nu multiple recent falls -7/29/14, R12 fell b -7/13/14, 9:00 a.m. ambulate in the hal fell in room while at - 6/28/14, R12 fell b -6/19/14, R12 was the bed. -6/19/14, R12 was the bed. On 8/12/14, at 10:1 seated on the side exhibited poor trunk backward onto his I were observed rais the bed. At 11:02 a.m. R12 w his left side. The low observed to remain	the use or need of side rails. Rail Assessment form ested side rails for nobility and independent bed eeded. The form also weakness, orthostatic balance deficit. The ssessment indicated side rails sessment dated 7/13/14, and R12 was at high risk for falls. rrsing progress notes revealed : etween bed and wheelchair. R12 fell attempting to lway, and at 12:20 p.m. R12 tempting a self-transfer. between bed and tray table. found lying on the floor next to found lying on floor in front of 0 a.m. R12 was observed of his bed drinking soda. R12 control and was falling bed. Bilateral quarter side rails ed on the lower, foot ends of was observed lying in bed on wer, bed side rails were raised.	{F 323}			

Facility ID: 00355

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	09/10/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED			
		245535	B. WING			F 08/1	< 2/2014		
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
JOURDA	IN PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
{F 323} {F 325} SS=D	each resident on a stated she was uns Assessment was th asked about the rai stated she understo A policy regarding s requested, none wa	supposed to be completed for quarterly basis. The DON ure if R12's undated, Siderail e most current or not. When ls on R12's bed the DON bod the problem. siderail assessments was as provided.	{F 3: {F 3:				10/3/14		
	resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t	cility must ensure that a stable parameters of nutritional y weight and protein levels,							
	by: Based on observat review, the facility fa (R4) who had exper loss was assessed provided alternate n	NT is not met as evidenced ion, interview and document ailed to ensure 1 of 3 residents rienced a significant weight for their food preferences, neal items and provided ing at meals to promote			Jourdain Perpich will ensure that all residents maintain acceptable parame of nutritional status unless medically explainable and receive a therapeutic when there is a nutritional problem. A. R4 has been reviewed and care pla updated. Residents food preferences have been documented and his plan care updated to indicate staff will tell h his food set up on his plate based on hour clock.	c diet an of him			

Event ID: ISKC12

Facility ID: 00355

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245535			F 08/1	२   <b>2/2014</b>
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/2014
JOURDA	IN PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
{F 325}	Continued From pa	age 24	{F 325	B. All residents will be monitore	ed for	
	diagnoses included blindness of both e R4's quarterly Minir 7/4/14, indicated R4 required limited ass had a weight loss of 30 days or 10% in t not on a planned w Area Assessment ( R4 was only able to explanation of food clock and guidance the foods at mealtin R4's care plan, date an alteration in nutr retinopathy/neuropa loss in last 180 day and refusal of nutrin plan indicated R4's (pounds). The plan independent in eati tray, opened and por (cut meat and butter location as on the f hands to food locat indicated R4 refuse assistance with eat plan also directed s needed, encourage (offer eggs every A	mum Data Set (MDS), dated 4 had impaired cognition, sistance of one staff to eat, of greater than 5% in the last the last six months and was eight loss program. R4's Care CAA), dated 7/4/14, indicated o see shapes, required an I location as if on the face of a e of his hands to the position of		significant weight loss by the re- dietitian on a quarterly basis un is a significant weight loss note at least a monthly basis. Nursin notify registered dietitian of all noted to have significant weigh Residents that have inaccurate will be reweighed. All residents a food preference sheet compl available to all staff responsible preparation and serving of resid C. Policy and procedure was re- and updated reflecting reweigh education will be provided on S 2014. Education of all staff will review of policy and procedure relates to meal preparation and resident assist if indicated. D. Plan of correction will monito observation daily x7days, 3x we week, then weekly until 100% of with resident service achieved designee. QAPI will be updated least quarterly.	egistered less there d then on og staff will residents t loss. weights shall have eted and e for the dent meals. eviewed ts. Staff rept 10th, include as it I need for pred by eekly x 1 compliance by DON or	

If continuation sheet Page 25 of 36

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	COM	E SURVEY PLETED
		245535	B. WING				R 1 <b>2/2014</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 325}	6/26/14, indicated F weight loss in the la recommended a dia additional Medical N Re-Assessment for try mighty shakes twi indicated R4's weigi ideal body weight of R4's medical therap 8/7/14, indicated R4 fluctuate. The note was a significant los 180 days, if accurat refused the mighty continue same plan calories at meals un assessments did no preferences. On 8/12/14, at 8:19 on the side of his be front of him and foo was not being assis and had not opened R4 stated he did no observed attemptin -At 9:15 a.m. R4 wa facing the window. room floor including be chocolate cake. name was called. -At 11:30 a.m. R4 w side of the bed, awa was placed in front of breaded chicker cream and a brown R4 stated he could	R4 had experienced a 23% ast 6 months and et change to regular. An Nutrition Therapy rm, dated 6/26/14, indicated to wice daily. In addition, the form th was 175 lbs and had an	{F 3.	25}			

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING	i			२ 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 325}	(NA)-A entered the to eat. R4 stated he desserts because th see. R4 did not cor stated R4 did not lik dry for him." NA-A no alternate food ite than the chicken. On 8/12/14, at 11:0 (WC)-B, stated R4 vegetable beef and not like cold cereal same time, licensed stated these were F During a telephone p.m. Cook (C)-A sta and was usually giv menu. C-A stated F oatmeal was availa that. C-A stated nur know what R4's foo kitchen staff were u dislikes. C-A stated request an alternate for him today. LPN telephone interview a food likes and dis supposed to be cor had never seen the During a telephone p.m. the registered unlikely R4 was ass via the food likes ar offering choices of thim, as he refused	ge 26 room and began assisting R4 e wanted to start with the hey were easiest for him to nsume the chicken, and NA-A ke the chicken, as it was "Too stated R4 liked soup, however em was offered to him other 1 a.m. ward clerk / NA preferred soups, especially tomato. WC-B stated R4 did and preferred oatmeal. At the d practical nurse (LPN)-A also R4's food preferences. interview on 8/12/14, at 1:09 ated R4 was on a regular diet ren whatever was on the R4 drank a lot of milk and said ble in morning if he wanted sing staff needed to let them of preferences were as the maware of the likes and no one came to the kitchen to e meal at breakfast or lunch -A was present during the and stated she was aware of likes form dietary was mpleting for the residents, but form on the resident charts. interview on 8/12/14, at 4:20 dietician (RD) stated it was sessed for food preferences and dislikes form and that food would be important for supplements. The RD stated use every other week and tried	{F 3	25}	}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURV COMPLETE R 08/12/20	STATEMENT (	
245535 B. WING 08/12/20	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PF	
JOURDAIN PERPICH EXT CARE FAC 24856 HOSPITAL DRIVE REDLAKE, MN 56671	JOURDAII	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 	PRÉFIX	
(F 325)       Continued From page 27 to watch R4 eat as able, but was unsure if the staff "consistently" offered him food choices.       (F 325)         Policies regarding weight loss and food preference assessment were requested at approximately 4:20 p.m. on 8/12/14. A blank form entitled Resident Initial Nutritional Visit Form - Red Lake Hospital/Health Care Facility, dated 3/08, was provided that included a place to record preferred breakfast foods and other likes/disilkes.         A policy entitled Nutritional Visit Form - Red Lake Hospital/Health Care Facility, dated 3/08, was provided that included a place to record preferred breakfast foods and other likes/disilkes.         A policy entitled Nutritional Intervention Program, dated 6/12/14, indicated all residents with actual or potential for insidious or significant weight loss would receive appropriate interventions to encourage weight gain. Real food options would be given the first priority with commercial nutritional supplements to follow. The procedure section of the policy indicated increased portions, especially if specific food favorites of the resident was a potential weight-gain program option.       {F 441}         SS=F       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 are record of incidents and corective	{F 441} SS=F	

Facility ID: 00355

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		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245535	B. WING			F <b>08/</b> 1	₹  2/2014
NAME OF I	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN PERPICH EXT CA	RF FAC			1856 HOSPITAL DRIVE		
				R	EDLAKE, MN 56671		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 441}	Continued From pa	-	{F 44	41}			
	actions related to in	ifections.					
	determines that a re prevent the spread isolate the resident. (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is inc professional practic	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					
		ndle, store, process and as to prevent the spread of					
	by: Based on observat review the facility fa resident (R59) room to prevent the sprea difficile(infectious d potential to affect 2 same room. The fa pressure cuff was p for 1 of 1 resident ( practice had the po residents who utiliz facility failed to trac	iarrhea) which had the of 2 residents residing in the acility failed to ensure a blood properly disinfected prior to use R58) observation. This tential to affect 28 of 40 ed the cuff. In addition, the k, trend and analyze resident d the potential to affect all 40			Jourdain Perpich will establish and maintain an infection control program provide a safe, sanitary and comfort environment and to help prevent the development and transmission of dis and infection. A. Resident infections and staff illnes will be investigated, controlled and th spread of infection prevented. Resid was asymptomatic upon readmission the facility. The infection control log is completed to include location of infe- the type of organism if available and reculture was obtained, based on po-	able sease sses he lent n to is ction, l if a	

Facility ID: 00355

If continuation sheet Page 29 of 36

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		045505			F	
		245535	B. WING _		•	2/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 24856 HOSPITAL DRIVE	, ZIP CODE	
JOURDA	IN PERPICH EXT CA	RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
{F 441}	Continued From pa	age 29	{F 44	1}		
	Findings include:			and procedure. An and resident infection will to monthly basis to deter or patterns of cross co	be compiled on a mine any similarities	
	Clostridium difficile	(C-diff):		Updated P&P will inclu cleansing solutions to	ide appropriate be used on resident	
	indicated R59 was difficile colitis (C-Di thickness tissue los or muscle) sacral p			care equipment, depe of equipment and any contamination concerr B. An infection control procedure has been d implemented. All resid	resident ns. policy and eveloped and ent and staff illness	
	indicated an order i milligrams (an antik tablet by mouth thre	Transfer Orders dated 8/6/14, for metronidazole 500 piotic used to treat C-Diff) one ee times a day until 8/14/14.		<ul> <li>will be monitored and measures will be taken spread of illness.</li> <li>C. Policy and procedu and updated on a year</li> </ul>	n to prevent the res will be reviewed rly basis. The	
	was continent of bo R59 to the commo	ted 6/24/14, indicated R59 owel and directed staff to assist de or toilet, assist to pull provide peri-rectal cares after		infection control nurse illnesses and impleme measures to prevent t and infection. The infe	nt the necessary he spread of illness	
	elimination. R59's of of the C-Diff diagno interventions and ir	care plan lacked identification osis and lacked care related infection control protocols in the risk of the transmission of		shall attempt to have of addressing symptoms available as it may rela- regimens. All staff sha the Infection Control P and specifically as it re	completed logs, and the organism if ate to antibiotic Il be educated on olicy and Procedure	
	a leave.	R59 was out of the building on		and care of resident care cleansing resident unit such as C-diff are diag	are equipment and ts when infections gnosed. Staff	
	(NA)-G stated she she was diagnosed was instructed to u precautions when o R59 used a facility were instructed to o special solution. R5	0 p.m. nursing assistant had cared for R59 once since d with C-Diff and stated she se gown and glove caring for R59. NA-G stated bedside commode and staff clean the commode with a 59 shared a room and ndependent resident who did		re-education will be pr 10th, 2014. D. The plan of correcti by the Director of Nurs control nurse in collab DON shall review all d infections of staff and similarities. QAPI will o updated monthly by th	ion will be monitored ses. The infection oration with the ocumented residents to analyze continue to be	

Facility ID: 00355

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COI	MPLETED		
		245535	B. WING		08	R / <b>12/2014</b>		
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE				
JOURD	NIN PERPICH EXT CA	RE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
{F 441}	use the shared bath R59 had not used t the surveyor to R58 cleaner, however, r the shared bathroo was kept in the hou further stated R59 she cared for her. On 8/12/14, at 2:57 worked with R59 or R59 utilizing the sh shift of 8/11/14, how had a stool at that t (tuberculosis) spray commode / equipm brought the surveyor and identified the s Cleaner Ready to U read on her comput that a 10:1 bleach s equipment with pot NA-D indicated the to use and had beed disinfectant spray of On 8/12/14, at 3:05 bedside commode housekeeping closs commode. NA-E at was independent a On 8/12/14, at 3:19 R59 refused to use upon using the sha she had helped R5	hroom. However, NA-G stated the bathroom. NA-G brought D's room to retrieve the none was stored in the room or m. NA-G stated the solution usekeeping closet. NA-G did have loose stools when Y p.m. NA-D verified she had nce and state she observed ared bathroom on the evening wever, she denied that R59 time. NA-D stated she used TB y or Sani-wipes to clean the nent used by R59. NA-D or to the housekeeping closet spay used was TB Disinfectant Jse. NA-D also stated she had ter based training program solution could be used to clean ential C-Diff contamination. y had not had bleach solution en directed to use the TB	{F 441}	Nurse or Director of Nursing.				

If continuation sheet Page 31 of 36

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245535	B. WING			R 08/12/2014	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 441}	On 8/12/14, at 6:11 (DON) confirmed R room should have to bleach solution and cleaner Ready To L were effective again confirmed C-diff wa care plan and state 8/13/14, at 10:44 a. he cleaned the roor facility and had cleat indicated TB Disinfe was used to wipe d H-A indicated the flat water and stated he gallon bucket (a 1:1 gallons). H-A state responsible to clean H-A stated the TB D used to clean the to bathroom and the b to mop the bathroot received training re use bleach water to The undated Clostr staff to routinely cle resident surfaces a disinfection of items required 1:10 house solution. Blood pressure cuff On 8/12/14, at 8:23 aide (TMA)-A was c	p.m. director of nursing 859's care equipment and been cleaned with a 10:1 4 that neither TB disinfectant Jse nor Sani-Cloth Plus wipes nst C-diff. The DON also as not addressed on R59's ed it should have been. .m. housekeeper (H)-A stated ms on each of the halls in the aned R59's room. He ectant Cleaner Ready to Use lown the bed and furniture. oor was mopped with bleach e used a cupful of bleach in a 5 10 solution equals 2 quarts to 5 id the nursing staff was n R59's bedside commode. Disinfectant Cleaner was also bilet and sink in the shared bleach water solution was used m floor. H-A stated he had garding C- diff and was told to b kill it.	{F 44	41}			

If continuation sheet Page 32 of 36

		AND HUMAN SERVICES				FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING			R 08/12/2014	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG				Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	R58's room. The b the attached basker TMA-A proceeded t pressure machine i blood pressure cuff TMA-A was observe size of Aloe Vesta s shampoo cleansing cloth and proceede pressure cuff and p arm. However, TM/ accurate blood press removed and place On 8/12/14, at 12:2 the blood pressure was drug behind the was wheeled into R Aloe Vesta cleansin most appropriate so pressure cuff and s alcohol wipe or som On 8/12/14, at 3:59 Aloe Vesta cleansin appropriate disinfect used for skin care. Sani-Cloth wipe (a disinfect reusable e used to clean the b placing the cuff on the The Cleaning and L Items and Equipment directed staff to follo Control and Prevent for cleaning and dis	<ul> <li>alood pressure cuff fell out of it and landed on the floor. to wheel the electronic blood into R58's room, dragging the f on the floorAt 8:24 a.m. ed to squirt a 50 cent piece solution (a body wash and g foam) on a dry disposable ed to wipe off the blood blace the cuff around R58's left A-A was unable to obtain an assure reading the cuff was ed on R58's right arm.</li> <li>29 p.m.TMA-A acknowledged cuff had fallen to the floor and e blood pressure machine as it 858's room. TMA-A stated the ng foam was probably not the olution to clean the dirty blood she should have used an mething stronger.</li> <li>9 p.m. the DON confirmed the ng foam was not an ctant and it should only be The DON verified a disposable wipe utilized to equipment) should have been lood pressure cuff before the patient.</li> <li>Disinfection of Resident-Care ent policy revised on 10/2009, ow current Center of Disease thion (CDC) recommendations sinfecting resident care g reusable items and durable</li> </ul>	{F 44	41}			

If continuation sheet Page 33 of 36

		AND HUMAN SERVICES			FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245535	B. WING			R 1 <b>2/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN PERPICH EXT CAI	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	Continued From pa	ge 33	{F 441}			
	Infection Control Lo	ogs:				
	July and August of 2 lacked data which of cultured, the type of caused by and if the following antibiotic t Additionally, the fac where each infection so that pattern and	ty's infection control logs for 2014, revealed the logs determined if the infection was f organism the infection was e infection was re-cultured treatment was not completed. cility surveillance including on had occurred in the building trends of the spread of eviewed was not completed.				
F 520 SS=F	Director of Nursing and verified the lack trending and surve		F 520			10/3/14
	assurance committe nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the				
	committee meets and issues with respect and assurance active develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.				

Facility ID: 00355

If continuation sheet Page 34 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM A	09/10/2014 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245535	B. WING	i		R 08/12/2014		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	NIN PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
F 520	A State or the Secr disclosure of the rec except insofar as su compliance of such requirements of this Good faith attempts and correct quality of a basis for sanction This REQUIREMEN by: Based on interview facility failed to ensu and Assurance (QA appropriate action p areas of concern du and federal monitor repeat quality defici to affect all 40 resid The Findings includ On 8/12/14, at 7:45 correction (POC) w of nursing (DON). or designee would a and identify those a rehabilitation servic thereafter to ensure indicated staff educ regarding the proper and audits would be designee weekly x a thereafter. Addition would be conducted they had been vacc	<ul> <li>retary may not require</li> <li>cords of such committee</li> <li>uch disclosure is related to the committee with the section.</li> <li>by the committee to identify deficiencies will not be used as s.</li> <li>NT is not met as evidenced</li> <li>and document review, the use the Quality Assessment</li> <li>&amp;A) committee implemented olans for previously identified uring the recent recertification ing surveys in order to prevent encies. This had the potential lents residing in the facility.</li> <li>le:</li> <li>p.m. the facility plan of as reviewed with the director The POC indicated the DON audit the rehabilitation notes trisk or have refusals of es x 4 weeks and monthly</li> <li>compliance. The POC also ation would be provided er administration of Renvela</li> <li>conducted by the DON or 4 weeks and then monthly hally, the POC indicated audits d on all residents to ensure</li> </ul>	F f	520	Jourdain Perpich Extended Care Cen will maintain a QAPI committee consis of the director of nursing, medical direct and 3 other members of the facility sta This committee will meet at least quart to identify issues, with respect to which quality assurance activities are necess and develop and implement appropriat plans of action to correct identified qua deficiencies. The committee will addre at a minimum incident and accident reporting, infection control and medica and pharmacy services. A. All audits will be completed as state B. An QAPI meeting will be held on September 10th, 2014 to discuss all ta audit formats and findings. C. All issues will be added to the QAPI agenda. D. Plan of correction will be monitored the director of nursing and administrate QAPI will continue to meet on a month basis, but minimally quarterly.	sting ctor aff. terly h sary te ality ess ation ed. ags, I l by cor.		

Facility ID: 00355

		AND HUMAN SERVICES					FORM	09/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED		E SURVEY PLETED
		245535	B. WING	i		R 08/12/2014		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP C	CODE	•	
JOURDA	IN PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 520	the proper administ resident immunizat as indicated. Refer to F155 relate benefit education p refuses treatment. Refer to F309 relate	inge 35 , audits and staff education of tration of Renvela and for ions had not been completed ed to the lack of risk vs. rovided when a resident ed to lack of medication the physician's order.	F	520				

Facility ID: 00355

If continuation sheet Page 36 of 36

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

					N AND TRANSMITTALID: ISKCATE SURVEY AGENCYFacility ID: 00355			
1. MEDICARE/MEDICAID PROVIDER N         (L1)       245535         2.STATE VENDOR OR MEDICAID NO.         (L2)       833840000         5. EFFECTIVE DATE CHANGE OF OW		<ol> <li>NAME AND ADI (L3) JOURDAIN/I (L4) 24856 HOSPI (L5) REDLAKE, N</li> <li>PROVIDER/SUP</li> </ol>	PERPICH EXT ( ITAL DRIVE MN	CARE FAC	AC         4. TYPE OF ACTION:         2 (L8)           (L6)         56671         1. Initial         2. Recertification                                                                                                                <			
(L9) 6. DATE OF SURVEY <b>05/22</b> 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ <b>2014</b> (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IIE 12 RHC	AD 13 PTIP 22 CLIA 14 CORF 711D 15 ASC 14 CORF 15 ASC 15 ASC 15 ASC 15 ASC 15 ASC	]		
<ol> <li>LTC PERIOD OF CERTIFICATION         From (a):         To (b):     </li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ol>	<b>47</b> (L18) <b>47</b> (L17)	X B. Not in Com	ce With quirements		And/Or Approved Waivers Of The Following Requirements:        2. Technical Personnel      6. Scope of Services Limit        3. 24 Hour RN      7. Medical Director        4. 7-Day RN (Rural SNF)      8. Patient Room Size        5. Life Safety Code      9. Beds/Room         * Code:       B*         15. FACILITY MEETS			
18 SNF 18/19 SNF 47 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1): (L15)			
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY APPROVAL Date:			
<u>Yvonne Switajewski</u> ,		(	06/20/2014	(L19)	Enforcement Specialist 07/15/2014			
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Par          2. Facility is not Eligible	7	20. COM	PLIANCE WITH C		AL OFFICE OR SINGLE STATE AGENCY 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			
22. ORIGINAL DATE OF PARTICIPATION 12/30/1991 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	DATE E SANCTIONS of Admissions:	4. LTC AGREEME ENDING DATE (L25) (L44)		26. TERMINATION ACTION:       (L30)         VOLUNTARY       00         INVOLUNTARY       01-Merger, Closure         01-Merger, Closure       05-Fail to Meet Health/Safety         02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Agreement         03-Risk of Involuntary Termination       OTHER         04-Other Reason for Withdrawal       07-Provider Status Change         00-Active       00-Active			
28. TERMINATION DATE:	29	. INTERMEDIARY/C.	(L45) ARRIER NO.		30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L28) 32	00400	DF APPROVAL DAT	(L31) TE	Posted 07/15/2014 Co.			
	(L32)			(L33)	DETERMINATION APPROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 10, 2014

Mr. William Eckblad, Administrator Jourdain/Perpich Extended Care Facility 24856 Hospital Drive Redlake, Minnesoa 56671

RE: Project Number S5535025

Dear Mr. Eckblad:

On May 22, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

# DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 1, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 1, 2015 the following remedy will be imposed:

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

# ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable. Jourdain/perpich Ext Care Fac June 10, 2014 Page 4

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Jourdain/perpich Ext Care Fac June 10, 2014 Page 5

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 November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us

Telephone: (651) 201-7205 Fax: (651) 215-0541 Jourdain/perpich Ext Care Fac June 10, 2014 Page 6

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

Sincerely,

Mark Meath

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	D. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		TE SURVEY MPLETED	
		245535	B. WING			05	5/22/2014	
NAME OF F	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	IN/PERPICH EXT CA	RE FAC			OSPITAL DRIVE KE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	FO	00				
F 155 SS=D	as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electror be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has bee your verification. 483.10(b)(4) RIGH ADVANCE DIRECT The resident has the refuse to participate and to formulate an specified in paragra The facility must co specified in subpart related to maintaini procedures regardi requirements include provide written info concerning the righ or surgical treatment option, formulate an includes a written d	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with T TO REFUSE; FORMULATE TIVES the right to refuse treatment, to e in experimental research, a advance directive as aph (8) of this section. To part 489 of this chapter ng written policies and ng advance directives. These de provisions to inform and rmation to all adult residents t to accept or refuse medical nt and, at the individual's n advance directive. This lescription of the facility's ant advance directives and	F 1	55			7/1/14	
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	
	ically Signed						06/20/2014	

**Electronically Signed** 

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

PRINTED: 06/20/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING			05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	Continued From pa	ge 1	F 1	155			
	This REQUIREMEN by: Based on interview facility failed to ensi- related to the disco- (ROM) rehabilitation with and documente the sample reviewe Findings include: R12's quarterly Min 2/24/14, indicated F anemia and depres R12 had intact cogr extremity impairme was Independent w dressing. The MDS unable to put left ha unable to fully close R12's, Rehabilitatio 5/2014, indicated R extremity strengthe discontinued on 7/1 On 5/21/14, at 2:30 independently ambi- walker. On 5/22/14, at 8:00 stated R12's rehab- the physical therapi	NT is not met as evidenced v and document review, the ure the risks and benefits ntinuation of a range of motion n program were addressed ed for 1 of 1 resident (R12) in d for ROM services. imum Data Set (MDS) dated R12 was diagnosed with sion. The MDS also indicated nition, one sided upper nt, communicated effectively, ith eating, toileting and further indicated R12 was and behind head and was e fingers on the left hand. n treatment sheet dated 12's upper and lower ning exercises were		00	Jourdain Perpich honor all resident wishes regarding refusal of care. A. Physical Therapist will re-evaluat for range of motion, explain the risk benefit to resident, if the resident re to participate in the program docum the therapy notes. B. Care plans will be reviewed for the residents who frequently refuse the services. Care plans will be updated reflect refusals of therapy services of discontinuing of services and include education was provided regarding r benefit. C. Will review policy and procedure update as needed. Education will be provided to staff at the nursing mee June 24th, 2014. DON or designee audit the rehabilitation notes and ide those that are at risk or have refusa rehabilitation services x 4 weeks an monthly there after to ensure compl D. The plan of correction will be mo by the DON or designee and reporte QAPI Committee at least quarterly.	e R12 vs. fuses eent in nose rapy d to or le that isk vs. and e ting on will entify uls of id liance. mitored	
	(RN)-A verified the	0 a.m. registered nurse PT had discontinued R12's OM) program per R12's					

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245535	B. WING			05/22/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	Continued From pa request.	ge 2	F	155			
	discontinued R12's did not want to part The PT verified he	p.m. the PT stated he had ROM program because R12 icipate in the ROM program. had not documented whether of the risk vs. benefits of m.					
F 159 SS=D	benefits to resident services was reque	he explanation of risk vs. s who decline rehabilitation sted and none was provided. CILITY MANAGEMENT OF S	F	159			6/30/14
	facility must hold, s account for the pers	rization of a resident, the afeguard, manage, and sonal funds of the resident acility, as specified in 8) of this section.					
	funds in excess of s account (or account the facility's operatii all interest earned of account. (In pooled	posit any resident's personal 50 in an interest bearing ts) that is separate from any of ng accounts, and that credits on resident's funds to that d accounts, there must be a g for each resident's share.)					
	funds that do not ex	aintain a resident's personal <ceed \$50="" a="" in="" non-interest<br="">terest-bearing account, or</ceed>					
	that assures a full a accounting, accord	stablish and maintain a system and complete and separate ing to generally accepted es, of each resident's personal					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245535	B. WING _			05/22/2014	
NAME OF I	PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE	
F 159	funds entrusted to t behalf. The system must p resident funds with	ge 3 he facility on the resident's reclude any commingling of facility funds or with the funds than another resident.	F 1	59			
	through quarterly st the resident or his c	cial record must be available atements and on request to or her legal representative.					
	Medicaid benefits w resident's account r SSI resource limit f section 1611(a)(3)(I amount in the acco the resident's other reaches the SSI res	tify each resident that receives when the amount in the reaches \$200 less than the or one person, specified in B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, source limit for one person, the ligibility for Medicaid or SSI.					
	by: Based on interview facility failed to ensi R13) with personal facility, had access weekends. Findings include: R25's quarterly Min 4/15/14, indicated F	NT is not met as evidenced y and document review, the ure 2 of 2 residents (R25, trust fund accounts with the to their money on the imum Data Set (MDS) dated R25 was cognitively intact.			Resident Trust Funds are protected available for emergencies. A. The availability of money on wee and evenings will be maintained thr lock box in the Medication room. N will have a listing of those residents funds available. The previous syste was not working, and residents wer accessing funds that they did not have policy will be written to identify the of procedures to make sure that residents	ekends ough a lurses with em re ave. A correct	
	office was closed o	p.m. R25 stated the business n the weekends and did not s on call to come in if she			trust funds are not accessed inappropriately. B. Funds are available for all reside with trust accounts.	ents	

Facility ID: 00355

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PRINTED: 06/20/2014

		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		. ,	DIE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245535	B. WING		05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDAIN/PERPICH EXT CARE FAC				24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 159	Continued From pa	ige 4	F 159			
	R13's quarterly MD R13 was cognitively	S dated 4/13/14, indicated y intact.		C. A new system will be devised to provide for expanded access to tru funds. A policy will be revised and clarified.	st	
	able to get his mon	p.m. R13 stated he was not ey on the weekends. R13 et your money when the e.		d. The plan of correction will be mo by the Administrator and the results reported to the QAPI Committee at quarterly.	s will be	
	stated they had trie the medication cart accounts to use on stated the nurses h had money and why the ADM stated the when they did not h stated that system which each contain resident's needs we was how they came The ADM verified th	7 p.m. the administrator (ADM) ad a system of putting money in as for residents with trust the weekends. The ADM ad a list of which residents o could get money. However, a nurses gave residents money have sufficient funds. The ADM consisted of 10 envelopes hed \$5.00. The ADM stated the ere for pop and candy so that e up with the \$5.00 amounts. he residents did not have t accounts on an on-going				
	indicated resident to during normal offic to 4:30 p.m. Monda holidays. The policy would be available resident could conta them of the need for nurse would determ not wait until the ne policy further indica	t Fund policy dated 1/30/13, rust funds were available the hours which were 9:00 a.m. ay through Friday, except y further indicated trust funds for emergencies in which the act nursing staff and inform or emergency funds and the nine if the emergency could ext normal business day. The ated the availability of vas not intended to take the siness hours.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM	06/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		245535	B. WING			05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	REET ADDRESS, CITY, STATE, ZIP CODE	00/1	
JOURDAIN/PERPICH EXT CARE FAC					1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 160 SS=D	483.10(c)(6) CONV FUNDS UPON DEA	EYANCE OF PERSONAL ATH	F 1	60			6/30/14
	deposited with the f within 30 days the r accounting of those	a resident with a personal fund acility, the facility must convey esident's funds, and a final funds, to the individual or administering the resident's					
	by: Based on interview facility failed to com deposited into trust 4 residents (R6, R1 from the facility and returned to their fan 30 days of discharg Findings include: The facility's trust fu indicated the follow greater than 30-day funds returned with R6 discharged on 1 balance of \$181.54 their family or R6's R9 discharged on 3 balance of \$200.01 their family or R9's R19 discharged on balance of \$250.01	und report dated 5/22/14, ing residents (who had died <i>v</i> s earlier) did not have their in 30 days of discharge. /12/14. R6's trust account had not been conveyed to estate until 4/4/14.			<ul> <li>A. At the time of the survey, all funds to deceased residents had been correctly returned. Accounting will notify administration of any funds available a discharge.</li> <li>B. A review of all records indicates that the funds for all discharged or deceased residents have a zero balance.</li> <li>C. All trust funds of deceased or discharged residents are closed.</li> <li>D. The plan of correction will be monitor by the Administrator and the results wireported to the QAPI Committee at lead quarterly.</li> </ul>	y after at ed cored ill be	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245535	B. WING _		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 160 F 170 SS=C	was requested from was not provided. The facility adminis 5/22/14, at 4:46 p.n accounts were clos had not been dispe date of discharge. 483.10(i)(1) RIGHT SEND/RECEIVE U The resident has th communications, in	ted to the conveyance of funds in the facility administrator but trator was interviewed on in. and confirmed the above ed and verified the trust funds rsed within 30 days from the TO PRIVACY -	F 16			7/1/14
	by: Based on interview facility failed to deliv Saturdays. This has residents who reside On 5/22/14, at 10:0 (AD) stated residen up from the post off Monday through Fri helped deliver it to to confirmed they do r Saturday, however, was open on Saturd facility business offi mail was not picked activities staff would	0 a.m. the activity director t and facility mail was picked fice by the business office staff iday and the activities staff the residents. The AD not deliver resident mail on she believed the post office days, however, stated the ice was closed therefore the d up. The AD indicated d be available to pick up and il on Saturdays, however they		<ul> <li>A. Mail will be collected at the Post each Saturday by Activities. The ket the PO Box will be in the nursing st for access.</li> <li>B. The post office in Red Lake was contacted, and they confirmed that Saturday mail service is limited.</li> <li>C. A new policy will be written to as that mail delivery of mail on Saturda continue.</li> <li>D. The plan of correction will be mon by the Administrator and reported to QAPI Committee at least quarterly.</li> </ul>	ey to cation sure ays will onitored o the	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/20/2014 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245535	B. WING _		05	/22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	IN/PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 170	Continued From pa	-	F 1	70		
F 279 SS=D	secretary (AS) state up the mail each da sorted it and reside activity staff to deliv didn't pick up the m "mostly junk mail." she would pick up t resident was expect The Resident Mail p mail would be delive hours of delivery by procedure for deliver received mail to a F times limited to the open: 7:00 a.m. to 4 Friday, and 10:00 to 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b	policy dated 1/30/13, indicated ered to residents within 24 the postal service. The ery of mail indicated the facility Post Office box with pick up hours that the post office was 4:45 p.m. Monday through to 12:00 a.m. on Saturday. (1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 2	79		7/1/14

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	KS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	( )	E SURVEY PLETED
		245535	B. WING _		05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
JOURDA	IN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 279	due to the resident	\$483.25 but are not provided s exercise of rights under the right to refuse treatment	F 2'	79		
	by: Based on interview facility failed to ensi- interventions relate accurately developed the sample reviewed The findings include R46's ADMISSION was diagnosed with (ESRD) secondary type II diabetes me hemorrhage and ce R46's physician orc Renvela (a medication in dietary intake and levels in patients wi (mg) take 2 tablets with snacks. R46 was interviewed and stated he had no a.m. and received he also included Renv breakfast or a snace administered to him observed to received	d to kidney dialysis were ed for 1 of 1 (R46) resident in ed for dialysis. e: FACE SHEET indicated R46 n end stage renal disease to chronic kidney disease and llitus, intercerebral erebrovascular disease. ders indicated and order for tion used to bind phosphorous d normalize phosphorous ho have ESRD) 800 milligrams three times a day and 2 tabs ed on 5/21/14, at 11:15 a.m. returned from dialysis at 10:30 his morning medications which ela. R46 stated he had not had ek at the time the Renvela was h. At 11:24 a.m. R24 was		Jourdain Perpich performs comprehensive care plannin interdisciplinary care team. ( A. R46's care plan has been updated to reflect that Renve administered with meals and was added to the medication was evaluated for the self ac of the Renvela and a physici obtained to allow resident to administer Renvela when he R46's care plan and treatme were updated to state that he no more than 1500 cc of fluid to be divided as follows: 420 meal, 80 cc with each med p is not to have a water pitches and ongoing education from as to the importance of being with the fluid restriction. B. Every shift is to record the given to the resident during t the nursing assistant record medication administration re night shift nurse is to total an Intake and Output amounts. compliance noted the night s to alert the DON or designed C. Staff education will be pro- importance of complete doct	IDT) reviewed and ela is to be snacks. This record. R46 liministration an order was self is eating. nt record e is to receive d per day. It is cc with each bass. Resident r at bedside nursing staff g compliant e amount heir shift in and the cord. The id monitor If there is non shift nurse is e. vided on the	

Facility ID: 00355

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		& MEDICAID SERVICES				APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
	PROVIDER OR SUPPLIER	RE FAC	2	STREET ADDRESS, CITY, STATE, ZIP 14856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 279	stated Renvela 800 to R46 at 11:00 a.m morning medication TMA stated she did given at the time fo not aware Renvela together with other R46's undated, curr had ESRD and reco week. The care pla 1500 cubic centime and directed staff to administer medicat lacked indication of prior to dialysis, the food and not to adm an hour before the after Renvela admii plan had not identiff dialysis access site licensed nurses to a contact in case of a dialysis. Lastly, the which discipline wo 1500 cc's and who monitoring R46's da Registered nurse (ff 5/22/14, at 10:02 a. plan had not deline provide fluids to equires responsible for mor RN-B also confirme identified the direct who to contact in ca dialysis, monitoring	erviewed at 11:32 a.m. and o mg 2 tabs was administered a. along with all of the other ns prescribed for him. The I not know Renvela had to be od was ingested and was also was not supposed to be given	F 279	compliance weekly x 4. D. The plan of correction v by the DON or designee at the QAPI committee at lea	nd reported to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/20/2014 FORM APPROVED OMB NO 0938-0391

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM /	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE	SURVEY
		245535	B. WING			05/2	2/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From pa	ge 10	F 2	279			
F 280 SS=D			F 2	280			7/1/14
	incompetent or othe incapacitated under participate in planni changes in care and A comprehensive ca within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as detern and, to the extent p the resident, the resi legal representative	<sup>r</sup> the laws of the State, to ng care and treatment or					
	by: Based on observat review, the facility fa 1 of 1 resident (R3) care and side rail (S residents (R23) rela reviewed for accide Findings include:	NT is not met as evidenced ion, interview and document ailed to revise the care plan for reviewed for incontinence SR) use and for 1 of 3 ated to fall interventions nts.			Jourdain Perpich will develop a comprehensive care plan within 7 days admission, and review quarterly. A. R-3- Side rail assessment complete on 5-28-14. Was assessed that sidera were not being consistently used. Physician order to discontinue side rai Side rails have been removed from residents bed and from his care plan. bowel and bladder assessment was	ed ails ils.	

Facility ID: 00355

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245535 **B** WING 05/22/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE JOURDAIN/PERPICH EXT CARE FAC REDLAKE, MN 56671 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 11 F 280 R3 was to be checked and changed every 2-3 completed on 6-2-14. Resident is hours for incontinence. In addition, R3's care plan incontinent of bowel and bladder and failed to address the use of bilateral side rail use. must be checked every 2 hours and changed as needed. Tissue tolerance also On 5/20/14, at 1:08 p.m. R3 was observed in bed, completed on 6-2-14, resident is to be on his right side, asleep. The bed was up against repositioned every 2 hours. Care plan the wall with a mat on the floor. There were reviewed and updated, NAR care sheets bilateral half SRs raised on the bed. updated to reflect changes. R-23: Care plan was reviewed and On 5/21/14, at 7:03 a.m. R3 was observed in bed updated to include the following falls with bilateral side rails raised. interventions. Every one hour visual safety checks, hi low bed in lowest position and On 5/22/14, at 9:37 a.m. registered nurse (RN)-A not to be left alone in his room in verified R3's care plan needed to be revised to wheelchair read incontinent brief change every 2 hours and B. All residents that are at risk for skin not every 2-3 hours as written. RN-A stated breakdown and falls will have their care according to the quarterly review dated 3/5/14, plans and assessments reviewed to completed by RN-B, R3 was to receive a brief ensure that adequate interventions are in change every 2 hours and had also utilized place and care planned accordingly. bilateral SRs on his bed. . C. Policy and Procedure for admission assessments reviewed and updated. DON On 5/22/14, at 9:55 a.m. R3 was observed in his or designee will randomly review at risk wheelchair in front of the nurses station. Nursing residents and admissions to ensure that assistant (NA)-G stated she had assisted R3 in all assessments and the care plan reflect the wheelchair at 7:00 a.m. which was the last the care that the residents are receiving. time R3's incontinent brief was changed. (a total This will be ongoing. of 3 hours later). D. The plan of correction will be monitored by the DON or designee and reported At 10:00 a.m. NA-G and NA-F were observed to findings to QAPI at least quarterly. transfer R3 into bed via a mechanical left. R3's incontinent brief was observed wet. NA-F stated R3's incontinent brief was to be changed every 2 hours. NA-G stated she was going to check R3 at 9:00 a.m. however, she got "busy." (3 hours later). A care plan policy related to revision was requested and none was provided.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/20/2014

		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 12	F 280			
	interventions to incl hi-low bed in lowes	plan dated 5/2/14, lacked fall lude every one hour checks, t position and not to be left room in the wheelchair.				
	sleeping in his roon	p.m. R23 was observed n in bed with a sensor alarm, and a fall mat on left side.				
	bed, sleeping. A se	a.m. R23 was observed in nsor alarm was in place, R23's on and a fall mat was observed ne bed.				
	(TMA)-A stated R23	p.m. trained medication aide 3 was on one hour visual onfirmed this intervention was plan.				
	(DON) verified the i were lacking from F	p.m. the director of nursing identified fall interventions R23's care plan. The DON aff needed to work on this.				
F 282 SS=D	verified R23's care include every one h in lowest position, a R23 unattended in wheelchair.	p.m. registered nurse (RN)-A plan needed to be revised to nour visual checks, hi-low bed and that staff were not to leave his room while seated in the RVICES BY QUALIFIED ARE PLAN	F 282			7/1/14
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of				

Facility ID: 00355

If continuation sheet Page 13 of 56

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION (		E SURVEY PLETED
		245535	B. WING	;		05/2	22/2014
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	00/1	
JOURDA	IN/PERPICH EXT CA	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From pa care.	ge 13	F2	282			
	by: Based on observat review, the facility fa written care plan fo required repositioni resident (R23) who ambulation and for required the applica prevent further cont Findings include: R3 was not repositi directed by his care R3's current care pl R3 had a potential fa related to paralysis R3 every 2 hours. On 5/21/14, R3 was 7:03 a.m. until 10:0 At 10:00 a.m. nursi were observed to a mechanical lift. A re across the back of she thought the ind R3 was seated on w At 10:04 a.m. NA-E repositioned every 3 last repositioned wf wheelchair at 7:15 a	oned every two hours as			Jourdain Perpich will provide service accordance with each residents writt plan of care. A. R-3- Tissue tolerance assessment performed on 6-2-14. Resident is to repositioned every 2 hours. Care plan NAR assignment sheets reviewed and updated. R-23- Resident was assess on 6-6-14 by physical therapy to clar ambulation orders. New orders receipt to ambulate resident to and from din room at lunch 5x week with FWW. Oplan was updated to reflect current of and to ensure that all ambulation or that are on the care plan are consist R-7- was assessed by physical thera 6-6-14. Received orders to implement brace full time except during AM/PM cares. Care plan and NAR assignment sheet updated to reflect change. B. Residents that are at risk for skin breakdown will be identified and ass at admission, quarterly and yearly. Comprehensive care plans updated changes in status or orders. C. Audits will be utilized to ensure th repositioning, ambulation and the application of splints are being done appropriately every shift by the wing nurse. D. DON or designee will monitor aud and compliance weekly x4 then mon thereafter. Will report findings to QA least quarterly.	ten t be in and nd sed ify ived ing Care order ders ent. apy on nt ent essed with at dits thy	

Facility ID: 00355

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM. MB NO.	06/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245535	B. WING			05/2	22/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	verified R3 was to be as directed by the c R3's care plan was On 5/22/14, at 9:55 in his wheelchair in NA-G stated she ha wheelchair at 7:00 a not been reposition At 10:00 a.m. NA-G transfer R3 into bec stated R3 was to be NA-G added, she w a.m. however, she g A care plan implem and none was provi R23's care plan dat ambulate R23 to an On 5/22/14, at 9:00 had never walked R because staff did no enough to walk that had never known R On 5/22/14, at 10:0 ambulate 200 feet w (FWW) with the reh stated R23's ability to day due to his Pa refusals to ambulate At 9:10 a.m. license	<ul> <li>isk for skin breakdown and e repositioned every 2 hours care plan. The DON confirmed not followed.</li> <li>a.m. R3 was observed seated front of the nurses station.</li> <li>ad assisted R3 into the a.m. and confirmed R3 had ed since that time.</li> <li>and NA-F were observed to d via a mechanical lift. NA-G e repositioned every 2-3 hours.</li> <li>was going to check R3 at 9:00 got "busy."</li> <li>entation policy was requested ided.</li> <li>a.m. NA-G stated the NA's R23 to the dining room.</li> <li>a.m. NA-G stated the NA's R23 to the dining room.</li> <li>a.m. R23 was strong t distance. NA-G added, she 23 to walk to the dining room.</li> <li>0 a.m. R23 was observed to with a front wheeled walker nab aide. The rehab aide to ambulate varied from day arkinson's disease and R23's</li> </ul>	F2	282			

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245535	B. WING			05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	ambulate to and fro directed staff to pro he walked. Shortly-thereafter, F care plan indicated meals with a FWW stand by assistance R7 did not received splint as directed by R7's current care p staff to apply a left f ordered. R7's physician orde R7's left hand splint twice a day and thro Splint Wear & Care indicated R7 was to times a day for 2 we a day and at night. to assess for redne On 5/21/14, during 7:03 a.m. through 9 not observed in pla- stored on a hamper -At 11:20 a.m. R7 we dining room table. independently eatin hand splint was not -At 1:25 p.m. R7 we	RN-B also confirmed R23's he was to walk to and from and directed staff to provide e. dapplication of a left hand y her care plan. lan dated 5/20/14, directed hand brace for contractures as ers dated 5/5/14, indicated t was to be worn for 4 hours oughout the night. e instructions dated 9/16/13, o wear the splint for 2 hours 4 eeks followed by 4 hours twice The instruction directed staff ess. continuous observations from 0:29 a.m. R7's left splint was ce. The splint was observed r in R7's room. was observed seated at a R7 was observed ng with her right hand. R7's left t worn. as observed resting in bed. t was observed stored on a	F 2	282			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	JOURDAIN/PERPICH EXT CARE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 16	F 282	2		
		as observed in bed, awake It remained stored on the bed.				
	-At 3:08 p.m. R7 w with the splint not w	as observed to remain in bed vorn.				
	care of R7 on 5/21/ was to be worn for a confirmed she had	1 a.m. NA-B stated she took 14, and confirmed R7's splint 2 hours. However, NA-B not applied R7's left hand uring the day on 5/21/14.				
F 309 SS=D	R7's orders directed hours twice per day DON stated her sh applied as ordered.	CARE/SERVICES FOR	F 30	9		7/1/14
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment				
	by: Based on observat review the facility fa related to kidney dia implemented for 1 of	NT is not met as evidenced ion, interview and document iled to ensure that monitoring alysis had been consistently of 1 resident (R46) in the ir end stage kidney disease		Jourdain Perpich will provide care/services to maintain or attain t highest well being. A. Resident was assessed for self administration of Renvela. It was	he	

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	was diagnosed with (ESRD) secondary type II diabetes mel hemorrhage and ce R46's physician orc Renvela (a medicat in dietary intake and levels in patients wi (mg) 2 tablets 3 tim snacks. R46 was interviewe and stated he had r dialysis at 10:30 a.r medications which R46 stated he had r dialysis at 10:30 a.r medications which R46 stated he had at the time the Ren At 11:24 a.m. R46 w when the noon mea Trained medication care of R46's medic of 5/21/14, was inter confirmed R46 was mg 2 tabs at 11:00 morning medication stated she did not k at the time food was supposed to be give medications. R46's undated, cur	e: FACE SHEET indicated R46 n end stage renal disease to chronic kidney disease and llitus, intercerebral erebrovascular disease. ders indicated and order for tion used to bind phosphorous d normalize phosphorous ho have ESRD) 800 milligrams tes a day and 2 tabs with ed on 5/21/14, at 11:15 a.m. returned from having kidney m. and received his morning included Renvela at that time. not had breakfast or a snack vela was administered to him. was observed in his room	F 309		ntly at ster n record o only with eviewed cation tration on ble for y of resident on will dication	

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	1500 cubic centime and directed staff to administer medicati lacked indication of prior to dialysis, the food and not to adm an hour before the after Renvela admin plan had not identifi dialysis access site licensed nurses to n contact in case of a dialysis. Lastly, the which discipline wo 1500 cc's and who monitoring R46's da R46's treatment she identified R46 had of treatment sheets al fistula access site for c daily fluid restrict total fluid consumpt blank. The registered nurse responsible for the the outpatient kidned interviewed by telep and stated the fluid dialysis treatments pounds of fluid weig total daily fluid intak monitored more clo exceed the physicia fluid restriction. Th stated the medication	an indicated R46 was on a eter (cc) daily fluid restriction o set up R46's meal tray and to ions as ordered. The care plan f which meds should be held e direction to give Renvela with ninister with other medications Renvela and up to 3 hours nistration. In addition, the care ied what type and where R46's e was and did not direct monitor for a thrill nor who to an emergency related to care plan had not delineated ould provide fluids to equal was responsible for aily total fluid intake. eets from 3/1/14-5/21/14, dialysis M-W-F's. The lso indicated R46 had a left a/v or dialysis and was on a 1500 tion and the 24 hour totals of tion per day had been left se (RN) clinical manager dialysis care of R46 while at ey dialysis clinic was ohone on 5/22/14, at 9:30 a.m. gains R46 had between were high (greater than 10 ght) and further stated that the ce for R46 should have been osely to ensure R46 did not an prescribed 1550 cc daily ie RN clinical manager further on Renvela should be given	F 309			
	stated the medication					

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	( )	G		PLETED
		245535	B. WING		05/2	22/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 19	F 309	9		
		patients fistula for a thrill at ensure patency of the fistula.				
F 311 SS=D	and confirmed Ren administered to R4 had been provided administered to R4 medications. RN-B fluid intake had not 1500 cc fluid restric also confirmed R43 evidence that a bru had been monitored 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given to services to maintain	confirmed R43's total daily been monitored to ensure the stion had been followed. RN-B I's medical record lacked it and a thrill of R46's fistula d. TMENT/SERVICES TO	F 31 <sup>,</sup>	1		7/1/14
	by: Based on observat review, the facility fi services in order to resident's ambulatio (R23) reviewed who assistance. Findings include: R23's significant ch (MDS) dated 4/25/1 diagnosed with a st hemiparesis (weak	NT is not met as evidenced tion, interview and document ailed to provide ambulation improve and/or maintain the on ability for 1 of 1 resident or required ambulation hange Minimum Data Set 14, indicated R23 was roke with right sided ness on one side of the body), on's disease and diabetes. The		Jourdain Perpich assures that resid are given the appropriate treatment/services to improve/main ADLS. A. R23 received evaluation by the p therapist on 6-6-14. Ambulation ord were clarified and resident is to amb with FWW to and from lunch only 52 week, and to use wheelchair. Care p and NAR assignment sheets were updated to reflect changes. B. Other residents were reviewed for appropriateness. The policy and procedure for ambulatory services w	tain hysical ers oulate x's plan or	

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		& MEDICAID SERVICES	0.00		OMB NO.	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245535	B. WING _		05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	NIN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 311	MDS also indicated impairment and red with ambulation. R23's current care R23 had decreased related to dementia sided hemiparesis care plan directed a extensive assistant meals. Additionally would ambulate with 15 minutes 3 times On 5/22/14, at 10:0 ambulate 200 feet (FWW) and the ref rehab aide stated F from day to day du and R23 refusing to On 5/22/14, at 9:00 (NA)-G stated the f ambulate to and fro had never walked f think R23 was strondistance. -At 9:10 a.m. licens confirmed R23's ca ambulate with a FV directed staff to pro he ambulated. At to (RN)-B also confirm the NA assignment which indicated ind directives) lacked t updated. Both confi	A R23 had cognitive quired extensive assistance plan dated 5/2/14, indicated d mobility with potential for falls a, diabetes, a stoke with right and Parkinson's disease. The staff to provide R23 with ce to ambulate to and from , the care plan indicated R23 th the rehab aide 280 feet over per week x 90 days. 00 a.m. R23 was observed to with a front wheeled walker hab aide's assistance. The R23's ability to ambulate varied e to his Parkinson's disease	F 31	<ul> <li>reviewed and updated as needed</li> <li>C. Staff education will be provide nursing staff meeting to be held.</li> <li>24th, 2014 regarding ambulation residents. Resident is currently be ambulated to lunch as ordered, we exception of when he refuses. The documented as such.</li> <li>D. The plan of correction will be aby the DON or designee will more 5x/week that this is being done at updated at least quarterly.</li> </ul>	d in a June of eing vith the nen it is monitored itor	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245535 B. WING 05/22/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE JOURDAIN/PERPICH EXT CARE FAC REDLAKE, MN 56671 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 311 Continued From page 21 F 311 Administrator stated R23 had fluctuating health from day to day due to the Parkinson's disease. -At 9:50 a.m. NA-A stated she had offered to ambulate R23 to meals but he had usually refused. -At 9:50 a.m. trained medication aide (TMA)-A stated it had been over 2 months since she had seen R23 ambulate to the dining room. -At 12:30 p.m. the physical therapist stated he was the person who developed R23's ambulation plan to include ambulating to and from meals. At the same time, LPN-A, stated NA-J had ambulated R23 to and from dinner without difficulty. A policy related to ambulation services was requested and none was provided. F 314 483.25(c) TREATMENT/SVCS TO F 314 7/1/14 PREVENT/HEAL PRESSURE SORES SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document Jourdain Perpich has a plan in place to review, the facility failed to ensure a resident who address possible pressure sores and

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						. 0938-039	
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED	
		245535	B. WING		05/	22/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
JOURDA	AIN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 314	<ul> <li>was identified at rist timely repositioning need for 1 of 1 rest positioning.</li> <li>Findings include:</li> <li>R3's quarterly Mini 3/5/14, indicated R impairment and wa (paralysis of all 4 li MDS also indicated assistance with be dependent on staff lift.</li> <li>R3's Braden Scale ulcer (PU) risk) dat risk for PU develop</li> <li>R3's Tissue Tolerat 8/27/13, and review indicated R3 was to hours.</li> <li>R3's current care p reviewed by staff o potential for impair paralysis and requi</li> <li>On 5/21/14, R3 wa 7:03 a.m. until 10:0 -At 7:03 a.m. R3 w bed.</li> <li>At 7:10 a.m. nursi was observed to tu and checked his bu</li> </ul>	sk for skin breakdown received g according to his assessed ident (R3) reviewed for mum Data Set (MDS) dated 3 had severe cognitive as diagnosed with quadriplegia mbs below the neck). The d R3 required extensive d mobility and was totally for transfers via a mechanical (a tool for predicting pressure ted 3/5/14, indicated R3 was at oment. Ince Observation form dated wed by staff on 3/5/14, o be repositioned every 2 blan dated 9/16/13, and n 3/12/14, indicated R3 had a ed skin integrity related to ired every 2 hour repositioning. s continuously observed from	F 31	<ul> <li>provide for the treatment of skir down.</li> <li>A. R3 will continue to be repositi every 2 hours. Nursing assistant educated of the importance of trepositioning. Care plan was reand updated.</li> <li>B. The repositioning of other reswas evaluated and no other prowere noted. The policy and prodassessing for risk of skin break all other comprehensive assess be reviewed and updated as net C. Staff will continue to receive via online education program. Salso be educated on the importarepositioning in a timely manne meeting on June 24,2014. The comprehensive assessment po been reviewed and updated.</li> <li>D. Plan of correction will be mo the Director of Nursing or desig results reported to the QAPI tea quarterly.</li> </ul>	ioned ts were re imely viewed sidents blems cedure for down and sments will cessary. education staff will ance of r in a staff licy has nitored by nee and		

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	NN/PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	mechanical lift sling seated in the wheel -At 7:23 a.m. NA-A whiteboard, on the what time R3 was p when their incontine -At 8:44 a.m. NA-I a room and placed hi station. -At 8:58 a.m. the ac to the activity room. -At 9:18 a.m. AA-A of the nurses statio -At 10:00 a.m. NA-E bed via the mechar changed and it was incontinent of urine observed across th stated she thought mechanical lift sling wheelchair. -At 10:04 a.m. NA-E repositioned every placed in the wheel it had been 2 hours last repositioned. -At 10:28 a.m. the overified R3 was at r that his care plan d every two hours. Th plan was not follow.	g remained under R3 while Ichair. stated they mark on the inside of R3's bathroom door olaced in the wheelchair, and ent brief was changed. assisted R3 out of the dining m in front of the nurses ctivity aide (AA)-A assisted R3 returned R3 back out in front n. E and NA-F assisted R3 into nical lift. R3's brief was a noted R3 had been . A red indentation was e back of R3's buttocks. NA-E the indentation was from the g that R3 was seated on in the E stated R3 was to be 2 hours. NA-E stated R3 was chair at 7:15 a.m. and verified a 45 minutes since he was director of nursing (DON) risk for skin breakdown and irected staff to reposition him he DON confirmed R3's care ed as directed. a.m. R3 was observed in his of the nurses station. At this she had assisted R3 into the	F 314			

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED
	of correction	IDENTIFICATION NUMBER.	A. BUILDING	3	COIVI	FLETED
		245535			05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE		
JOURDA	NN/PERPICH EXT CA	RE FAC		REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 314 F 315 SS=D	-At 10:00 a.m. NA- transfer R3 into bee incontinent brief wa to be incontinent of be repositioned eve R3's brief change v changed every 2 ho going to check R3 "busy." The Repositioning a resident would be needs and a care p	G and NA-F were observed to d via the mechanical lift. R3's as changed and R3 was noted furine. NA-G stated R3 was to ery 2-3 hours. NA-F stated vas to be checked and ours. NA-G stated she was at 9:00 a.m. however, she got policy revised 10/10, indicated e assessed for repositioning blan would be developed. HETER, PREVENT UTI,	F 314 F 315			7/1/14
	assessment, the fa resident who enters indwelling catheter resident's clinical c catheterization was who is incontinent of treatment and serv	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.				
	by: Based on observa review, the facility f justification for the was provided for 2 were reviewed for u the facility failed to care was provided	NT is not met as evidenced tion, interview and document ailed to ensure medical use of an indwelling catheter of 2 residents (R46, R17) who urinary catheters. In addition, ensure timely incontinence according to the assessed dent (R3) reviewed for		Jourdain Perpich will ensure that will be medical justification for eve indwelling catheter. A. R46 has diagnosis of neurogen bladder. R17 is deceased. R3 will incontinent care provided as per c plan. B. All medical records of residents	ry ic have are	

Facility ID: 00355

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDAI	N/PERPICH EXT CAI	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	justification for its u R46 was admitted t an indwelling catheter Indwelling Catheter dated 12/23/13, ind retention which requ R46's quarterly Min 3/19/14, indicated F Diseases Index Rep stage renal disease On 5/20/14, at 1:11 observed hanging of -At 4:10 p.m. R46 w communicate with a communicate of the splaced last Now the hospital. R46 st remove the cathete his bladder resulting reinserted. On 5/21/14, at 7:17 stated R46 had left and would return at On 5/22/14, at 11:03 (RN)-B stated the ir on 11/17/13, while F stated R46 was haw	ing catheter without medical se. o the facility on 12/11/13, with ter. The Urinary Incontinence / Care Area Assessment (CAA) icated R46 had urinary uired the use of the catheter. imum Data Set (MDS) dated R46 was cognitively intact. The port indicated R46 had end (ESRD). p.m. R46's catheter bag was on the side of his bed. vas noted to be able to a white erasable urd. R46 stated the catheter vember 2013, when he was in ated they had tried twice to r and he was unable to empty g in the catheter needing to be a.m. nursing assistant (NA)-A for dialysis about 5:30 a.m.	F 315		ation eter. ined for neter. lated e will ssary. red by	

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING	;		05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	catheter placement medical record lack had seen a urologis in problems of the u determine the caus RN-B stated on 12/ discontinued, howe (empty his bladder) had to be straight c catheter was reinse -At 3:03 p.m. RN-B attempted bladder r clamping the cathet experiencing pain s stopped and the inc place. RN-B confirm physician's order to an evaluation of the -At 3:57 p.m. RN-B lacked documentati indication of R46's r indwelling catheter. The facility's Urinar 10/10, indicated if a an indwelling cathet would identify the ra placement. In additi identify and refer, a might benefit from u improve continence	tion followed by the indwelling a. RN-B confirmed R46's (a physician who specialized urinary tract) in order to be of the urinary retention. (25/13, the catheter was ever, R46 was unable to void of following the removal and tatheterized and the indwelling perted on 12/30/13. stated on 3/4/14, they retraining with R46, by ter. RN-B stated R46 was so the bladder retraining was dwelling catheter was kept in med there had been no o send R46 to the urologist for a urinary retention. stated R46's medical record ion of the cause or medical urinary retention and y Incontinence policy revised a resident was admitted with ter the attending physician ationale for the original ion, the physician would is appropriate, individuals who urological procedures to	F	315			
	directed by the care						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245535	B. WING _			05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER	·	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NN/PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE		
JOORDA				R	EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	Continued From pa	ıge 27	F 31	15			
	indicated R3 was in	nence CAA dated 9/9/13, ncontinent of bladder and I every 2 hour check and ontinent brief.					
	was diagnosed with 4 limbs below the n impairment. The MI extensive staff assi toileting, was totally	6 dated 3/5/14, indicated R3 in quadriplegia (paralysis of all neck) and had severe cognitive DS also indicated R3 required istance with bed mobility and y dependent on staff for echanical lift and was always el and bladder.					
	reviewed by staff or	lan dated 9/16/13, and n 3/12/14, indicated R3 was to anged every 2-3 hours for					
	7:03 a.m. until 10:0 -At 7:03 a.m. R3 wa bed. NA-A stated sl her pocket so she o R3's incontinent bri -At 7:10 a.m. NA-A to side in the bed at incontinence. -At 7:15 a.m. R3 wa with the mechanica -At 7:23 a.m. NA-A	as asleep on his left side in he carried a piece of paper in could keep track of the times ief was changed. and NA-E turned R3 from side and checked his brief for as assisted into the wheelchair al lift by NA-A and NA-E. stated they mark on the					
	what time R3 was a and when his incon -At 8:44 a.m. NA-I a room and placed hi station.	inside of R3's bathroom door, assisted into the wheelchair atinent brief was changed. assisted R3 out of the dining im in front of the nurses ctivity aide (AA)-A assisted R3					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	PLE CONSTRUCTION		E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	to the activity room. -At 9:18 a.m. AA-A the nurses station. -At 10:00 a.m. NA-B bed via the mechar changed and he wa of urine. At 10:04 a.m. NA-E into the wheelchair been 2 hours & 50 brief was last check On 5/22/14, at 9:37 plan needed to be r and change R3's in and not every 2-3 h according R3's qua completed by RN-E change every 2 hou On 5/22/14, at 9:55 wheelchair in front stated she had ass 7:00 a.m. right after At 10:00 a.m. NA-G transfer R3 into bee brief was changed of urine. NA-F conf incontinent brief che hours. NA-G stated 9:00 a.m. however, confirmed it had be was last checked o	assisted R3 back in front of E and NA-F assisted R3 into hical lift. R3's brief was as observed to be incontinent E- confirmed R3 was assisted at 7:15 a.m. and verified it had minutes since R3's incontinent ked or changed. 7 a.m. RN-A verified R3's care revised to direct staff to check nontinent brief every 2 hours hours as written. RN-A stated arterly review dated 3/5/14, 3, R3 was to receive a brief urs. 6 a.m. R3 was observed in his of the nurses station. NA-G isted R3 into the wheelchair r his brief change. 6 and NA-F were observed to d via the mechanical lift. R3's and he had been incontinent firmed R3 was to have his ecked and changed every 2 d she was going to check R3 at , she got "busy." Both een 3 hours since R3's brief or changed.	F 315			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245535	B. WING			05/:	22/2014
NAME OF	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDA	AIN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	R17's admission M R17 was admitted t catheter on 2/18/14 renal failure, diabet (accumulation of flu causing abdominal identified R17 had s and required extens staff for bed mobili assistance of one s hygiene. The Nurse Practitio 2/18/14, indicated F facility for end-of-lift a palliative care refu [congestive heart fa and directed staff to twice a month, char irrigate PRN. The r the justification for the R17's Urinary Incor CAA] dated 3/3/14, extensive staff assi to an indwelling cat R17's catheter was PRN [as needed] fo lacked indication of catheter. R17's current physi indicated and order however, lacked ino the use of the cathe On 5/19/14, at 4:24	IDS dated 2/24/14, indicated to the facility with an indwelling 4, with diagnoses that included tes, edema and ascites uid in the peritoneal cavity, swelling). The MDS further severe cognitive impairment sive assistance of two plus ity and transfers and extensive staff for toileting and personal oner chart review note dated R17 was transferred to the fe care and included orders for ferral for advanced CHF ailure] and indwelling catheter o change the catheter bag inge the catheter monthly and note lacked documentation of the catheter. ntinence / Indwelling Catheter , indicated R17 required istance for toileting secondary theter. The CAA also indicated a changed every month and or malfunction. The CAA f the justification for use of the ician orders signed 4/29/14, r for the indwelling catheter, dication of the justification for	F 3	\$15			

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245535	B. WING _			05/:	22/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	observed to be cov bed frame. On 5/22/14, at 3:34 was admitted from services. RN-A sta the previous facility stated the catheter confirmed there have it since admission. the facility did not h the catheter. On 5/22/14, at 4:06 (DON) stated she b for the catheter was output readings due ascites and edema was no longer rece edema as she was asked if it was still r measurement where treated, DON respond The DON confirmed documentation of t the catheter. The facility's Urinar Protocol revised Oo treatment / manage to include; "If a resi hospital with a new the attending physic potential for removic condition and the ra placement" and "Th situations where an	age 30 ereed and hanging from the e.e. p.m. RN-A confirmed R17 another facility with hospice ted the catheter was placed at of R17's comfort. RN-A was changed monthly and d been no attempts to remove At 3:46 p.m. RN-A confirmed have justification for the use of p.m. the director of nursing believed the original rationale is to produce accurate urinary e to R17's diagnoses of . The DON confirmed R17 iving active treatment for the on palliative care. When necessary to have an accurate in R17 was not being actively onded "that is a good point." ed R17's medical record lacked the justification for the use of ry Incontinence - Clinical ctober 2010, indicated the ement of urinary incontinence ident is admitted from the ly placed indwelling catheter, cian and staff will evaluate the ing it, depending on the current ationale for its original ne physician will identify indwelling urethral or ar are indicated, and will		15			

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	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURV COMPLETE	/EY
		245535			05/22/20	14
NAME OF F	PROVIDER OR SUPPLIER	2.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	03/22/20	14
JOURDA	IN/PERPICH EXT CA	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMP	X5) PLETIC ATE
F 315		age 31 er alternatives are not	F 315			
F 318 SS=D	feasible." 483.25(e)(2) INCRI IN RANGE OF MO	EASE/PREVENT DECREASE TION	F 318		7/1/1	4
Based on the comprehensive assessment of a resident, the facility must ensure that a resident 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.						
	by: Based on observa review, the facility f of a splint device in contractures (a cor to passive stretch o (R7) reviewed for li Findings include: R7's undated Disea R7 was diagnosed of the arm, leg and body).	NT is not met as evidenced tion, interview and document ailed to ensure the application order to prevent further adition of fixed high resistance of a muscle) for 1 of 1 resident mitations in range of motion. ases Index Report indicated with hemiplegia (total paralysis trunk on one side of the mum Data Set (MDS) dated		Jourdain Perpich will increase/preve decrease in range of motion. A. R7 orders for application of splint clarified by Physical Therapy. R7 now wears left hand splint at all times exc during cares. Care plan updated. B. All residents with orders for splints have care plan reviewed and updated residents with splints will have slints applied as per care plan. C. Policy and procedure for the application of splints will be reviewed updated as needed. Staff education of be conducted on June 24th at a mee D. Plan of correction will be monitore	were ept d. All and will ting.	
	2/16/14, indicated I impairment and rec two plus staff for be and toileting and re person for persona identified R7 to hav	R7 had severe cognitive quired extensive assistance of ed mobility, transfer, dressing equired extensive assist of one I hygiene. The MDS further re functional limitation in range er and lower extremity		the Director of Nursing or designee. Report will be made to QAPI at least quarterly.	5	

		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING			05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	Continued From pa impairment on one R7's physician order to apply R7's left ha day and throughout The Splint Wear & 0 9/16/13, indicated F hours 4 times a day hours twice a day a to asses for skin rea R7's care plan date apply R7's left hand ordered. On 5/21/14, during 7:03 a.m. through 9 to be wearing the le observed stored on -At 11:20 a.m. R7 w dining room table. F applied. -At 1:25 p.m. R7 ob splint was observed R7's bed. -At 2:28 p.m. R7 wa The left hand splint to R7's bed. -At 3:08 p.m. R7 rear remained on the be	age 32 side. ers dated 5/5/14, directed staff and splint for 4 hours twice a t the night. Care instructions dated R7's splint was to be worn 2 y for 2 weeks followed by 4 and at night and directed staff dness. ed 5/20/14, directed staff to d splint for contractures as continuous observations from 0:29 a.m. R7 was observed not eft hand splint. The splint was a hamper in R7's room. was observed seated at a R7's left hand splint was not observed in bed. The left hand d stored on a hamper next to as observed in bed, awake. the remained on the hamper next emained in bed and the splint edside hamper.	F	318			
	(NA)-C stated the N	8 a.m. nursing assistant NAs were responsible to apply t every day. NA-A indicated the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245535	B. WING			05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 F 323 SS=D	both indicated the a times to be worn we -At 10:21 a.m. NA- care of R7 on 5/21/ applied R7's splint a NA-B stated the spl at a time. -At 3:17 p.m. the d confirmed R7's orde splint was to be wor throughout the nigh assignment sheet w residents needs and direction as to how The DON stated sh applied as ordered. A policy on the use none was provided. 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and adequate supervision prevent accidents.	rn all day. NA-C and NA-A application of the splint and ere not documented. B confirmed she had taken 14, and verified she had not at any time throughout the day. int was to be worn for 2 hours irector of nursing (DON) ers indicated the left hand rn 4 hours twice per day and t and also confirmed the NA which informed the staff of the d care directives lacked long the splint should be worn. e expected R7's splint to be of splints was requested but F ACCIDENT VISION/DEVICES usure that the resident has as free of accident hazards each resident receives on and assistance devices to NT is not met as evidenced ion, interview and document		318	Jourdain Perpich has a plan in plac	e to	7/1/14
	by: Based on observat				Jourdain Perpich has a plan in plac ensure the safety of all residents.	e to	

Facility ID: 00355

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STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			ECONSTRUCTION	· /	SURVEY
		IDENTIFICATION NONDER.	A. BUILDIN	NG _		COM	
		245535	B. WING _			05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 323	1 resident (R3) in the for side rail use. In complete an assess residents (R23) rev Findings include: R3 was observed to the facility failed to related to the safe of R3s quarterly Minin 3/5/14, indicated R3 impairment and wa (paralysis of all 4 lin MDS also indicated assistance with bed dependent on staff mechanical lift. R3's Fall Risk asse 2/7/14, 3/5/14, 3/26 R3 was at high risk assessment dated bilateral side rails (state)	to the use of side rails for 1 of he facility who was reviewed addition, the facility failed to sment after falls for 1 of 3 iewed for accidents. The have bilateral side rails and complete a safety assessment use of the rails. The mum Data Set (MDS) dated 3 had severe cognitive s diagnosed with quadriplegia mbs below the neck). The I R3 required extensive staff d mobility and was totally	F 32	23	<ul> <li>A. R3 was reassessed for use of harails. Side rails have been discontirand removed from bed. Care plana NAR assignment sheets updated.</li> <li>B. All side rails were reviewed as appropriate. Policy and Procedure comprehensive assessments will breviewed and updated as needed. Comprehensive assessment include falls and side rails.</li> <li>C. Policy for comprehensive assess was reviewed by Interdisciplinary teand updated. Side rail and fall assessments will be done at within of admission, quarterly and yearly or residents. Fall assessments are completed after each fall and report the QAPI team monthly. Staff will be reducated on procedures on compassessments at the June 24th meet D. Plan of correction will be monito Director of nursing or designee and results will be reported to QAPI teal least quarterly</li> </ul>	for e The es both sments eam 7 days on all ted to be pleting eting. red by	
	to identify R3's hist R3's current care p reviewed by staff or potential for falls re directed staff to ass mechanical lift. The utilized a hi-lo bed i mattress, wheelcha	ction of the assessment failed ory of rolling out of bed. lan dated 9/16/13, and n 3/5/14, indicated R3 had a lated to quadriplegia and sist R3 with transfers via a e care plan also indicated R3 n lowest position, concave sir and bed clip alarms, mats ected staff to not leave R3					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245535	B. WING _			05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	Continued From pa unattended in his ro and to provide ever However, the care p the bilateral half SR The Incident Repor 9/16/13, and 9/20/1 Investigation (FSI) 11/14/13, through 5 revealed: -9/16/13, at 10:20 p the mat and half on position. R3 did not concave mattress v intervention. -9/20/13, at 11:00 p bed in lowest position alarm was on and v injury. All the current been implemented -11/14/13, at 7:30 p prior to being found boxing on TV and v boxing," which cause did not sustain an in -2/7/14, at 1:15 p.m out of the bed. R3 co -3/3/14, at 12:00 a.t staff that R3 had ro floor. The floor mat was on and working	age 35 born while in the wheelchair ry 1 hour visual safety checks. plan did not address the use of Rs. the Forms were reviewed from 3. The Fall Scene Reports were reviewed from 5/11/14 and the following was o.m. R3 was found lying half on the floor, bed in lowest t sustain an injury. The was added as a fall o.m. R3 was found on the floor, floor mats on the floor, clip working. R3 did not sustain an int care plan interventions had at this time. o.m. R3 was found on the floor, d on the floor R3 was watching was very excited and was "air sed him to fall out of bed. R3 njury. n. R3 had an unwitnessed roll did not sustain an injury. m. R3's roommate alerted olled out of bed and was on the t was in place and the alarm g. R3 did not sustain an injury.	F 32	23			
		m. R3's roommate alerted n the floor, wrapped in					

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING		05/22/2014	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 4856 HOSPITAL DRIVE		
JOURDAIN/PERPICH EXT CARE FAC				REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa blankets laughing a an injury. -4/12/14, at 6:00 a.r next to his bed. R3 sustain an injury. -4/28/14, at 6:40 a.r and the alarm could door. When entered mat by the bedside. -5/11/14, at 10:20 p in his room on his s his elbows in the cr R3 was again found staff. R3 did not sus On 5/20/14, at 1:08 on his right side, as the wall with a mate alarm was attached bilateral half SRs ra On 5/21/14, at 7:03 on his left side, asle attached to the bott on the floor. -At 7:10 a.m. nursin were observed to use repositioning. NA-A lowest position it wo	and smiling. R3 did not sustain m. R3 was found on the floor was smiling. R3 did not m. R3's room call light was on d be heard through the closed d room, R3 was found on the . R3 did not sustain an injury. o.m. R3 was found on the floor stomach and was leaning on awling motion. At 10:50 p.m. d on the mat next to his bed by stain an injury. g p.m. R3 was observed in bed sleep. The bed was up against on the floor. The bed clip d to R3's shirt. There were aised on the bed. a.m. R3 was observed in bed sleep. The bed clip alarm was tom of his shirt. The mat was hg assistant (NA)-A and NA-E urn R3 from side to side in the ief for incontinence. R3 was e either SR to assist with the a stated R3's bed was in the ould go. She stated there were	F 323			
		hat did go all the way to the				

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CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE JOURDAIN/PERPICH EXT C (X4) ID SUMMARY S PREFIX (EACH DEFICIEN	CARE FAC	A. BUILD B. WING ID PREFI	S S 24 R	O E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 4856 HOSPITAL DRIVE EDLAKE, MN 56671 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	FORM <u>MB NO.</u> (X3) DATE COM 05/2	06/20/2014 APPROVED 0938-0391 E SURVEY PLETED 22/2014 COMPLETION DATE
TAG REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
<ul> <li>assist R3 into the lift. The wheelch</li> <li>-At 10:00 a.m. N/ assist R3 into beer rolled from side to R3 was no obser assist with reposi attached to R3.</li> <li>On 5/21/14, at 3:: was admitted the lived at home with floor without a pill use the SRs with bed alarm notified the mat. NA-H sta hourly and so did medications.</li> <li>On 5/22/14, at 8:: (DON) and RN-A stated the SR assi quarterly at a mir stated when RN-on 3/5/14, R3 had therefore, the ass DON and RN-A s and slept on a flo</li> <li>-At 8:41 a.m. RN-R3's quarterly SR December and st turning.</li> <li>-At 8:55 a.m. the (TMA)-B stated s</li> </ul>	A and NA-E were observed to wheelchair via the mechanical air clip alarm was attached. A-E and NA-F were observed to d via the mechanical lift. R3 was o side to have his brief checked. ved to use either side rail to tioning. The bed clip alarm was 25 p.m. NA-H stated when R3 facility, staff was told R3 had h family and had slept on the low. NA-H stated R3 would only turning. NA-H also stated the d staff that R3 was already on ated the NAs checked on R3 the staff person administering 26 a.m. the director of nursing were interviewed. The DON sessment should be reviewed himum. The DON and RN-A both B reviewed the SR assessment d a history of rolling out of bed, sessment was not correct. The tated R3 had lived with family	F3	323			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES		 0	FORM. MB NO.	06/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING	 	05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC		4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Continued From pa administration reco -At 9:00 a.m. the Durisk for falls and statchecks. The DON a NAs to do the seco brief at that time. The intervention had no DON added the nig cares between 5:30 time she wanted R3 after those cares wishift staff. The DON also not been include -At 9:46 a.m. the Durisk committee she everyone. On 5/22/14, at 10:0 observed to transfer mechanical lift. R3 brief change, and R either SR. On 5/22/14, at 1:02 not have a policy re R23 had a history of complete a post fall causes and intervet R23's significant chindicated R23 had of diagnosed with a st	age 38 ord (MAR). ON confirmed R3 was at high ated R3 was on hourly safety added, it would not hurt for the ind step and just check R3's he DON verified this it been care planned. The pht shift provided morning 0 a.m. and 6:30 a.m. at which 3 assisted into the wheelchair rere completed by the night N stated this intervention had ded on R3's care plan. ON stated she had been the cility falls and at the last fall opened the meeting to 0 a.m. NA-F and NA-G were er R3 into bed via the was rolled side to side for a R3 was not observed to use P.p.m. the DON stated she did egarding SR assessments. of falls and the facility failed to I analysis to determine root ntions to prevent further falls.	TAG		RIATE	DATE
	dementia, Parkinso mellitus. The MDS	ness to one side of the body), on's disease and diabetes further indicated R23 required ce with mobility, toileting and				

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING			05/2	22/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	AIN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	had occasional blac also indicated since completed on 1/26/ injury, one fall with injury. R23's Activity of Da and Fall Potential C indicated R23 was stabilize without sta and ambulation and R23's current care R23 had decreased related to dementia hemiparesis and Pa plan indicated R23 assistance to sit up legs into bed. Staff extensive assist for interventions includ brakes locked, fall u light within reach, n strips at bedside, of sensor alarm on be attempts to self tran R23 would ambulat times per week x 90 to ambulate R23 to the care plan did no visual checks, hi-lot that staff were not t room while in the w On 5/22/14, at 10:0 ambulate 200 feet of (FWW), with the re rehab aide stated F	dder incontinence. The MDS e the last assessment (14, R23 had two falls without injury, and no falls with major and no falls with major (14, R23 had two falls with major (14, R23 had two falls with major (14, R23 had two falls with major (15, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10	F3	323			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED	
		245535	B. WING			05/;	22/2014
NAME OF F	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDAIN/PERPICH EXT CARE FAC					24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa and refusals to amb The Nurse Notes at Report and Fall Sce were reviewed from revealed the followi - 1/23/14, at 5:30 a. Observation form in floor by the end of h right eye with small going to the bathroo was unsure where g -The 1/23/14, at 5:3 Investigation Report balance, was found ambulating, going to wearing socks. No added. The Falls Scene Inv documentation rega used, last time toile interventions to pre updated, nurse aide Team Meeting Note - 2/6/14, (no time) r indicated R23 had a head and right fore abrasion on R23's r R23 returned from The 2/6/14, ER/Clin	ge 40 pulate. Ind Observation, Incident ene Investigation Report forms a 1/23/14, and 5/18/14, and ng information: Im. the Nursing Notes and adicated R23 was found on the his bed with a small cut above amount of blood. R23 was om and lost his balance, and got cut. B0 a.m. Fall Scene t form indicated R23 lost on floor, in his room, was on the bathroom and was new fall interventions were vestigation Report lacked arding if alarms were being ted, root cause of fall, vent future falls, care plan e assignment updated, Fall es and conclusion. Invising notes and observation a fall in his room, right side of arm hurt. Noted a small right forearm. At 1:10 p.m. the emergency room. tic Referral form indicated R23 hit the right side of his face	1	323	DEFICIENCY)		
	Report indicated R2 chair to bed, he had	3 a.m. Fall Scene Investigation 23 tried to self transfer from 3 shoes on. The report 5 not being used and root					

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245535	B. WING			05/2	22/2014
NAME OF PROVIDER OR SUPP	LIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JOURDAIN/PERPICH EX	ТСА	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
PREFIX (EACH DEFIC	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
The Falls Scendocumentation interventions t updated, nurse Fall Team Mee No new interver - 3/13/14, at 11 indicated R23 facing face firs bathroom, bra wheelchair. Ne On 5/21/14, at report should I At 3:05 p.m. th not leave R23 seated in the v bathroom assi place after the were not adde - 3/17/14, p.m Observation fle from his chair stated "my har noted bruises put in place. The 3/17/14, F lacked docum root cause of f falls, care plar updated, Fall conclusion.	as the ne in reg. o pre- e aid- ention :40 a was st. R2 kes v o nju :1:45 have o no inju :1:45 have o no ov stand fall. (no ow sl while nd sli or inj Fall S entat all, ir o upd Faam 50 p. had I	ne alarm not sounding. vestigation Report lacked arding last time toileted, event future falls, care plan e assignment sheet updated, Notes, and conclusion. Ins put into place. .m. the Vital Sign Report sheet found on the floor, by his bed 23 stated he was going to the were noted not to be locked on		323			

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245535	B. WING _			05/	22/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
JOURDA	NN/PERPICH EXT CA	RE FAC			1856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 323	Continued From pa fell, going from bath complained of forea was completed with and R23 returned b No new intervention The 5/18/14, Fall S lacked documentati root cause of fall, in falls, care plan upda updated, Fall Team conclusion. On 5/21/14, at 2:55 Fall Assessment sh fall. The DON state some issues with si needed information DON stated staff we with filling out incide RN-A stated the fac with the licensed sta complete incident for perform a thorough occurrence and sta work on the issue. On 5/22/14, TMA-A visual checks and if medication adminis stated it was the res with completing the On 5/23/14, at 7:00 (LPN)-B (night staff	age 42 hroom to bed, hit his head, and arm pain. An x-ray of forearm n of findings, no new orders back to the facility. Ins put into place. cene Investigation Report ion regarding last time toileted, herventions to prevent future ated, nurse aide assignment Meeting Notes and i p.m. the DON stated a full hould be completed after every d the facility had been having taff completing the required after residents had a fall. The ere having issues in complying ent reports completely. cility recently had meetings aff regarding the need to orms and instructed them to assessment after each fall ff were currently continuing to A stated R23 was on hourly t was documented on R23's stration record (MAR). TMA-A sponsibility of all staff to assist e one hour checks. a.m. licensed practical nurse b stated R23 usually yelled	F 32	23		RIATE	DATE
	the one hour visual	omething. She stated she felt checks were very beneficial. p.m. RN-A verified complete					

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		245535	B. WING _		05/22/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
JOURDA	IN/PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323 F 325 SS=D	fall assessments we R23's care plan was had been put in plan The facility policy, A Causes, dated 4/24 the procedure was assessing a resider in identifying causes directed staff to tak what to do after the details of the fall, id risk, performing a p identifying complicat 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the fac resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that to (2) Receives a there	ere lacking on R23 falls and s lacking fall interventions that ce. Assessing Falls and Their I/13, indicated the purpose of to provide guidelines for nt after a fall and to assist staff s of the fall. The policy e steps in the procedure of, fall, the need to define the entifying causes of a fall or fall tost-fall evaluation and ations of falls. N NUTRITION STATUS DABLE tt's comprehensive cility must ensure that a ptable parameters of nutritional ly weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a	F 3:			7/1/14	
	by: Based on observat review, the facility fa loss was comprehe interventions impler	NT is not met as evidenced tion, interview and document ailed to ensure ongoing weight ensively assessed and mented to minimize further 3 residents (R4) in the facility		Jourdain Perpich will ensure that a residents maintain acceptable para of nutritional status unless medica explainable and receive a therape when there is a nutritional problem A. R4 was reevaluated on 5-28-14	ameters Ily utic diet 1.		

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING			05/2	22/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				24	4856 HOSPITAL DRIVE		
JOURDA	IN/PERPICH EXT CAI	RE FAC		R	EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 44	F 3	25			
	The findings include	э:			recommendations were made. Car was reviewed and updated. Improv status with a significant decrease ir	ed fluid	
	was admitted to the	FACE SHEET identified R4 a facility with diagnoses that			edema contributed to the weight los Protein needs were calculated by d	ietitian	
	mellitus, anemia, bl	ot limited to: type II diabetes lindness of both eyes,			on January 2, 2014 and the same r continue to hold for current weight.		
	pressure ulcer, ven esophageal reflux.	ous stasis ulcer and			B. All residents will be monitored fo significant weight loss by the registe	ered	
		nge Minimum Data Set (MDS) cated R4 had severe cognitive			dietitian on a quarterly basis unless is a significant weight loss noted the at least a monthly basis. Nursing st	en on	
	impairment, was ind tray set up and had	dependent with eating after a weight loss of 5% or more r a loss of 10% or more in the			notify registered dietitian of all resid noted to have significant weight los bath CNA will reweigh if there is a p minus 5 pound weight change.	lents s. The	
	Review of the weigh	ht record for R4 revealed that			C. Policy and procedure was review and updated to include a nutritional		
	R4 weighed 201. O	ned 232.6 pounds. On 2/10/14, n 3/10/14, R4 weighed 186.			intervention program utilizing real for first, then the addition of high calori	e, high	
	5/12/14, R4 weighe	ghed 187 pounds, and on d 178 pounds. The record st 54 pounds since 1/1/14.			protein foods. Staff education will b provided June 24th, 2014 at the nu staff meeting		
		eated up on the edge of the			D. Plan of correction will be monitor DON or designee on a weekly basis		
	ready and served. F	7:57 a.m. when breakfast was R4 received the meal but demanded to be assisted back			weeks, then monthly thereafter. QA be updated on at least quarterly.	NPI will	
	into bed. R4 did not	t eat the breakfast meal. R4 ny further nutrition until the					
	noon meal at 11:37 was served a bread	a.m. during which time R4 ded chicken patty, egg					
	ice cream for desse	d, a bowl of tomato soup and ert. R4 stated to nursing					
	served but was not	at he did not like the meal observed to be offered an ce. R4 was observed to					
	consume 75% of th	the tomato soup, 0% ice					

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245535	B. WING			05/:	22/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	cream, 0% bread a observed to be enc the meal and the m room at 12:23 p.m. R4's care plan for n R4 had a goal to ha weight of 195# (+ /- The care plan direct regular diet, set up arrange food to enh provide built-up silv offer healthy snacks intake of high prote percentages and to dietician at least qu care plan also direct weight, labs and vit Review of the last of dietician progress n R4 had a significan and 17% in 180 day R4's weight fluctuat and R4 was still in t Additionally, the not consistent carbohyd diet and consumed the occasional 100° indicated R4 was in tray set up with the R4's usual weight w was hard to assess refused all blood su medications. The R lower extremity ede reporting R4 had so and had a decline in	nd 0% milk. R4 was not ouraged to eat any more of leal tray was removed for R4's	F	325			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245535 B. WING 05/22/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE JOURDAIN/PERPICH EXT CARE FAC REDLAKE, MN 56671 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 325 Continued From page 46 F 325 weight. The RD assessment had not identified what nutritional interventions were going to be implemented to minimize further weight loss. Additionally, the RD had not identified R4's protein needs for wound healing and had not initiated a nutritional supplement despite the massive weight loss in 5 month's time nor issues related to impaired skin integrity. The RD was interviewed via telephone on 5/22/14, at 1:13 p.m. during which she stated she was not aware that R4 continued to have weight loss after she had assessed R4 on 3/27/14. The RD stated she consulted at the facility twice a month and monitored all of the residents weights monthly. The RD confirmed nutritional interventions had not been implemented to minimize ongoing weight loss for R4. The director of nursing was interviewed on 5/22/14, at 1:27 p.m. and confirmed she was not aware R4 had a 54 pound weight loss since 1/1/14, and stated R4 should have been comprehensively assessed and nutrition interventions should have been implemented to minimize further weight loss. 483.25(n) INFLUENZA AND PNEUMOCOCCAL 7/1/14 F 334 F 334 **IMMUNIZATIONS** SS=B The facility must develop policies and procedures that ensure that --(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245535 B. WING 05/22/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE JOURDAIN/PERPICH EXT CARE FAC REDLAKE, MN 56671 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 334 Continued From page 47 F 334 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization: and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization: and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization: and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY
	O CONNECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG	COM	
		245535	B. WING _			22/2014
	PROVIDER OR SUPPLIER	RE FAC		STREET ADDRESS, CITY, STATE, ZIP CODE 24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	(X5) COMPLETIO DATE
F 334	pneumococcal imm (B) That the residu pneumococcal imm the pneumococcal contraindication or (v) As an alternative and practitioner rec pneumococcal imm years following the immunization, unless	nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F 33	34		
	by: Based on interview facility failed to ens influenza immuniza R39) residents or the received the require benefits and potent immunization. Findings include: R18's family membe influenza immuniza this information did and risks of a influent R43's family members.	NT is not met as evidenced y and document review, the ure that prior to receiving the tition 4 of 4 (R18, R43, R3, heir legal representative ed education regarding the tial side effects of the end to via phone on 9/12/13. The ation form, which documented not address all the benefits enza immunization. R18 iza immunization on 9/26/13.		Jourdain Perpich will provide e on benefits and side effects of influenza and pneumococcal va prior to the administration. A. Facility will utilize the informat obtained from the CDC to educ residents and/or responsible pa B. Consent and refusal form fo influenza and pneumococcal va has been updated to include th education was provided. If vert is obtained, infection control nu mail the educational informatio C. Policy and Procedure has be developed and approved by the Administator and Medical Direc D. Plan of correction will be mo the Director of Nursing or desig Results will be reported to QAF	the accination, ation sheet sate all arty. r the accination at cal consent rse will n sheet. een etor. nitored by pnee.	

Facility ID: 00355

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STATEMENT OF DEFICIENCIES       (X) PROVDERSUPPLIENCLA IDENTIFICATION NUMBER:       (X) MULTIPLE CONSTRUCTION A BUILDING       (X) DATE SUPVEY COMPLETED         VAME OF PROVDER OR SUPPLIEN       245535       B. WING       05/22/2014         INME OF PROVDER OR SUPPLIEN       STREET ADDRESS, CITY, STATE, ZIP CODE       24656 HOSPITAL DRIVE REDLAKE, MN 56671       05/22/2014         INME OF PROVDER VOIDS DE ENTIFYING WFOMMENDON       PRETX REDLAKE, MN 56671       DR PROVDERS PLAN OF CORRECTIVE ACTION SHOULD BE CONSERVENCE ACTION SHOULD BE DEPROVENCE STATE ADDRESS, CITY, STATE, ZIP CODE       Continued From page 49 and risks of a influenza immunization. R43 received his influenza immunization on 9/26/13.       F 334         R3's family member gave verbal consent for the influenza immunization on 9/26/13.       F 334       F 334         R3's gave written consent for the influenza immunization on 9/26/13.       F 334         R3's gave written consent for the influenza immunization on 9/26/13.       F 334         R3's gave written consent for the influenza immunization on 9/26/13.       F 334         No 5/22/14, at 7:52 a.m. registered nurse (RN)-B stated she knew the alert residents received the vaccination information sheet (VIS). However, there was no documentation that R39 had received the VIS sheet prior to the influenza immunizations.       -A1 7:55 a.m. licensed practical nurse (LPN)-A stated if the family member was present at the time of the immunization. There was no documentation that ndicated if the family members had received the education.       At 8:47 a.m. the director of nursing (DON) state			I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2IP CODE       JOURDAIN/PERPICH EXT CARE FAC     24856 HOSPITAL DRIVE       Image: Control of the state of the	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
JOURDAIN/PERPICH EXT CARE FAC         24856 HOSPITAL DRIVE RELAKE, IMN 56671           (PA) ID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY FULL FAG         ID PREFX REGULATORY OR LSC DENTIFYING NFORMATION)         ID PREFX TAG         PREFX PREFX         PREFX CONSERVENE ACTION SHOULD BE DEFICIENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREFX TAG         PREFX PREVENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREFX TAG         PREFX PREVENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREFX TAG         PREFX PREVENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREVENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         CONCENTRY TAG         PREVENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREVENCENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREVENCENCENCY         CONCENTRY OF LSC DENTIFYING NFORMATION)         ID PREFX         PREVENCENCENCENCENCENCENCENCENCENCENCENCENCE			245535	B. WING _			05/:	22/2014
JOURDAIN/PERPICH EXT CARE FAC         REDLAKE, INN 56671         (24) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES INCLOSE OF THE APPROPRIATE IECACLEPTICIENCY MUST BE PRECEEDED BY FULL RECOULATORY OR LSC IDENTIFYING INFORMATION)       IDENTIFYING INFORMATION         F 334       Continued From page 49 and risks of a influenza immunization on 9/26/13.       F 334       F 334       F 334       F 334         R35 family member gave verbal consent for the influenza immunization on 9/26/13.       F 334       F 334       F 334         R39 gave writhen consent for the influenza immunization of p13/3. The Influenza immunization of 9/36/13.       F 334       F 336         R39 gave writhen consent for the influenza immunization of 1/25/14.       On 5/22/14, at 7:52 a.m. registered nurse (RN)-B stated she knew the alert residents received the vaccination information that R39 had received the VIS sheet prior to the influenza immunizations.       -At 7:55 a.m. incensed practical nurse (LPN)-A stated if the family member was present at the time of the immunization nurse (LPN)-A stated if the family member was no documentation that R39 had received the ducation, and stated if the family members had received the education.         At 8:47 a.m. the director of nursing (DON) stated she thought the influenza immunization consent form was up to date and that RN-B was following	NAME OF F	PROVIDER OR SUPPLIER						
Pričej TAG       (EACH OERICENCY NUST BE FRECEDBO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE APROPRIATE DEFICIENCY)       COMMENT         F 334       Continued From page 49 and risks of a influenza immunization. R43 received his influenza immunization on 9/26/13.       F 334         R3's family member gave verbal consent for the influenza immunization of 9/12/13. The Influenza immunization on 9/26/13.       F 334         R3's family member gave verbal consent for the influenza immunization on 9/12/13. The Influenza immunization on 9/26/13.       F 334         R3's gave written consent for the influenza immunization on 9/12/13. The Influenza immunization on 9/12/13. The Influenza immunization on 9/12/14.       F 334         On 5/22/14, at 7:52 a.m. registered nurse (RN)-B stated she knew the aler treidents received the vaccination information did of the fullenza immunizations.       F 39 had         -At 7:55 a.m. licensed practical nurse (LPN)-A stated if the family member was present at the time of the immunization then they would have received the vill sheet prior to the influenza immunizations.       -At 7:55 a.m. the director of nursing (DON) stated she thought the influenza immunization consent form was up to date and the RN-B was following	JOURDA	IN/PERPICH EXT CA	RE FAC					
and risks of a influenza immunization. R43 received his influenza immunization on 9/26/13. R3's family member gave verbal consent for the influenza immunization or m, which documented this information did not address all the benefits and risks of a influenza immunization. R3 received his influenza immunization on 9/26/13. R39 gave written consent for the influenza immunization form, which documented this information did not address all the benefits and risks of a influenza immunization. R39 received his influenza immunization. R39 received his influenza immunization. R39 received his influenza immunization. R39 received his influenza immunization on 1/25/14. On 5/22/14, at 7:52 a.m. registered nurse (RN)-B stated she knew the alert residents received the vaccination information sheet (VIS). However, there was no documentation that R39 had received the VIS sheet prior to the influenza immunizations. -At 7:55 a.m. licensed practical nurse (LPN)-A stated if the family member was present at the time of the immunization that hey did not receive the information. There was no documentation that indicated if the family member was not present, then they did not receive the information. At 8:47 a.m. the director of nursing (DON) stated she thought the influenza immunization consent form was up to date and that RN-B was following	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
-At 2:43 p.m. RN-B stated the influenza	F 334	and risks of a influer received his influent R3's family member influenza immunizat Influenza Immunizat this information did and risks of a influer received his influent R39 gave written co- immunization on 9/ Immunization form, information did not risks of a influenza his influenza immun On 5/22/14, at 7:52 stated she knew the vaccination informat there was no docur received the VIS shi immunizations. -At 7:55 a.m. licens stated if the family it time of the immunization received the education member was not pri- receive the informat documentation that members had received At 8:47 a.m. the dir she thought the infl form was up to date up on it.	enza immunization. R43 iza immunization on 9/26/13. er gave verbal consent for the ation via phone on 9/12/13. The ation form, which documented not address all the benefits enza immunization. R3 iza immunization on 9/26/13. onsent for the influenza 13/13. The Influenza , which documented this address all the benefits and immunization. R39 received nization on 1/25/14. 2 a.m. registered nurse (RN)-B e alert residents received the ation sheet (VIS). However, mentation that R39 had neet prior to the influenza sed practical nurse (LPN)-A member was present at the zation then they would have tion, and stated if the family resent, then they did not indicated if the family ived the education. rector of nursing (DON) stated luenza immunization consent e and that RN-B was following	F 3:	34	DEFICIENCY)		

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		245535	B. WING	i		05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC			24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334 F 356 SS=C	Disease Control (C to the resident/fami documentation that representative had The Influenza Vacc indicated prior to the resident's legal reprinformation and edu and potential side effrom the CDC. This documented in the 483.30(e) POSTED INFORMATION The facility must por a daily basis: o Facility name. o The current date. o The total number by the following catuunlicensed nursing resident care per sh - Registered nu - Licensed prac vocational nurses (a - Certified nurse o Resident census. The facility must por specified above on of each shift. Data o Clear and readab	y indicated the Centers for DC) VIS sheet would be given ily. RN-B verified there was no t residents / legal received it. the policy revised 12/12, the vaccination, the resident or resentative would be provided ucation regarding the benefits effects of the influenza vaccine is education would be resident's medical record. O NURSE STAFFING the following information on and the actual hours worked regories of licensed and staff directly responsible for hift: trises. trical nurses or licensed as defined under State law). e aides.		334			7/1/14
	The facility must, up	pon oral or written request,					

Facility ID: 00355

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING			05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	NN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE EDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	make nurse staffing for review at a cost standard. The facility must mas staffing data for a n required by State la This REQUIREMEN by: Based on interview facility failed to ens and the total number category of staff we posting as required affect all 43 resider as well as any visitor information Findings Include: On 5/22/14 at 3:05 Staff Directly Respon forms dated 5/19/14 5/22/14, were revie (DON) and ward clean included fields for co included columns for and night), licensed and night), licensed and LPN columns) (including TMA and hours worked for ea total number of hou of staff. The WC ve include the rehabiliti it contain the nurse registered nurse (R	ge 51 g data available to the public not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater. NT is not met as evidenced y and document review, the ure the actual hours worked er of hours worked for each ere reflected on the nurse staff . This had the potential to its who resided in the facility prs who wished to view this p.m. the Report of Nursing possible for Resident Care 4, 5/20/14, 5/21/14, and wed with director of nursing erk (WC). The reports late and census. It also or shift (including day, evening I nursing staff (including RN and certified nursing staff NA). The form lacked actual ach individual shift and the trs worked for each category erified the report did not ative aid hours worked nor did manager hours in the N) column. The DON red information was lacking.	F3	356	Jourdain Perpich will post accurate staffing information. A. Staff information data sheet was revised to reflect facility name, curr date, and total number of staffing h and actual hours worked and reside census. B. Staff information will be posted b ward clerk and/or charge nurse dai information will be kept for a minim 18 months. C. Policy and procedure will be revi and updated as needed. Staff educ regarding posting will be provided in meeting June 24, 2014. D. Plan of correction will be moniton Director of Nursing or designee and reported to QAPI at least quarterly.	ent ours ent by the ly. Staff um of iewed cation n staff red by	

Facility ID: 00355

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		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/:	22/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CAI	RE FAC		24856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 356	Continued From pa	ge 52	F 356			
F 441 SS=F	requested but none	nurse staffing posting was e was provided. N CONTROL, PREVENT	F 441			7/1/14
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inco professional practic	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted				
	(c) Linens Personnel must har	ndle, store, process and				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245535	B. WING		05/2	22/2014
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	NIN/PERPICH EXT CAI	RE FAC		4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	transport linens so a infection. This REQUIREMEN by: Based on interview facility failed to anal infections for both s the facility was lack policies and proced affect all 43 residen Findings include: The facility's infection surveillance program patterns and trends Monthly Infection C reviewed from Nove 2014. The IC logs r prescribed antibiotic tracking system lac without antibiotics.	ge 53 as to prevent the spread of NT is not met as evidenced y and document review, the lyze patterns and trends of staff and residents. In addition, ing current infection control lures. This had the potential to its who resided in the facility.	F 441	Jourdain Perpich will establish and maintain an infection control progra provide a safe, sanitary and comfor environment and to help prevent th development and transmission of d and infection. A. Resident infections and staff illne will be investigated, controlled and spread of infection prevented. B. An infection control policy and procedure has been developed and implemented. All resident and staff will be monitored and tracked, appr measures will be taken to prevent t spread of illness. C. Policy and procedures will be re- and updated on a yearly basis. The infection control nurse will track and illnesses and implement the necess	im to rtable e sisease esses the illness opriate he viewed c log all	
	surveillance betwee illnesses had not be On 5/21/14, at 1:35 who functioned as t interviewed. RN-C s nurse on 3/7/14. RN performed any hand became the IC nurs documented handw 2012. RN-C stated nurse, RN-B had be	en resident and employee		<ul> <li>measures to prevent the spread of and infection.</li> <li>D. The plan of correction will be moby the Director of Nurses. QAPI will continue to be updated monthly by Infection Control Nurse or Director Nursing.</li> </ul>	illness onitored I the	

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245535 RE FAC	. ,	S 24		FORM MB NO. (X3) DATE COM	06/20/2014 APPROVED 0938-0391 E SURVEY PLETED 22/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	attention that it desi worked on the floor time for extra duties that RN-B had beer adequate IC surveil The undated Clostr spore which causes reviewed with RN-C procedures indicate contamination and However, the C-DIF the disinfection wou C-DIFF policy indica state how. RN-C stated stated they were to ask for stated there were for employee was sick symptoms. RN-C si were given to the di RN-C stated she has employee illness for stated the employee like they should be, indicated an employ rechecked when the RN-C stated this wa trying to get "on top was not sure if ther illness policy. In addition, RN-C si of communicable d reported to the MN stated there were s lacking, RN-C stated	erved. RN-C stated she also as a RN, and there was no s. RN-C stated she did feel n given the time to do llance. idium Difficile (C-DIFF) (a s watery diarrhea) policy was C. The C-DIFF isolation	F 4	141			

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		AND HUMAN SERVICES				FORM	06/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245535	B. WING			05/	22/2014
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
JOURDA	IN/PERPICH EXT CA	RE FAC			4856 HOSPITAL DRIVE REDLAKE, MN 56671		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	antibiotics. RN-C st resident infections of May. According to t March 2014 IC logs identified related to IC logs failed to ide obtained. RN-C ver she was not the IC stated she had nev without antibiotics. RN-C stated there	track resident illnesses without tated she had not logged the for the months of April and the November 2013, through s, the organism had not been the infection. In addition, the entify if a culture had been ified the findings, and stated nurse at that time. RN-C er tracked resident illnesses	F 4	141			

Facility ID: 00355

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	MENT OF HEALTH		ICES	F55:	35023	FORM	: 05/27/2014 MAPPROVED
STATEMEN	S FOR MEDICARE	& MEDICAID SERV (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTI	PLE CONSTRUCTION G 01 - NURSING HOME	(X3) DATE S COMPL	
90		245535		B. WING		05/2	20/2014
	ROVIDER OR SUPPLIER	ARE FAC	24856 H	RESS, CITY, S HOSPITAL KE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE " BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm time of this survey Extended Care Cer compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conduct nent of Public Safety. The Jourdain/ Perpion ter was found in sub requirements for pa- tid at 42 CFR, Subpa- ety from Fire, and the Fire Protection Assoc 01, Life Safety Code Health Care.	At the h ostantial articipation art 2000 ciation				σ
	1-story building with was constructed in construction. An as building, constructe the building with a 2 and a hospital build care building is sep barrier is to the eas	ich Extended Care C nout a basement. The 1989 and is of Type ssisted living apartme d in 2006 is separate 2-hour fire barrier to t ing, built prior to the arated with a 2-hour t. The building is divints with 1-hour fire ra	e building II(000) ent ed from the west extended fire ided into 3				
	accordance with NF Installation of Sprin The facility has a m corridor smoke dete common areas and notification in accor National Fire Alarm automatic fire detect	sprinkler protected i PA 13 Standard for kler Systems 1999 e anual fire alarm syst ection, smoke detect automatic fire depard dance with NFPA 72 Code" 1999 edition ction in all areas requ	dition. em with ion in all rtment "The and has uired by				
	The facility was sur	veyed as one buildin	g.				
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	NTATIVE'S SIG	NATURE	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.

EPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES ICES				APPROVE 0. 0938-03
TATEMEN		(X1) PROVIDER/SUPPLIED	R/CLIA		PLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		245535		B. WING		05/2	20/2014
	ROVIDER OR SUPPLIER	2			TATE, ZIP CODE		
OURDA	IN/PERPICH EXT (	CARE FAC		IOSPITAL KE, MN 50			
(X4) ID Prefix Tag	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
K 000	Continued From pa	age 1		K 000			
		apacity of 47 beds. A ensus was 43 resider					
	The requirement at MET.	t 42 CFR, Subpart 48	3.70(a) is				
							al
		3					
	2567(02-99) Previous Ve	arsions Obsolete			ISKC21	If continuation	sheet Page 2

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