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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JLTF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**
2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/28/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)
13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 10/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/26/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245495

November 8, 2016

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

Dear Mr. Roche:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 13, 2016 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 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.

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 12, 2016

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

RE: Project Number S5495026

Dear Mr. Roche:

On August 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 8, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On September 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 8, 2016, effective September 13, 2016 and therefore remedies outlined in our letter to you dated August 23, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245495 Y1	A. Building B. Wing Y2	9/28/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0242	Correction	ID Prefix F0253	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(h)(2)	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	09/13/2016
ID Prefix F0280	Correction	ID Prefix F0314	Correction	ID Prefix F0322	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(g)(2)	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	09/13/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0465	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.70(h)	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	09/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	10/12/2016	34983	09/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245495 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	09/13/2016	LSC K0038	09/13/2016	LSC K0050	09/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	09/13/2016	LSC K0062	09/13/2016	LSC K0069	09/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	09/13/2016	LSC K0154	09/13/2016	LSC K0155	09/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	10/12/2016	27200	09/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/4/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 12, 2016

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

Re: Reinspection Results - Project Number S5495026

Dear Mr. Roche:

On September 28, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 8, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00299 Y1	A. Building B. Wing Y2	9/28/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20570	Correction	ID Prefix	20900	Correction	ID Prefix	20930	Correction
Reg. #	MN Rule 4658.0405 Subp. 4	Completed	Reg. #	MN Rule 4658.0525 Subp. 3	Completed	Reg. #	MN Rule 4658.0525 Subp. 7 B.	Completed
LSC		09/13/2016	LSC		09/13/2016	LSC		09/13/2016
ID Prefix	21015	Correction	ID Prefix	21695	Correction	ID Prefix	21800	Correction
Reg. #	MN Rule 4658.0610 Subp. 7	Completed	Reg. #	MN Rule 4658.1415 Subp. 4	Completed	Reg. #	MN St. Statute144.651 Subd. 4	Completed
LSC		09/13/2016	LSC		09/13/2016	LSC		09/13/2016
ID Prefix	21830	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144.651 Subd. 10	Completed	Reg. #		Completed	Reg. #		Completed
LSC		09/13/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	10/12/2016	34983	09/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JLTF

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)
13.Total Certified Beds 109 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 09/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5495

At the time of the survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. In addition the following investigations were conducted and found to be unsubstantiated:

H5495046
H5495048

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 23, 2016

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

RE: Project Number

Dear Mr. Roche:

On August 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5495046 and H5495048 that were found to be unsubstantiated.

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

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

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

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

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

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

Informal Dispute Resolution - 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 September 17, 2016, 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 September 17, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 8, 2016 (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 February 8, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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
Health Regulation Division
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	08/08/2016

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H Complaints H5495048 and H5494046 were investigated and not substantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156		9/13/16

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

Electronically Signed | 09/01/2016

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

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F 156	Continued From page 1	F 156		

facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and

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F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of Medicare Part A skilled services for 1 of 3 residents (R130) reviewed for liability notice and beneficiary appeal right review. Findings include: R130's admission record indicated she was admitted to the facility on 5/11/16, on Medicare Part A. R130's diagnosis sheet indicated diagnoses that included cerebrovascular disease, stroke, muscle weakness, and degenerative	F 156	Immediate corrective action: Education was provided to the Medicare Coordinator on issuing the correct Medicare Denials Action as it applies to others: The Policy and Procedure for denial notices was reviewed and remains current. Effective immediately, all residents who are ending their Medicare covered stay by discharging from the facility will receive the appropriate Medicare Denial notice. Date of completion: 9/13/2016 Recurrence will be prevented by: The Medicare Coordinator will keep a log	

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F 156	Continued From page 3 disease of the nervous system. R130's Discharge Plans Care Plan, dated 5/11/6, indicated R130 anticipated a short stay with a discharge to an assisted living within 30-45 days. On 8/4/16, at 9:53 a.m. registered nurse (RN)-C stated residents receive a notice of Medicare Non-coverage if their Medicare A services are ending and the resident continues to reside in the facility. However, if a resident is discharged and leaving the facility, the resident, or their family are not given a notice of Medicare non-coverage. RN-C stated they assume the resident and family are in agreement with the end of Medicare services if the resident is going home. RN-C reiterated if a resident is going home, the facility doesn't give a written notification to the resident or family. RN-C stated she gives a CMS form 10123 two days prior to the end of Medicare A services when a resident's Medicare A services are ending and they are staying in the facility. RN-C said they assume the resident wants to leave when they are going home, and that residents and therapy are talking. However, RN-C agreed that they do not have the opportunity to appeal the decision if, by some chance, the resident wanted to continue in therapy. RN-C stated R130 did not receive a written notice of her Medicare services ending and did not have the awareness of, nor opportunity to appeal the discharge decision. SNFABN and denial notices for R130 were requested but not received from the facility. A policy and procedure on provision of denial notices was requested but not received from the facility.	F 156	of all Medicare Denials issued and will report weekly at the Medicare meeting. An audit of Medicare Denials will be conducted weekly for 90 days and the results of the audits will be shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: MDS Coordinator and Administrator	

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were allowed a choice between a tub bath or a shower for 2 of 3 residents (R31, R121) reviewed for choices. Findings include: R31's Diagnosis Sheet dated 8/3/16, indicated R31's diagnoses included multiple sclerosis. An Initial Activity Assessment dated 6/7/16, indicated it was very important to choose between a tub bath, shower, bed bath or a sponge bath. The admission Minimum Data Set (MDS) dated 6/9/16, indicated R31 had moderately impaired cognition and required the physical assistance of one staff with bathing. The Unit 2 Shower Schedule (not dated) indicated R31 was scheduled for a shower on Monday and Friday on the evening shift. On 8/02/16, at 10:42 a.m. R31 stated there was not a bath tub and she would like a tub bath if there was a bath tub. On 8/3/16, at 1:00 p.m. licensed practical nurse	F 242	Immediate corrective action: Residents # 31 and 121 were informed of the ability for tub bathing vs. showers. Action as it applies to others: The Policy and Procedure for resident preferences was reviewed and remains current. A house wide audit of residents and families will be conducted to assure bathing preferences are confirmed and added to the Care Plan and Care Card. The practice of establishing Customary Routine will continue to be established upon admission and included in the resident Care Plan and Care Card and verified through Care Conferences. Education was provided to the Activity Director on establishing bathing preferences (shower vs tub) and assuring the preference is added to the Care Plan and Care Card. Nursing staff to review the resident preference policy and procedure. Date of completion: 9/13/2016 Recurrence will be prevented by: Audits will be conducted weekly on	9/13/16

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F 242	Continued From page 5 (LPN)-C stated the the facility had an accessible bath tub on wing 3, and there were only a couple of residents who had asked for a tub bath. On 8/3/16, at 2:15 p.m. nursing assistant (NA)-F stated R31 received a shower two times week and had never asked for a tub bath. On 8/3/16, at 2:19 p.m. LPN-A stated all residents were scheduled a shower two times week. LPN-A was not aware of R31 wanting a tub bath. LPN-A further stated R31 usually refused her shower once week and they had to coax her to take one shower a week. LPN-A stated all residents were scheduled for shower and she does not ask bath or shower preferences on admission. LPN-A further stated if a resident voiced they did not want or like a shower then they were told of their options. LPN-A stated there was a whirlpool bath tub on unit 3 and if a resident wanted a tub bath they could go there. On 8/3/16, at 10: 35 a.m. R31 stated she would not refuse bathing if she could have a tub bath. R31 was not aware there was a bath tub in the facility. R31 stated she did not like a shower because it was cold and she took a tub bath at home. R31 was informed there was a whirlpool tub on wing 3. R31 stated,"Well I'll be damned, no one ever told me there was a bath tub." R31 stated tomorrow was her bath day and she would take a tub bath. On 8/5/16, at 8:00 a.m. the director of nursing (DON) stated an activity assessment was done to determine the resident's customary routine prior to coming into the facility. If a resident preferred a morning or evening shower then we try to accommodate that. The type of bath depended	F 242	different Units x 3 residents x90 days to assure their bathing preferences are being accommodated. The results of the audits will be shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Activity Director and DON	

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F 242	Continued From page 6 on which they prefer. If a resident refused the shower the DON would expect staff to offer a tub or a bed bath and find out why the resident does not want a shower. The facility's Shower/Tub Bath policy dated 6/14, indicated residents would be offered a choice of shower or bath if physically appropriate for either. The policy further directed staff to notify the supervisor if a resident refused the shower or tub bath. R121's order summary report, printed 8/4/16, indicated diagnoses that included fibromyalgia. R121's quarterly MDS, dated 6/2/16, indicted R121 was cognitively intact, was independent with her activities of daily living. R121's admission MDS, dated 3/2/16, indicated preferences in choosing between a shower, tub, bed bath or sponge bath was somewhat important to her. Review of the nursing assistant's workbook revealed R121 is scheduled for a shower on Wednesday and Sunday evenings. On 8/1/16, at 6:52 p.m. R121 stated she did not have the choice between a shower, tub or a bed bath. R121 stated a shower was the only option, and "I've gotten used to them." R121 said she had fibromyalgia and a soak in a tub would feel really good. On 8/4/16, at 10:55 a.m., R121 said she did not know there was a tub available on wing 3, saying, "that sounds nice."	F 242		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		9/13/16

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F 253 SS=E	Continued From page 7 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an environment free of urine odors for all 24 residents residing on wing 4. Findings include: On 8/1/16, at 6:07 p.m. the hallway on wing 4, smelled strongly of urine. Throughout the survey, the hallway on wing 4 continued to have a urine odor, which was stronger toward the center of the hallway. On 8/2/16, at 10:27 a.m. family member (FM)-H reported there was always a strong urine odor in the hallway and some family members would not visit because of the strong urine smell. On 8/3/16, at 8:33 a.m. housekeeper (H)-A stated the odor comes primarily from one room. H-A stated this room is cleaned more thoroughly and more often than other rooms. H-A verified the odor is also in the hall carpet and was not sure when it was last cleaned. H-A stated the odor is improved from last year. On 8/4/16, at 9:55 a.m. licensed nurse (LPN)-B verified the urine odor in the hallway of wing 4 and stated the odor was more evident when it was more humid. LPN-B stated she was not	F 253	Immediate corrective action: Resident□s mattress was replaced on 8-4 -16 and the room was deep cleaned. The carpet on Unit 4 was cleaned and extracted on 8-20-16 and placed on a routine schedule Action as it applies to others: The Maintenance and Housekeeping Director were educated on the need to assure daily rounds include assessing for odors. Ongoing deep room cleaning will be conducted weekly for any resident with a concern of an unavoidable odor. Carpet cleaning/extracting will be placed on a routine schedule. Date of completion: 9/13/2016 Recurrence will be prevented by: Audits of the environment will be conducted 3x weekly x 90 days to assure odors are not present. The results of these audits will be shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Administrator/Maintenance Director	

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F 253	Continued From page 8 aware of the family concerns regarding the urine odor on wing 4. On 8/4/16, from 10:15 a.m. to 11:00 a.m. during an environmental tour, administrator(A)-A and maintenance staff (M)-B verified the urine odor in the hallway. A-A stated he was aware of where the odor was coming from near the center of the hallway, but also verified the odor was in the hallway carpet. A-A stated that there will be a company coming to extract the carpet. A-A was unsure of last time the carpet was extracted. On 8/4/16, at 2:39 p.m. the director of nursing (DON)-B verified the urine odor on wing 4. She stated they needed to extract the carpet and stated the facility has an extractor for the carpet. The undated policy and procedure for Physical Plant directed a daily inspection of the physical plant would be completed. The policy and procedure directed monthly, resident rooms would be inspected and any deficiencies would be documented and repairs would be scheduled, and paint and wall coverings would be inspected and repairs scheduled for identified damage.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		9/13/16

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F 280	Continued From page 9 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include identification of, or interventions for, an unstageable pressure ulcer for 1 of 3 residents (R17) reviewed for pressure ulcers. Findings include: R17's Order Recap Report printed 8/4/16, indicated R17 had diagnoses of chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, congestive heart failure (CHF), and atrial fibrillation. A physician order dated 7/13/16, directed the CPAP to be placed by the nurse at bedtime for sleep apnea. R17's admission Minimum Data Set (MDS) dated 7/20/16, indicated R17 had moderately impaired cognition, and required extensive assistance with bed mobility, transfer, toileting, dressing and personal hygiene. The MDS also indicated R17 was short of breath, reported frequent severe pain, was at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS	F 280	Immediate corrective action: The Care Plan for resident # 17 was updated on 8/2/16 to include the lesion on her nose and interventions. Action as it applies to others: The Policy and Procedure for Care Planning was reviewed and remains current. Resident Care Plans will be reviewed to assure they are an accurate reflection of the current resident care needs, which includes new skin issues. Nurses will be Inserviced on the need to assure each Care Plan is current with any new skin issues. Date of completion: 9/13/2016 Recurrence will be prevented by: One Care Plan from each Unit will be audited 3x weekly to assure it is an accurate reflection of the resident□s care needs. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.	

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F 280	Continued From page 10 further indicated R17 received anticoagulants, insulin and diuretics. In addition, the MDS indicated R17 received both oxygen and CPAP treatments. R17 was observed on 8/1/16, at 5:42 p.m. to have a pressure ulcer on the bridge of her nose. R17 stated it was from her CPAP (continuous positive airway pressure) mask. At 4:57 p.m. registered nurse (RN)-A stated R17 did not have a pressure ulcer. R17's care plan dated 7/26/16, indicated R17 had multiple skin tears on her upper extremities and her skin was very fragile and tears easily. Nursing staff were directed to be extremely careful with R17's skin as it was very fragile, to turn and reposition R17 every two hours in bed and in the wheelchair, and observe R17's skin at least weekly on bath day. The care plan also directed nursing staff to set up R17 ' s CPAP machine every night before bed, and have R17 wear the CPAP for 6-8 hours a night. The care plan lacked identification of, or interventions for the pressure ulcer on the bridge of the nose. R17's Pocket Care Plan indicated R17 had skin tears, fragile skin and used oxygen, however, it lacked identification of, or interventions for R17's pressure ulcer. On 8/4/16, at 8:47 a.m. RN-A stated R17 did not have the pressure ulcer on her nose when she was admitted on 7/13/16. RN-A stated the wound hadn't been measured and there were no notes, assessments or measurements of R17's pressure ulcer. RN-A did not know when the pressure ulcer developed. RN-A stated she was aware of the "scab" on R17's nose, but had not	F 280	The correction will be monitored by: DON/Nurse Managers	

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F 280	Continued From page 11 assessed or measured the pressure ulcer. RN-A stated she would describe the pressure ulcer as an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] or eschar [tan, brown or black] in the wound bed). RN-A stated the pressure ulcer was not being treated, and was left open to air during the day. RN-A further stated the pressure ulcer on R17's nose was from her CPAP machine. RN-A stated R17 has always had a spot on her nose, but not open. RN-A also stated staff would pad the mask with a cotton ball at night. RN-A reiterated R17 did not have the nose wound on admission, R17 developed it while a resident at the facility. R17 brought the CPAP mask from home and has used this mask for over a year. RN-A stated the pressure ulcer was never open, it had only been black eschar. RN-A stated she had verbally notified the nurse practitioner (NP) last week, but RN-A did not document the concern or the communication to the NP. On 8/8/16, at 2:30 p.m. the director of nursing (DON) stated nurse managers are responsible for identifying pressure ulcers. The DON stated she would expect documentation to include initial weekly documentation of the pressure ulcer, the resident's risk for development of a pressure, notification of the MD, and interventions added to the care plan. A policy and procedure on care plan revision was not provided.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		9/13/16

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F 314	Continued From page 12 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the development of and worsening of, document the presence of, and monitor and treat an unstageable pressure ulcer on the bridge of the nose for 1 of 3 residents (R17) reviewed for pressure ulcers. R17 experienced actual harm due to the development of a new pressure ulcer that worsened. Findings include: R17 was observed on 8/1/16, at 5:42 p.m. to have a pressure ulcer on the bridge of her nose. R17 stated it was from her CPAP (continuous positive airway pressure) mask. At 4:57 p.m. registered nurse (RN)-A stated R17 did not have a pressure ulcer. R17's Order Recap Report printed 8/4/16, indicated R17 had diagnoses of chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, congestive heart failure (CHF), and atrial fibrillation. A physician order dated 7/13/16, directed the CPAP to be placed by the nurse at bedtime for sleep apnea.	F 314	Immediate corrective action: Resident # 17 no longer resides in the facility. Action as it applies to others: The policy and procedure for skin wound assessing has been reviewed and remains current. Training will be completed for nurses on the process of identifying, assessing, obtaining orders and care planning for any resident skin wounds. Residents with any skin wounds will be reviewed to assure a comprehensive skin assessment, treatment and care plan have been developed. Date of completion: 9/13/2016 Recurrence will be prevented by: Weekly skin rounds will continue and an audit weekly of all wounds, skin assessments, treatments and care plans will be completed. This will be an ongoing process. The correction will be monitored by: DON/Nurse Managers	

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R17's admission Minimum Data Set (MDS) dated 7/20/16, indicated R17 had moderately impaired cognition, and required extensive assistance with bed mobility, transfer, toileting, dressing and personal hygiene. The MDS also indicated R17 was short of breath, reported frequent severe pain, was at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS further indicated R17 received anticoagulants, insulin and diuretics. In addition, the MDS indicated R17 received both oxygen and CPAP treatments.

R17's Care Area Assessment (CAA) worksheet dated 7/20/16, indicated R17 was on antidepressants and antianxiety medications, which increased the risk for pressure ulcer development. The CAA also identified R17 used a device that can cause pressure ulcers, such as oxygen tubing. A CAA progress note, dated 7/26/16, indicated R17 was at risk for the development of pressure ulcers, had no current pressure ulcers, and to proceed to the care plan with a goal of preventing skin breakdown.

R17's care plan dated 7/26/16, indicated R17 had multiple skin tears on her upper extremities and her skin was very fragile and tears easily. Nursing staff were directed to be extremely careful with R17's skin as it was very fragile, to turn and reposition R17 every two hours in bed and in the wheelchair, and observe R17's skin at least weekly on bath day. The care plan also directed nursing staff to set up R17 ' s CPAP machine every night before bed, and have R17 wear the CPAP for 6-8 hours a night. The care plan lacked identification of, or interventions for the pressure ulcer on the bridge of the nose.

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R17's Pocket Care Plan indicated R17 had skin tears, fragile skin and used oxygen, however, it lacked identification of, or interventions for R17's pressure ulcer.

R17's Initial Nursing Evaluation and Vitals dated 7/14/16, indicated the appearance of R17's nose was "ok" and no abnormalities were noted.

R17's Braden Scale Assessment for Predicting Pressure Score Risk dated 7/13/16, identified a score of 18, which indicated moderate risk for developing pressure ulcers.

R17's Comprehensive Evaluation of Skin and Risk Factors, dated 7/13/16, 7/20/16, 7/27/16, and 8/3/16, all lacked indications of any skin concerns to R17's nose.

On 8/3/16, at 12:57 p.m. RN-A stated R17 had 3 skin tears along her arm and R17 is on Coumadin (a medication that can treat and prevent blood clots) which affects her healing.

On 8/4/16, at 8:37 a.m. R17 was again observed to have a pressure ulcer on the bridge of her nose.

On 8/4/16, at 8:47 a.m. RN-A stated R17 did not have the pressure ulcer on her nose when she was admitted on 7/13/16. RN-A stated the wound hadn't been measured and there were no notes, assessments or measurements of R17's pressure ulcer. RN-A did not know when the pressure ulcer developed. RN-A stated she was aware of the "scab" on R17's nose, but had not assessed or measured the pressure ulcer. RN-A stated she would describe the pressure ulcer as an unstageable pressure ulcer (full thickness

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tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] or eschar [tan, brown or black] in the wound bed). RN-A stated the pressure ulcer was not being treated, and was left open to air during the day. RN-A further stated the pressure ulcer on R17's nose was from her CPAP machine. RN-A stated R17 has always had a spot on her nose, but not open. RN-A also stated staff would pad the mask with a cotton ball at night. RN-A reiterated R17 did not have the nose wound on admission, R17 developed it while a resident at the facility. R17 brought the CPAP mask from home and has used this mask for over a year. RN-A stated the pressure ulcer was never open, it had only been black eschar. RN-A stated she had verbally notified the nurse practitioner (NP) last week, but RN-A did not document the concern or the communication to the NP.

R17's progress notes from 7/13/16, to 8/3/16, revealed only one mention of her pressure ulcer: On 7/17/16, at 4:02 a.m. it was noted that R17 had a scant amount of blood on her nose. R17 stated it was from her CPAP mask.

The NP's Nursing Home Note dated 7/28/16, identified a 0.75 cm scabbed lesion to the top of the nose. The note further indicated R17 told the NP it was from the CPAP, and she was using a cotton ball under the mask at night.

A Physician Appointment Note dated 8/2/16, lacked identification of the pressure ulcer, but indicated it was okay to use any device from home to decrease rubbing on R17's nose from CPAP.

On 8/4/16, at 9:17 a.m. RN-A measured R17's

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pressure ulcer as 1.3 centimeters (cm) long by 1.7 cm wide. RN-A described the area as a black spot, covered with eschar surrounded by redness. RN-A stated the pressure ulcer was all eschar, and it would be classified as unstageable.

On 8/4/16, at 9:20 a.m. R17 stated she continued to wear the CPAP mask every night.

On 8/8/16, at 2:30 p.m. the director of nursing (DON) stated nurse managers are responsible for identifying pressure ulcers. The DON stated weekly wound rounds are done on Wednesdays or Thursdays. The DON stated nurse managers, the MDS nurse and sometimes the quality nurse attended the weekly rounds. The DON stated she has not attended for some time. The DON stated she had just found out about the pressure ulcer on R17's nose. The DON stated she thought the staff had noted it as a scab, and they were not looking at it as a pressure ulcer. The DON stated the MD should have been notified and treatment initiated. The DON further stated staff should have documented if they saw a "scab" and the CPAP that she uses. The DON stated she would expect documentation to include initial weekly documentation of the pressure ulcer, the resident's risk for development of a pressure, notification of the MD, and interventions added to the care plan.

The facility policy Prevention of Pressure Ulcers revised February 2014, indicated pressure ulcers are often made worse by continual pressure on the resident's skin and directed staff to report any signs of a developing pressure ulcer to the supervisor.

The facility policy Pressure Ulcer Risk

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F 314	Continued From page 17 Assessment revised April 2016, directed staff to routinely assess and document the condition of the residents' skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown and to immediately report any signs of a developing pressure ulcer to the supervisor. The facility policy Pressure Ulcers/Skin Breakdown revised in February 2016, directed the nurse to assess and document a full assessment of a pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		9/13/16

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F 322	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a gastrostomy tube (g-tube, a tube which goes into the stomach for food and or medications) prior to medication administration for 1 of 1 residents (R91) observed for medication administration through a G-tube. Findings include: R91's Diagnosis Report dated 8/3/16, indicated R91's diagnoses included aphonia (loss of the ability to speak from disease or damage to the larynx or mouth), dysphagia (difficulty swallowing), gastric ulcer, and pneumonitis due to inhalation of food or vomit. R91's care plan dated 10/20/15, indicated R91 required a tube feeding for all of his medication and nutritional needs. The care plan interventions included the g-tube placement was to be checked according to the facility policy. On 8/2/16, at 8:17 a.m. registered nurse (RN)-B was observed during the administration of R91's omeprazole suspension 20 milligrams (mg) via the g-tube. RN-B disconnected the g-tube from the enteral feeding tube. RN-B then attached a large syringe to the g-tube and filled the syringe with approximately 60 mililiters (ml) of water twice. RN-B then poured the liquid omeprazole into the syringe followed by approximately 120 ml of water. The water and medication flowed from the syringe into the g-tube via gravity. The RN then closed the g-tube. RN-B verified R91's tube was a gastrostomy tube. RN-B stated he had	F 322	Immediate corrective action: RN-B was immediately re-educated on the G-Tube placement policy. Action as it applies to others: The policy and procedure for checking G Tube placement each time any feeding, flush or medication is inserted was reviewed and is current. All licensed nurses will be educated on the G Tube placement policy which will include return demonstrations. Date of completion: 9/13/2016 Recurrence will be prevented by: 1 nurse daily on different shifts and different units x 3 days weekly will be visually audited to assure they are following the GTube placement policy and procedure. These audits will continue x 90 days and the results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Staff Development	

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F 322	Continued From page 19 checked the g-tube placement when he administered R91's medications, and he did not check placement prior to the administration of the water and omeprazole because the length of the g-tube had not changed. On 8/3/16, at 2:35 p.m. the director of nursing (DON) stated she would expect staff to check the placement of a g-tube before the administration of medications, enteral feeding and or water, even if the g-tube had been checked recently and the length of the tube had not changed. The facility's Medication Administration through Gastric Tube policy revised on 11/15, directed if the feeding was running at the time of the medication administration, check for residual and placement by attaching a 60 milliliter (ml) syringe to the g-tube and gently pull back no more than 150 ml of stomach content. The appearance of the gastric content implied the g-tube was patent and in the stomach.	F 322		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS 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 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	F 334		9/13/16

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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 pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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F 334	Continued From page 21 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer recommended pneumococcal vaccinations for 9 of 20 residents (R3, R38, R110, R52, R7, R75, R19, R77, R88) reviewed for immunizations. Findings include: On 8/4/16, at 10:00 a.m. the facility's Healthcare Associated Infection Summary Report for April 2016, was reviewed. This report indicated seven residents on Wing three were diagnosed with pneumonia. Immunization records for these seven residents were reviewed. The records indicated three residents had not received pneumococcal vaccinations per Center for Disease Control (CDC) recommendations (R3, R38, R110) R3's Admission Record indicated R3 was admitted to the facility on 4/6/16. R3's admission Minimum Data Set (MDS) dated 4/23/16, noted R3 was cognitively impaired, was understood and able to communicate with others and did not reject cares. The MDS further noted R3's	F 334	Immediate corrective action: Residents # 52, 19, 77, and 88 were administered the PCV 13 pneumococcal vaccine on Aug 5th, 2016. Resident # 7 received the PCV 13 vaccine on August 7th, 2016. Resident # 75 refused the pneumococcal vaccination. Residents # 3, 38,110, and 75 no longer reside in facility. Action as it applies to others: All current residents have been researched to determine whether or not the resident is in need of pneumococcal vaccination. Consent or declinations were signed. Vaccinations were administered for those giving consent. The Policy and Procedure for Pneumococcal vaccine administration is current. Re-education on the Policy was provided to the IC Nurse on 8/4/2016 and 8/9/2016 Licensed nurses will be re-educated on the Pneumococcal vaccine Policy and Procedure. Recurrence will be prevented by: All new admissions will be researched to	

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F 334	Continued From page 22 pneumococcal immunizations were not up to date. R3's Diagnosis Report included diagnoses of end stage renal disease, atherosclerotic heart disease and congestive heart failure. A review of the facility's April line listing of infections indicated R3 developed symptoms of cough and congested lungs on 4/11/16, with the type of infection described as healthcare acquired pneumonia. R3's chest X-ray report dated 4/12/16, noted an impression of developing right lower lung consolidation (lung space filled with fluid rather than air.) The line listing report indicated R3 was given antibiotics for four days. R3's cough and wheezing persisted on 4/18/16, and R3 was again given antibiotics for four days beginning 4/21/16. The diagnosis noted on the April line listing report was healthcare acquired pneumonia. A review of April progress notes indicated R3 was found lying in bed with no pulse, no breathing on 5/2/16, at 7:11 a.m. The facility Death Record noted R3's date and time of death on 5/2/16, at 7:00 a.m. The Death Record did not indicate a cause of death. R3's Immunization Report dated 8/4/16, indicated R3 received a single dose of Pneumococcal vaccine (PCV13) at another facility on 7/17/14. The report lacked documentation of any other pneumococcal vaccinations or consents. R38's Admission Record indicated R38 was admitted on 3/29/16. R38's admission MDS dated 4/15/16, indicated R38 was mostly cognitively intact, understood and was understood by others and did not reject cares. The MDS also indicated R38's pneumococcal immunizations were not up to date. R38's medical diagnosis report included diagnoses of heart failure, myocardial infarction	F 334	determine whether or not the resident is in need of pneumococcal vaccination. Consent or declinations will be signed. Vaccinations will be administered for those giving consent. All new admissions and all current residents due for a pneumococcal vaccine will be audited weekly and discussed at Quality Conferences each week. This audits will continue x90 days and shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Staff Development/MDS Coordinator Date of completion: 9/13/2016	

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and hypothyroidism.

A review of the facility's April line listing of infections indicated R38 developed symptoms on 4/13/16, of cough, congestion and wheezes with an oxygen saturation level of 83% (considered low if below 90%) despite the use of supplemental oxygen. The report further indicated R38 was hospitalized on 4/14/16, with a diagnosis of pneumonia, and this infection was healthcare acquired. R38's chest X-ray report dated 4/14/16, indicated R38 had worsening opacities and aeration of the right lung. The April line listing of resident infections indicated R38 returned to the facility on 4/20/16. The line listing report indicated R38 was symptomatic with shortness of breath on 4/29/16, and hospitalized on 4/30/16 with pneumonia. R38's progress notes revealed R38 returned to the facility on 5/5/16, on comfort cares. The progress notes indicated R38 as found in her bed in the facility with no pulse and no signs of life at 4:56 p.m. on 5/5/16. The facility Death Record note placed R38's date and time of death on 5/5/16, at 4:40 p.m. The Death Record did not indicate a cause of death.

R38's Immunization Report dated 8/4/16, lacked documentation of any pneumococcal immunizations or consents.

R110's Admission Record indicated R110 was admitted on 12/9/15. R110's quarterly MDS dated 3/17/16, indicated R110 was cognitively intact, understood and was understood by others and did not reject cares. The MDS also indicated R110's pneumococcal immunizations were not up to date. R110's admission medical diagnosis report included diagnoses of type 2 diabetes mellitus, peripheral vascular disease, bacterial

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infection and disruption of internal operation (surgical) wound.

A review of the facility's April 2016, line listing of resident infections indicated R110 developed symptoms of an elevated temperature (99.9 degrees), cough and wheezing on 4/24/16, with the type of infection described as pneumonia. The report indicated R110's infection was healthcare acquired. R110's chest X-ray report dated 4/26/16, indicated findings that included patchy opacities (white areas) in the right lung suggestive of pneumonitis. R110's Discharge Summary dated 5/10/16, indicated R110 was discharged on 5/10/16.

R110's Immunization Report dated 8/4/16, lacked documentation of any pneumococcal vaccinations or consent status.

Documents and immunization reports were reviewed for four residents who developed respiratory symptoms chosen randomly from the May, June and July line listing of resident infections. The immunization reports indicated three of four residents had not received pneumococcal vaccinations per Center for Disease Control (CDC) recommendations (R52,R7,R75)

R52's Admission Record indicated R52 was admitted on 2/12/14. R52's quarterly MDS dated 4/28/16, indicated R52 was cognitively impaired, sometimes understood and was understood by others and did not reject cares. The MDS also indicated R52's pneumococcal immunizations were up to date. R52's Diagnosis Report included diagnoses of dementia, pneumonia, anxiety, type 2 diabetes mellitus and atherosclerotic heart

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disease.

A review of R52's Progress notes indicated R52 developed symptoms on 5/11/16, at 10:00 p.m. of lethargy, weakness and an elevated temperature (99.8 degrees.) R52 was sent to the hospital for evaluation and admitted with a diagnosis of pneumonia at 10:25 p.m. R52 was discharged from the hospital to the facility on 5/14/16, with a diagnosis of community acquired pneumonia. R52 remained in the facility during the survey dates.

R52's Immunization Report dated 8/4/16, indicated R52 received a Pneumovax dose 1 on 11/30/13, at another facility. The report lacked documentation of other pneumococcal vaccinations or consents.

R7's Admission Record indicated R7 was admitted on 2/01/10. R7's quarterly MDS dated 5/12/16, indicated R7 was cognitively impaired, understood and was understood by other and sometimes rejected cares. The MDS also indicated R7's pneumococcal vaccinations were not up to date. R7's Diagnosis Report included diagnoses of dementia, psychosis, pneumonia, dysphagia, COPD and chronic kidney disease.

A review of R7's Progress Notes indicated R7 developed symptoms of an elevated temperature (101.8 degrees), cough and lung sounds with crackles (an indication of fluid in the lungs) on 6/10/16, at 2:04 p.m. R7 was admitted to the hospital on 6/11/16, at 1:23 a.m. for pneumonia. R7 returned to the facility on 6/15/16. A physician progress note dated 6/23/16, indicated R7 was admitted to the hospital with a diagnosis of healthcare acquired pneumonia. R7 remained in

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the facility during the survey dates.

R75's Immunization Report dated 8/4/16, indicated R7 received Pneumovax dose 1 on 10/7/13. The report lacked documentation of other pneumococcal vaccinations or consents.

R75's Admission Record indicated R75 was admitted on 6/07/16. R7's admission MDS dated 6/14/16, indicated R75 was cognitively impaired, understood and was understood by others, and sometimes rejected care. The MDS also indicated R75's pneumococcal immunizations were up to date.

A review of a physician report dated 6/23/16, indicated R75 was admitted to the facility at the beginning of June and was found to have a urinary tract infection and possible pneumonia with basilar infiltrate (fluid in the bottom of the lungs). The report assessment included a diagnosis of pneumonia. R75 remained in the facility during the survey dates.

R75's Immunization Report dated 8/4/16, indicated R75 received a Pneumococcal vaccine (PPSV23) at another facility on 11/02/05. The report lacked documentation of other pneumococcal vaccinations or consents.

Documents and immunization reports were reviewed for three residents chosen randomly from the facility census report. The reports indicated three of three residents had not received pneumococcal vaccinations per Center for Disease Control (CDC) recommendations (R19, R77, R88).

R19's Admission Record indicated R19 was

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admitted on 9/27/05. R19's quarterly MDS dated 7/21/16, indicated R19 was cognitively intact, understood and was understood by others and did not reject cares. The MDS also indicated R19's pneumococcal vaccinations were up to date. R19's Diagnosis Report included diagnoses of cerebral palsy, peripheral vascular disease, hypertension and diabetes.

R19's Immunization report dated 8/4/16, indicated R19 received a Pneumovax dose 1 on 11/01/01, at another facility. The report lacked documentation of other pneumococcal vaccinations or consents.

R77's Admission Report indicated R77 was admitted on 2/25/13. R77's quarterly review MDS dated 5/9/16, indicated R77 was cognitively impaired, understood and was understood by others and did not reject cares. The MDS also indicated R77's pneumococcal vaccinations were up to date. R77's Diagnosis Report included diagnoses of dementia, anxiety and depressive disorder and hypertension.

R77's Immunization Report dated 8/4/16, indicated R77 received a Pneumovax dose 1 on 11/13/91, and a Pneumovax dose 2 on 9/28/06, both at another facility. The report lacked documentation of other pneumococcal vaccinations or consents.

R88's Admission Record indicated R88 was admitted on 3/10/14. R88's quarterly MDS dated 5/4/16, indicated R88 was cognitively impaired, understood and was understood by others and sometimes rejected cares. The MDS also indicated R77's pneumococcal vaccinations were to date.

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R88's Immunization Report dated 8/4/16, indicated R77 received a Pneumovax dose 1 on 5/06/09, at another facility. The report lacked documentation of other pneumococcal vaccinations or consents.

All residents assessed for pneumococcal vaccinations as above were over the age of 65.

CDC recommendations for pneumococcal vaccines include: one dose of PCV13 (also called Prevnar 13) is recommended for all adults aged 65 or older who've not previously received the vaccine. A dose of PPSV23 (also called Pneumovax 23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23.
On 8/04/16, at 11:14 a.m. registered nurse (RN)-D confirmed pneumococcal vaccinations were not up to date for all residents, including some of those residents who developed pneumonia in April 2016, on wing three. RN-D said she was now checking all new resident admissions for immunization records at admission. RN-D said she did not check residents admitted before last month, and the facility had been focusing on tuberculosis immunization records. RN-D further stated resident records had not been assessed before last month. RN-D said she knew this had been a problem.
On 8/4/16, at 1:44 p.m. the director of nursing (DON) was interviewed and stated she was responsible for infection control in April 2016. The DON stated wing 3 residents were quarantined

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F 334	Continued From page 29 and staffing was consistent on that wing when the outbreak of pneumonia was assessed. The DON said she was not aware pneumococcal immunizations had not been completed for all residents, and these immunizations should have been checked and offered on admission. The DON confirmed immunizations were not up to date for R3, R38 and R110. On 8/8/16, RN-D gave the survey team a Resident List Report printed on 7/28/16, with handwritten notes detailing each resident's pneumococcal immunizations or lack of pneumococcal immunizations. RN-D also gave the survey team an undated word document with a list of residents who had refused pneumococcal immunizations. A review of the facility's undated Quality Assurance and Performance Improvement meeting minutes provided by the facility indicated the facility had revised the pneumococcal vaccination policy and cheat sheet. The facility Pneumococcal Vaccination-Resident/Patient policy dated 3/16, directed all adults aged 65 or older who have not previously received pneumococcal vaccine should receive a single dose of PCV13 followed by a dose of PPSV23, 12 months after the PCV13 vaccination was administered. The policy further directed all residents who previously received PPSV23 at age 65 or older should receive PCV13 one year or more after the PPSV23 dose was administered. The policy directed further all residents who previously received one or more PPSV23 vaccinations prior to age 65 who are now aged 65 or older should receive PCV13 one year or more after receipt of the most recent PPSV23 dose.	F 334		
F 371	483.35(i) FOOD PROCURE,	F 371		9/13/16

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F 371 SS=E	Continued From page 30 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food pans were free of food debris, and were dried in a sanitary manner. This had the potential to affect 75 of 79 residents residing in the facility who received food served from the kitchen. Findings include: On 8/1/16, at 1:24 p.m. during a tour of the kitchen, 7 of the 27 food service pans of various sizes were wet. One of the pans was also dirty with white food debris in the bottom corner. The dietary manager (DM)-E verified the pans were wet and should have been completely dry before stacking them and putting them away. DM-E stated the pans are air dried after washing. DM-E stated she was not sure what the food at the bottom of the pan was, but thought it was mashed potatoes. She was able to scrape it off with her fingernail, and returned it to be washed. Several baking pans were wet and ready for use. The DM-E verified 7 pans out of 27 pans were wet, and 1 pan was also dirty with white food debris in	F 371	Immediate corrective action: The Dietary Manager and Cook removed all pots and pans that were damp/had residue and rewashed and dried them as soon as the issue was identified. Action as it applies to others: The Policy and Procedure for not putting away wet pots/pans was removed and remains current. Re-education began on August 2, 2016 to all Dietary staff on the need to check pots and pans for any wetness before putting them away. Date of completion: 9/13/2016 Recurrence will be prevented by: The Dietary Manager will check the kitchen 3x weekly x 90 days to assure no pans/pots are put away wet and the results will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue these audits. The correction will be monitored by: Dietary Manager	

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F 371	Continued From page 31 bottom corner. On 8/4/16, at 11:10 a.m. 1 food service pan of 14 was observed to be wet. DM-E verified the pan was wet and stated she had educated staff regarding wet pans. On 8/4/16, at 3:05 p.m. DM-E stated the pans were used for foods that included vegetables, meats, potatoes, noodles, and soups. DM-E stated that all but 4 residents received food from the kitchen. The facility policy and procedure for Cleaning Dishes-Manual Dishwashing dated 2010, directed staff to allow dishes to air dry.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and homelike environment was provided for 11 of 35 rooms reviewed for environment. Findings include: During the environmental tour the administrator and environmental services manager (ESM)-D verified the following findings:	F 465	Immediate corrective action: The scraped paint between dining room and Unit 4 was repainted. Entry door and door frame, bathroom door and frame repainted room 402. Entry door frame repainted room 405. Door frame and bathroom door repainted room 406 and grouting around toilet cleaned. Room 407-tile stripped and cleaned in bathroom, doors repaired and door knob replaced. Room 408-Bathroom door frame	9/13/16

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F 465	Continued From page 32 -Wing 4 had an area of paint scraped and peeling on the wall between the dining room and the beginning of the hallway. Maintenance staff (M)-B stated the mailbox that had been hanging on the wall, had fallen off. -Room 402: the entry door and door frame and the bathroom door and door frame were scuffed and gouged. -Room 405: the entry door frame was scuffed/marred. -Room 406: the entry door frame and the bathroom door frame were scuffed, and scratched. The grouting around the base of the toilet was dark stained. -Room 407: strong urine smell, and the floor near the bathroom had dirty, brown build-up on the tile. There was build-up in the corner by the sink, the bathroom door frame was badly gouged to the metal, inside the bathroom door was gouged, and the room door was gouged. The room door knob did not fit the cutout for the door knob, exposing the cutout area and the unpainted area surrounding the cutout. The bathroom was shared with room 405. -Room 408: bathroom door frame was badly gouged to the metal and had a rusty appearance. There were white patched areas on the bathroom wall across from the bathroom door. There was dark staining of the grouting at the base of the toilet. There was no transition strip between the room tile and the bathroom tile, leaving a deep gap that collected dirt. The closet doors were badly gouged and scraped down to the wood. There was bubbling of the paint and the wall was	F 465	repainted; patched areas painted; grout around toileted cleaned; closet doors repaired; transition strip replaced. Door frame for bathroom in room 409 repainted. Bathroom door for room 410 repainted and floor stripped and cleaned. Room 412-Wall across from bathroom door repaired; missing linoleum repaired and bathroom floor stripped and cleaned. Entry door repaired and door frame room 315 was repainted. Room 215 bathroom is closed for further repairs. Action as it applies to others: An entire walk through of other like issues was conducted by the Maintenance Director and Administrator with a plan to address each issue on a schedule. An updated maintenance rounding system was developed to assure areas in need of immediate attention are identified earlier. Date of completion: 9/13/16 Recurrence will be prevented by: Rounds will be conducted 3x weekly by the Administrator and the Maintenance Director x90 days to assure all needed repairs are being addressed timely. The results of these rounds will be discussed at the facility QAPI meeting and based upon results, input on how often these rounds should continue to occur. The correction will be monitored by: Maintenance Director/Administrator	

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scuffed near the closet and bathroom.

-Room 409: bathroom door frame was badly scraped and had a rusty appearance with a brown smear that had the appearance of feces on the door frame to the right of and below the towel rack. This brown smear was present from 8/1/16, at 4:21 p.m. until the tour on 8/4/16, during the environmental tour. A-A asked staff to clean the door frame. This bathroom was shared with room 411.

-Room 410: the bathroom door was badly gouged to the metal and had a rusty appearance. there was dirt build-up in the corners in the bathroom.

-Room 412: the bathroom wall across from the door was badly gouged. There was dirt build-up in the corners in the bathroom. The floor linoleum in front of the bathroom doorway was torn and a piece approximately 2 inches x 4 inches torn out, allowing dirt to collect in the depression of missing linoleum. There was build up of dirt between the tiles in the bathroom floor.

-Room 315: the entry door and door frame had chipped paint and was scuffed.

-Room 215: the walls were bubbling in the bathroom.

ESM-D stated staff identify problems and write it in the maintenance book on each unit or they verbally notify him. He stated he checks the book every day and was not sure if any of the identified problems were noted in the maintenance book. The administrator and ESM-D stated they do a walk through and work on one unit every week so

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F 465	Continued From page 34 they look at each unit monthly, and were currently working on wing 2. The wing 4 maintenance book was reviewed and it lacked identification of the room problems identified on the environmental tour. The undated policy and procedure for Physical Plant directed a daily inspection of the physical plant would be completed. The policy and procedure directed monthly, resident rooms would be inspected and any deficiencies would be documented and repairs would be scheduled, and paint and wall coverings would be inspected and repairs scheduled for identified damage.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Evergreen Terrace 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Evergreen Terrace is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8	K 000		

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K 000	Continued From page 2 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms installed in accordance with NFPA 72 "The National Fire Alarm Code 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 109 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections	K 011	1. The door cited will have the fire rating posted. All Barrier doors will be assessed for proper fire rating. 2. Date of completion: 9/13/2016	9/13/16

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K 011	Continued From page 3 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 35 of 77 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, observations and staff interviews revealed that the door in the 2 hour fire barrier by resident room 416 did not have fire rating labels that specifically specified the fire rating of the doors. This deficient condition was verified by a Maintenance Supervisor.	K 011	3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.5.1 and the 2015 MN State Fire Code, Appendix I. This deficient practice could affect 20 of 77 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, Observation revealed that the exit door located at the wing 1 exit has a coded keypad used to unlock the door to the exit, but did	K 038	1. The exit door located on wing 1 exit will have the code or instructions on how to open the door posted at the location of the exit. All exit doors will be reviewed. 2. Completion date of 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	9/13/16

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K 038	Continued From page 4 not have a the code or instructions on how to open the door posted at the location of the keypad. This deficient condition was verified by a Maintenance Supervisor.	K 038		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 77 of 77 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not conducted the overnight fire drill at	K 050	1. Fire Drills will be conducted on the overnight shift at varying times. Fire drills for all shifts will be conducted at various times. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	9/13/16

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K 050	Continued From page 5 varying time by conducting 3 of 4 drills in the 2 AM hour. This deficient condition was verified by a Maintenance Supervisor.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 77 of 77 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, observations and a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 1 of 12 monthly tests of the digital alarm communicator transmitter	K 052	1. A system will be in place to document reports and fire alarm maintenance/testing to verify monthly tests of the digital alarm communicator transmitter (DACT) are occurring. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	9/13/16

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K 052	Continued From page 6 (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 77 of 77 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide documentation for 3 of 4 quarterly fire sprinkler flow test verifying that they have been completed.	K 062	1. Quarterly fire sprinkler tests will be conducted and a system for documentation will be kept to verify the tests have been completed. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	9/13/16

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K 062	Continued From page 7 This deficient condition was verified by a Maintenance Supervisor.	K 062		
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect 35 of 77 residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by a Maintenance Supervisor.	K 069	1. The facility kitchen hood ventilation and fire suppression system will be professionally inspected per guidelines. Documentation will be kept to verify inspections were completed. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	9/13/16
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		9/13/16

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K 144 SS=F	Continued From page 8 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 77 of 77 residents as well as an undetermined number of staff, and visitors to the facility in the event of an emergency. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the facility could not provide 41 of 52 weekly emergency generator inspection reports at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 144	1. The facilities emergency generator will be tested weekly and documentation logs maintained. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by:	K 154		9/13/16

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K 154	Continued From page 9 Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 77 of 77 residents, visitors and staff. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, observations made during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by a Maintenance Supervisor.	K 154	1. An acceptable written policy for out of service fire alarm will be completed and kept updated and placed in the emergency binder. 2. Date of Completion 9-13-16 3. The facility QAPI committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This	K 155	1. An acceptable written policy for out of service fire alarm will be completed and kept updated and placed in the emergency binders. 2. Date of Completion 9-13-16 3. The facility QAPI committee will	9/13/16

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K 155	Continued From page 10 deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 77 of 77 residents, visitors and staff. Findings include: On facility tour between 9:30 AM to 1:30 PM on 08/04/2016, observations made during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by a Maintenance Supervisor.	K 155	review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 23, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5495026, H5495046, H5495048

Dear Mr. Roche:

The above facility was surveyed on August 1, 2016 through August 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5495046, H5495048. that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at: (218) 302-6151 or email: teresa.ament@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	08/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/1/16 through 8/8/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. H Complaints H5495046 and H5495048 were investigated and not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include identification of, or interventions for, an unstageable pressure ulcer for 1 of 3 residents (R17) reviewed for pressure ulcers. Findings include: R17's Order Recap Report printed 8/4/16, indicated R17 had diagnoses of chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, congestive heart failure (CHF), and atrial fibrillation. A physician order dated 7/13/16, directed the CPAP to be placed by	2 570	Corrected	9/13/16

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2 570	Continued From page 3 the nurse at bedtime for sleep apnea. R17's admission Minimum Data Set (MDS) dated 7/20/16, indicated R17 had moderately impaired cognition, and required extensive assistance with bed mobility, transfer, toileting, dressing and personal hygiene. The MDS also indicated R17 was short of breath, reported frequent severe pain, was at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS further indicated R17 received anticoagulants, insulin and diuretics. In addition, the MDS indicated R17 received both oxygen and CPAP treatments. R17 was observed on 8/1/16, at 5:42 p.m. to have a pressure ulcer on the bridge of her nose. R17 stated it was from her CPAP (continuous positive airway pressure) mask. At 4:57 p.m. registered nurse (RN)-A stated R17 did not have a pressure ulcer. R17's care plan dated 7/26/16, indicated R17 had multiple skin tears on her upper extremities and her skin was very fragile and tears easily. Nursing staff were directed to be extremely careful with R17's skin as it was very fragile, to turn and reposition R17 every two hours in bed and in the wheelchair, and observe R17's skin at least weekly on bath day. The care plan also directed nursing staff to set up R17 ' s CPAP machine every night before bed, and have R17 wear the CPAP for 6-8 hours a night. The care plan lacked identification of, or interventions for the pressure ulcer on the bridge of the nose. R17's Pocket Care Plan indicated R17 had skin tears, fragile skin and used oxygen, however, it lacked identification of, or interventions for R17's pressure ulcer.	2 570		

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2 570	Continued From page 4 On 8/4/16, at 8:47 a.m. RN-A stated R17 did not have the pressure ulcer on her nose when she was admitted on 7/13/16. RN-A stated the wound hadn't been measured and there were no notes, assessments or measurements of R17's pressure ulcer. RN-A did not know when the pressure ulcer developed. RN-A stated she was aware of the "scab" on R17's nose, but had not assessed or measured the pressure ulcer. RN-A stated she would describe the pressure ulcer as an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] or eschar [tan, brown or black] in the wound bed). RN-A stated the pressure ulcer was not being treated, and was left open to air during the day. RN-A further stated the pressure ulcer on R17's nose was from her CPAP machine. RN-A stated R17 has always had a spot on her nose, but not open. RN-A also stated staff would pad the mask with a cotton ball at night. RN-A reiterated R17 did not have the nose wound on admission, R17 developed it while a resident at the facility. R17 brought the CPAP mask from home and has used this mask for over a year. RN-A stated the pressure ulcer was never open, it had only been black eschar. RN-A stated she had verbally notified the nurse practitioner (NP) last week, but RN-A did not document the concern or the communication to the NP. On 8/8/16, at 2:30 p.m. the director of nursing (DON) stated nurse managers are responsible for identifying pressure ulcers. The DON stated she would expect documentation to include initial weekly documentation of the pressure ulcer, the resident's risk for development of a pressure, notification of the MD, and interventions added to the care plan.	2 570		

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2 570	Continued From page 5 A policy and procedure on care plan revision was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are revised. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		9/13/16

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2 900	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the development of and worsening of, document the presence of, and monitor and treat an unstageable pressure ulcer on the bridge of the nose for 1 of 3 residents (R17) reviewed for pressure ulcers. R17 experienced actual harm due to the development of a new pressure ulcer that worsened. Findings include: R17 was observed on 8/1/16, at 5:42 p.m. to have a pressure ulcer on the bridge of her nose. R17 stated it was from her CPAP (continuous positive airway pressure) mask. At 4:57 p.m. registered nurse (RN)-A stated R17 did not have a pressure ulcer. R17's Order Recap Report printed 8/4/16, indicated R17 had diagnoses of chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, congestive heart failure (CHF), and atrial fibrillation. A physician order dated 7/13/16, directed the CPAP to be placed by the nurse at bedtime for sleep apnea. R17's admission Minimum Data Set (MDS) dated 7/20/16, indicated R17 had moderately impaired cognition, and required extensive assistance with bed mobility, transfer, toileting, dressing and personal hygiene. The MDS also indicated R17 was short of breath, reported frequent severe pain, was at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS further indicated R17 received anticoagulants, insulin and diuretics. In addition, the MDS indicated R17 received both oxygen and CPAP	2 900	Corrected	

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2 900	Continued From page 7 treatments. R17's Care Area Assessment (CAA) worksheet dated 7/20/16, indicated R17 was on antidepressants and antianxiety medications, which increased the risk for pressure ulcer development. The CAA also identified R17 used a device that can cause pressure ulcers, such as oxygen tubing. A CAA progress note, dated 7/26/16, indicated R17 was at risk for the development of pressure ulcers, had no current pressure ulcers, and to proceed to the care plan with a goal of preventing skin breakdown. R17's care plan dated 7/26/16, indicated R17 had multiple skin tears on her upper extremities and her skin was very fragile and tears easily. Nursing staff were directed to be extremely careful with R17's skin as it was very fragile, to turn and reposition R17 every two hours in bed and in the wheelchair, and observe R17's skin at least weekly on bath day. The care plan also directed nursing staff to set up R17 ' s CPAP machine every night before bed, and have R17 wear the CPAP for 6-8 hours a night. The care plan lacked identification of, or interventions for the pressure ulcer on the bridge of the nose. R17's Pocket Care Plan indicated R17 had skin tears, fragile skin and used oxygen, however, it lacked identification of, or interventions for R17's pressure ulcer. R17's Initial Nursing Evaluation and Vitals dated 7/14/16, indicated the appearance of R17's nose was "ok" and no abnormalities were noted. R17's Braden Scale Assessment for Predicting Pressure Score Risk dated 7/13/16, identified a score of 18, which indicated moderate risk for	2 900		

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2 900	Continued From page 8 developing pressure ulcers. R17's Comprehensive Evaluation of Skin and Risk Factors, dated 7/13/16, 7/20/16, 7/27/16, and 8/3/16, all lacked indications of any skin concerns to R17's nose. On 8/3/16, at 12:57 p.m. RN-A stated R17 had 3 skin tears along her arm and R17 is on Coumadin (a medication that can treat and prevent blood clots) which affects her healing. On 8/4/16, at 8:37 a.m. R17 was again observed to have a pressure ulcer on the bridge of her nose. On 8/4/16, at 8:47 a.m. RN-A stated R17 did not have the pressure ulcer on her nose when she was admitted on 7/13/16. RN-A stated the wound hadn't been measured and there were no notes, assessments or measurements of R17's pressure ulcer. RN-A did not know when the pressure ulcer developed. RN-A stated she was aware of the "scab" on R17's nose, but had not assessed or measured the pressure ulcer. RN-A stated she would describe the pressure ulcer as an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] or eschar [tan, brown or black] in the wound bed). RN-A stated the pressure ulcer was not being treated, and was left open to air during the day. RN-A further stated the pressure ulcer on R17's nose was from her CPAP machine. RN-A stated R17 has always had a spot on her nose, but not open. RN-A also stated staff would pad the mask with a cotton ball at night. RN-A reiterated R17 did not have the nose wound on admission, R17 developed it while a resident at the facility. R17 brought the CPAP mask from	2 900		

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2 900	Continued From page 9 home and has used this mask for over a year. RN-A stated the pressure ulcer was never open, it had only been black eschar. RN-A stated she had verbally notified the nurse practitioner (NP) last week, but RN-A did not document the concern or the communication to the NP. R17's progress notes from 7/13/16, to 8/3/16, revealed only one mention of her pressure ulcer: On 7/17/16, at 4:02 a.m. it was noted that R17 had a scant amount of blood on her nose. R17 stated it was from her CPAP mask. The NP's Nursing Home Note dated 7/28/16, identified a 0.75 cm scabbed lesion to the top of the nose. The note further indicated R17 told the NP it was from the CPAP, and she was using a cotton ball under the mask at night. A Physician Appointment Note dated 8/2/16, lacked identification of the pressure ulcer, but indicated it was okay to use any device from home to decrease rubbing on R17's nose from CPAP. On 8/4/16, at 9:17 a.m. RN-A measured R17's pressure ulcer as 1.3 centimeters (cm) long by 1.7 cm wide. RN-A described the area as a black spot, covered with eschar surrounded by redness. RN-A stated the pressure ulcer was all eschar, and it would be classified as unstageable. On 8/4/16, at 9:20 a.m. R17 stated she continued to wear the CPAP mask every night. On 8/8/16, at 2:30 p.m. the director of nursing (DON) stated nurse managers are responsible for identifying pressure ulcers. The DON stated weekly wound rounds are done on Wednesdays or Thursdays. The DON stated nurse managers,	2 900		

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2 900	Continued From page 10 the MDS nurse and sometimes the quality nurse attended the weekly rounds. The DON stated she has not attended for some time. The DON stated she had just found out about the pressure ulcer on R17's nose. The DON stated she thought the staff had noted it as a scab, and they were not looking at it as a pressure ulcer. The DON stated the MD should have been notified and treatment initiated. The DON further stated staff should have documented if they saw a "scab" and the CPAP that she uses. The DON stated she would expect documentation to include initial weekly documentation of the pressure ulcer, the resident's risk for development of a pressure, notification of the MD, and interventions added to the care plan. The facility policy Prevention of Pressure Ulcers revised February 2014, indicated pressure ulcers are often made worse by continual pressure on the resident's skin and directed staff to report any signs of a developing pressure ulcer to the supervisor. The facility policy Pressure Ulcer Risk Assessment revised April 2016, directed staff to routinely assess and document the condition of the residents' skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown and to immediately report any signs of a developing pressure ulcer to the supervisor. The facility policy Pressure Ulcers/Skin Breakdown revised in February 2016, directed the nurse to assess and document a full assessment of a pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue.	2 900		

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2 900	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to prevent deterioration of the pressure ulcer, and to promote healing, prevent infection and prevent new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.	2 930		9/13/16

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2 930	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a gastrostomy tube (g-tube, a tube which goes into the stomach for food and or medications) prior to medication administration for 1 of 1 residents (R91) observed for medication administration through a G-tube. Findings include: R91's Diagnosis Report dated 8/3/16, indicated R91's diagnoses included aphonia (loss of the ability to speak from disease or damage to the larynx or mouth), dysphagia (difficulty swallowing), gastric ulcer, and pneumonitis due to inhalation of food or vomit. R91's care plan dated 10/20/15, indicated R91 required a tube feeding for all of his medication and nutritional needs. The care plan interventions included the g-tube placement was to be checked according to the facility policy. On 8/2/16, at 8:17 a.m. registered nurse (RN)-B was observed during the administration of R91's omeprazole suspension 20 milligrams (mg) via the g-tube. RN-B disconnected the g-tube from the enteral feeding tube. RN-B then attached a large syringe to the g-tube and filled the syringe with approximately 60 mililiters (ml) of water twice. RN-B then poured the liquid omeprazole into the syringe followed by approximately 120 ml of water. The water and medication flowed from the syringe into the g-tube via gravity. The RN then closed the g-tube. RN-B verified R91's tube was a gastrostomy tube. RN-B stated he had checked the g-tube placement when he administered R91's medications, and he did not	2 930	Corrected	

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	00299	A. BUILDING: _____ B. WING _____	08/08/2016

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2 930	Continued From page 13 check placement prior to the administration of the water and omeprazole because the length of the g-tube had not changed. On 8/3/16, at 2:35 p.m. the director of nursing (DON) stated she would expect staff to check the placement of a g-tube before the administration of medications, enteral feeding and or water, even if the g-tube had been checked recently and the length of the tube had not changed. The facility's Medication Administration through Gastric Tube policy revised on 11/15, directed if the feeding was running at the time of the medication administration, check for residual and placement by attaching a 60 milliliter (ml) syringe to the g-tube and gently pull back no more than 150 ml of stomach content. The appearance of the gastric content implied the g-tube was patent and in the stomach. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		

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21015	Continued From page 14	21015		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food pans were free of food debris, and were dried in a sanitary manner. This had the potential to affect 75 of 79 residents residing in the facility who received food served from the kitchen. Findings include: On 8/1/16, at 1:24 p.m. during a tour of the kitchen, 7 of the 27 food service pans of various sizes were wet. One of the pans was also dirty with white food debris in the bottom corner. The dietary manager (DM)-E verified the pans were wet and should have been completely dry before stacking them and putting them away. DM-E stated the pans are air dried after washing. DM-E stated she was not sure what the food at the bottom of the pan was, but thought it was mashed potatoes. She was able to scrape it off with her fingernail, and returned it to be washed. Several baking pans were wet and ready for use. The DM-E verified 7 pans out of 27 pans were wet, and 1 pan was also dirty with white food debris in bottom corner. On 8/4/16, at 11:10 a.m. 1 food service pan of 14 was observed to be wet. DM-E verified the pan was wet and stated she had educated staff	21015	Corrected	9/13/16

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21015	Continued From page 15 regarding wet pans. On 8/4/16, at 3:05 p.m. DM-E stated the pans were used for foods that included vegetables, meats, potatoes, noodles, and soups. DM-E stated that all but 4 residents received food from the kitchen. The facility policy and procedure for Cleaning Dishes-Manual Dishwashing dated 2010, directed staff to allow dishes to air dry. SUGGESTED METHOD OF CORRECTION: The food service director or designee could review any policies, procedures or facility processes to ensure safe and sanitary food service and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop audits to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an	21695	Corrected	9/13/16

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21695	Continued From page 16 environment free of urine odors for all 24 residents residing on wing 4. Findings include: On 8/1/16, at 6:07 p.m. the hallway on wing 4, smelled strongly of urine. Throughout the survey, the hallway on wing 4 continued to have a urine odor, which was stronger toward the center of the hallway. On 8/2/16, at 10:27 a.m. family member (FM)-H reported there was always a strong urine odor in the hallway and some family members would not visit because of the strong urine smell. On 8/3/16, at 8:33 a.m. housekeeper (H)-A stated the odor comes primarily from one room. H-A stated this room is cleaned more thoroughly and more often than other rooms. H-A verified the odor is also in the hall carpet and was not sure when it was last cleaned. H-A stated the odor is improved from last year. On 8/4/16, at 9:55 a.m. licensed nurse (LPN)-B verified the urine odor in the hallway of wing 4 and stated the odor was more evident when it was more humid. LPN-B stated she was not aware of the family concerns regarding the urine odor on wing 4. On 8/4/16, from 10:15 a.m. to 11:00 a.m. during an environmental tour, administrator(A)-A and maintenance staff (M)-B verified the urine odor in the hallway. A-A stated he was aware of where the odor was coming from near the center of the hallway, but also verified the odor was in the hallway carpet. A-A stated that there will be a company coming to extract the carpet. A-A was unsure of last time the carpet was extracted.	21695		

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21695	Continued From page 17 On 8/4/16, at 2:39 p.m. the director of nursing (DON)-B verified the urine odor on wing 4. She stated they needed to extract the carpet and stated the facility has an extractor for the carpet. The undated policy and procedure for Physical Plant directed a daily inspection of the physical plant would be completed. The policy and procedure directed monthly, resident rooms would be inspected and any deficiencies would be documented and repairs would be scheduled, and paint and wall coverings would be inspected and repairs scheduled for identified damage. Based on observation, interview, and document review, the facility failed to ensure a clean and homelike environment was provided for 11 of 35 rooms reviewed for environment. Findings include: During the environmental tour the administrator and environmental services manager (ESM)-D verified the following findings: -Wing 4 had an area of paint scraped and peeling on the wall between the dining room and the beginning of the hallway. Maintenance staff (M)-B stated the mailbox that had been hanging on the wall, had fallen off. -Room 402: the entry door and door frame and the bathroom door and door frame were scuffed and gouged. -Room 405: the entry door frame was scuffed/marred. -Room 406: the entry door frame and the	21695		

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21695	Continued From page 18 bathroom door frame were scuffed, and scratched. The grouting around the base of the toilet was dark stained. -Room 407: strong urine smell, and the floor near the bathroom had dirty, brown build-up on the tile. There was build-up in the corner by the sink, the bathroom door frame was badly gouged to the metal, inside the bathroom door was gouged, and the room door was gouged. The room door knob did not fit the cutout for the door knob, exposing the cutout area and the unpainted area surrounding the cutout. The bathroom was shared with room 405. -Room 408: bathroom door frame was badly gouged to the metal and had a rusty appearance. There were white patched areas on the bathroom wall across from the bathroom door. There was dark staining of the grouting at the base of the toilet. There was no transition strip between the room tile and the bathroom tile, leaving a deep gap that collected dirt. The closet doors were badly gouged and scraped down to the wood. There was bubbling of the paint and the wall was scuffed near the closet and bathroom. -Room 409: bathroom door frame was badly scraped and had a rusty appearance with a brown smear that had the appearance of feces on the door frame to the right of and below the towel rack. This brown smear was present from 8/1/16, at 4:21 p.m. until the tour on 8/4/16, during the environmental tour. A-A asked staff to clean the door frame. This bathroom was shared with room 411. -Room 410: the bathroom door was badly gouged to the metal and had a rusty appearance. there was dirt build-up in the corners in the	21695		

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21695	Continued From page 19 bathroom. -Room 412: the bathroom wall across from the door was badly gouged. There was dirt build-up in the corners in the bathroom. The floor linoleum in front of the bathroom doorway was torn and a piece approximately 2 inches x 4 inches torn out, allowing dirt to collect in the depression of missing linoleum. There was build up of dirt between the tiles in the bathroom floor. -Room 315: the entry door and door frame had chipped paint and was scuffed. -Room 215: the walls were bubbling in the bathroom. ESM-D stated staff identify problems and write it in the maintenance book on each unit or they verbally notify him. He stated he checks the book every day and was not sure if any of the identified problems were noted in the maintenance book. The administrator and ESM-D stated they do a walk through and work on one unit every week so they look at each unit monthly, and were currently working on wing 2. The wing 4 maintenance book was reviewed and it lacked identification of the room problems identified on the environmental tour. The undated policy and procedure for Physical Plant directed a daily inspection of the physical plant would be completed. The policy and procedure directed monthly, resident rooms would be inspected and any deficiencies would be documented and repairs would be scheduled, and paint and wall coverings would be inspected and repairs scheduled for identified damage.	21695		

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21695	Continued From page 20 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident environments are kept clean and free of urine odors. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of	21800		9/13/16

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21800	Continued From page 21 the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of Medicare Part A skilled services for 1 of 3 residents (R130) reviewed for liability notice and beneficiary appeal right review. Findings include: R130's admission record indicated she was admitted to the facility on 5/11/16, on Medicare Part A. R130's diagnosis sheet indicated diagnoses that included cerebrovascular disease, stroke, muscle weakness, and degenerative disease of the nervous system. R130's Discharge Plans Care Plan, dated 5/11/6, indicated R130 anticipated a short stay with a discharge to an assisted living within 30-45 days. On 8/4/16, at 9:53 a.m. registered nurse (RN)-C stated residents receive a notice of Medicare Non-coverage if their Medicare A services are ending and the resident continues to reside in the facility. However, if a resident is discharged and leaving the facility, the resident, or their family are not given a notice of Medicare non-coverage.	21800	Corrected	

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21800	Continued From page 22 RN-C stated they assume the resident and family are in agreement with the end of Medicare services if the resident is going home. RN-C reiterated if a resident is going home, the facility doesn't give a written notification to the resident or family. RN-C stated she gives a CMS form 10123 two days prior to the end of Medicare A services when a resident's Medicare A services are ending and they are staying in the facility. RN-C said they assume the resident wants to leave when they are going home, and that residents and therapy are talking. However, RN-C agreed that they do not have the opportunity to appeal the decision if, by some chance, the resident wanted to continue in therapy. RN-C stated R130 did not receive a written notice of her Medicare services ending and did not have the awareness of, nor opportunity to appeal the discharge decision. SNFABN and denial notices for R130 were requested but not received from the facility. A policy and procedure on provision of denial notices was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, regardless of the residents destination upon termination of Medicare A services. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing	21800		

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21800	Continued From page 23 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable	21830		9/13/16

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21830	Continued From page 24	21830		

efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and

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21830	Continued From page 25 the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were allowed a choice between a tub bath or a shower for 2 of 3 residents (R31, R121) reviewed for choices. Findings include: R31's Diagnosis Sheet dated 8/3/16, indicated R31's diagnoses included multiple sclerosis. An Initial Activity Assessment dated 6/7/16, indicated it was very important to choose between a tub bath, shower, bed bath or a sponge bath. The admission Minimum Data Set (MDS) dated 6/9/16, indicated R31 had moderately impaired cognition and required the physical assistance of one staff with bathing. The Unit 2 Shower Schedule (not dated) indicated R31 was scheduled for a shower on Monday and Friday on the evening shift. On 8/02/16, at 10:42 a.m. R31 stated there was	21830	Corrected	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 26 not a bath tub and she would like a tub bath if there was a bath tub. On 8/3/16, at 1:00 p.m. licensed practical nurse (LPN)-C stated the the facility had an accessible bath tub on wing 3, and there were only a couple of residents who had asked for a tub bath. On 8/3/16, at 2:15 p.m. nursing assistant (NA)-F stated R31 received a shower two times week and had never asked for a tub bath. On 8/3/16, at 2:19 p.m. LPN-A stated all residents were scheduled a shower two times week. LPN-A was not aware of R31 wanting a tub bath. LPN-A further stated R31 usually refused her shower once week and they had to coax her to take one shower a week. LPN-A stated all residents were scheduled for shower and she does not ask bath or shower preferences on admission. LPN-A further stated if a resident voiced they did not want or like a shower then they were told of their options. LPN-A stated there was a whirlpool bath tub on unit 3 and if a resident wanted a tub bath they could go there. On 8/3/16, at 10: 35 a.m. R31 stated she would not refuse bathing if she could have a tub bath. R31 was not aware there was a bath tub in the facility. R31 stated she did not like a shower because it was cold and she took a tub bath at home. R31 was informed there was a whirlpool tub on wing 3. R31 stated,"Well I'll be damned, no one ever told me there was a bath tub." R31 stated tomorrow was her bath day and she would take a tub bath. R121's order summary report, printed 8/4/16, indicated diagnoses that included fibromyalgia.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	08/08/2016

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21830	Continued From page 27 R121's quarterly MDS, dated 6/2/16, indicted R121 was cognitively intact, was independent with her activities of daily living. R121's admission MDS, dated 3/2/16, indicated preferences in choosing between a shower, tub, bed bath or sponge bath was somewhat important to her. Review of the nursing assistant's workbook revealed R121 is scheduled for a shower on Wednesday and Sunday evenings. On 8/1/16, at 6:52 p.m. R121 stated she did not have the choice between a shower, tub or a bed bath. R121 stated a shower was the only option, and "I've gotten used to them." R121 said she had fibromyalgia and a soak in a tub would feel really good. On 8/4/16, at 10:55 a.m., R121 said she did not know there was a tub available on wing 3, saying, "that sounds nice." On 8/5/16, at 8:00 a.m. the director of nursing (DON) stated an activity assessment was done to determine the resident's customary routine prior to coming into the facility. If a resident preferred a morning or evening shower then we try to accommodate that. The type of bath depended on which they prefer. If a resident refused the shower the DON would expect staff to offer a tub or a bed bath and find out why the resident does not want a shower. The facility's Shower/Tub Bath policy dated 6/14, indicated residents would be offered a choice of shower or bath if physically appropriate for either. The policy further directed staff to notify the supervisor if a resident refused the shower or tub bath.	21830		

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21830	Continued From page 28 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are offered choices regarding their bathing preferences. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		