### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: KNY3 Facility ID: 00725

		10 22 00::11			EDURYETHOEITO		1 401111 / 121 00 / 20
MEDICARE/MEDICAID PROVII     NO.(L1) 245243	DER	3. NAME AND AD (L3) <b>GRANITE</b> M		CILITY		4. TYPE OF ACT	TION: $\underline{7}^{(L8)}$
	D. M.O.	(L4) <b>250 JORDA</b>				1. Initial	2. Recertification
2. STATE VENDOR OR MEDICALI (L2) <b>375340900</b>	D NO.	(L5) GRANITE F			(L6) <b>56241</b>	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey A	ter Complaint
6. DATE OF SURVEY <b>02</b> /2	<b>25/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EIGGAL VEAD EN	DINICIDATE (LAS)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR EN	DING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		X A. In Complia	ance With		And/Or Approved Waivers O	f The Following Require	ements:
To (b):		_	equirements		2. Technical Personne	el 6. Scope of	Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical	Director
12.Total Facility Beds	<b>48</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural S	SNF) 8. Patient R	oom Size
13.Total Certified Beds	<b>48</b> (L17)	B. Not in Comp	lionaa with Pract	2022	5. Life Safety Code	9. Beds/Roo	om
13. Total Certified Beds	10 (217)	-	and/or Applied		* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
48					(-) (-) () (-).		
(L37) (L38)	(L39)	(L42)	(L43)				
(237)	(E37)	(2.12)	(E13)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Joseph Garvey, HFE	NE II	0	02/09/2016	(L19)	Kamala Fiske-Downing, Enf	forcement Specialist	03/09/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WIT	H CIVIL	<ol> <li>Statement of Fin</li> <li>Ownership/Cont</li> </ol>	ancial Solvency (HCFA-2 trol Interest Disclosure St	
1. Facility is Eligible to	Participate				3. Both of the Abov		
2. Facility is not Eligib	le (L21)						
	(E21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	N:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY	00 INVOL	UNTARY
07/06/1981					01-Merger, Closure	05-Fail	to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur	rsement 06-Fail	to Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS			03-Risk of Involuntary Terminat	ion OTHER	<b>!</b>
		n of Admissions:			04-Other Reason for Withdrawa	1	ider Status Change
			(L44)			00-Acti	ve
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)	00001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	L DATE			
				L			
	(L32)			(L33)	DETERMINATION API	PROVAL	



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245243

March 8, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

Dear Mr. Kooiman:

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 January 14, 2016 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 8, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

RE: Project Number \$5343024

Dear Mr. Kooiman:

On January 29, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective February 3, 2016. (42 CFR 488.422)

On February 5, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of \$4,900.00 per day for the one (1) day beginning January 12, 2016 and continuing through January 12, 2016 for a total of \$4,900.00
- Federal Civil Money Penalty of \$150.00 per day beginning January 13, 2016
- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 13, 2016. (42CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of February 5, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 13, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on January 13, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On February 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 13, 2016.

We presumed, based on your plan of correction, that your facility had corrected thes deficiencies as of January 14, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 25, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 14, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 5, 2016:

- Per day civil money penalty be discontinued as of January 14, 2016. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 13, 2016 be rescinded effective January 14, 2016. (42 CFR 488.417 (b))

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

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Kumala Fiske Downing

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	/ISIT
245243 <sub>Y1</sub>	B. Wing		Y2	2/25/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GRANITE MANOR		250 JORDAN DRIVE			
		GRANITE FALLS, MN 56241			

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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5
ID Prefix Reg. # LSC	F0167 483.10(g)(1)	Correction  Completed 01/14/2016	ID Prefix Reg. #	F0282 483.20(k)(3)(ii)	Correction Completed 01/14/2016	ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 01/14/2016
ID Prefix Reg. # LSC	F0323 483.25(h)	Correction  Completed 01/14/2016	ID Prefix Reg. #	F0431 483.60(b), (d), (e)	Correction Completed 01/14/2016	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AN REVIEWE CMS RO FOLLOW 1/13/201	ED BY	REVIEWED BY (INITIALS) KS/kfd REVIEWED BY (INITIALS) Y COMPLETED ON		SIGNATURE OF S  22 TITLE  CK FOR ANY UNCORRECTED DEFICIENCIE	113 TED DEFICIEN		D. A SUMMARY OF	ATE 2/25/2 ATE	



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

March 8, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

Re: Reinspection Results - Project Number S5243027

Dear Mr. Kooiman:

On February 25, 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 February 25, 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

				STAT	E FORM: RE	VISIT	REPORT				
	ER / SUPPLIER . CATION NUMBE		MULTIPLE CON A. Building B. Wing	STRUCTIO	N				Vo.	DATE 0	OF REVISIT
NAME OF	F FACILITY E MANOR	Y1	<u> </u>			250 JC	ET ADDRESS, C DRDAN DRIVE ITE FALLS, MN		ZIP CODE	1	710 <sub>Y3</sub>
correctiv	e action was a	ccomplis	shed. Each defi	ciency sho	se deficiencies p ould be fully iden urvey Report (p	tified us	ing either the r	egulation o	r LSC provision	number	and the
ITE	M		DATE	ITEM	ļ		DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20565		Correction	ID Prefix	20830		Correction	ID Prefix	20855		Correction
Reg. #	MN Rule 4658. Subp. 3	0405	Completed	Reg. #	MN Rule 4658.09 Subp. 1	520	Completed	Reg.#	MN Rule 4658.05 Subp. 2 E.	520	Completed
LSC			01/14/2016	LSC			01/14/2016	LSC			01/14/2016
ID Prefix	21615		Correction	ID Prefix	21975		Correction	ID Prefix			Correction
Reg.#	MN Rule 4658. Subp. 2	1340	Completed	Reg. #	MN St. Statute 1 Subd. 3	44A.10	Completed	Reg.#			Completed
LSC			01/14/2016	LSC			01/14/2016	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			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC			_	LSC			-	LSC			
REVIEWS		REVIEN (INITIA	WED BY LS) KS/kfd	<b>DATE</b> 3/8/201		URE OF	SURVEYOR 22113			DATE	5/2016
REVIEWS CMS RO	ED BY	REVIEN	WED BY	3/8/2010 DATE	TITLE		<u> </u>			DATE	1/2U IU
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2016				CK FOR ANY UNCORRECTED DEF					YE	s 🗆 no	

Page 1 of 1 EVENT ID: KNY312

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-	_		AND TRANSMITTAL TE SURVEY AGENCY		ID: KNY3 Facility ID: 00725
MEDICARE/MEDICAID PROVIDER     NO.(L1) 245243      STATE VENDOR OR MEDICAID NO.     (L2) 375340900      EFFECTIVE DATE CHANGE OF OWNE     (L9)	ERSHIP	3. NAME AND ADDRESS OF FACILITY (L3) GRANITE MANOR (L4) 250 JORDAN DRIVE (L5) GRANITE FALLS, MN  7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			(L6) <b>56241</b> <u>02</u> (L7)  13 PTIP 22 CLIA	4. TYPE OF AC  1. Initial 3. Termination 5. Validation 7. On-Site Visi 8. Full Survey	2. Recertification 4. CHOW 6. Complaint
6. DATE OF SURVEY 01/13/20 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	16 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR E	NDING DATE: (L35)
· ·	<b>48</b> (L18) <b>48</b> (L17)	X B. Not in Com	e guirements e Based On:	gram	And/Or Approved Waivers Of  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code  * Code: B	6. Scope 6 7. Medica	of Services Limit al Director Room Size
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  48  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS See Attached Remarks	(IF APPLICA	BLE SHOW LTC CA	NCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	'APPROVAL	Date:
Joseph Garvey, HFE NE	<u>II</u>	0	2/08/2016	(L19)	Kamala Fiske-Downing, Enfo	rcement Specialist	03/08/2016 (L20)
PART II  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Particip  2. Facility is not Eligible		20. COM	BY HCFA REPLIANCE WITH		21. 1. Statement of Fina 2. Ownership/Contro 3. Both of the Above	ncial Solvency (HCFA ol Interest Disclosure S	a-2572)
22. ORIGINAL DATE 23.  OF PARTICIPATION  07/06/1981  (L24)	LTC AGREEN BEGINNING		LTC AGREEN ENDING DA		26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburs	<u>INVC</u> 05-Fa	(L30)  DLUNTARY  il to Meet Health/Safety  il to Meet Agreement
25. LTC EXTENSION DATE: 27.	ALTERNATI A. Suspension	VE SANCTIONS of Admissions: aspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTH	ovider Status Change

30. REMARKS

Posted 03/08/2016 Co.

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, maintaining and improving the health of all Minnesotans

Electronically Submitted January 29, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

RE: Project Number S5243027

Dear Mr. Kooiman:

On January 13, 2016, a standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

#### **REMOVAL OF IMMEDIATE JEOPARDY**

We also verified, on January 13, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

#### **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:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

#### **NO OPPORTUNITY TO CORRECT - REMEDIES**

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective February 3, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323, effective January 12, 2016. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

#### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Granite Manor is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 13, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### **APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are

incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

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

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

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

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

If substantial compliance with the regulations is not verified by April 13, 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 July 13, 2016 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Kumalu Fiske Downing

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 02/08/2016 FORM APPROVED OMB NO. 0938-0391

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245243	B. WING _		01/	
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 00	00		
	Department of Heat 13, 2016. The surve Jeopardy (IJ) at F32 failure to comprehe implement fall interhigh potential for ha	ucted by the Minnesota Ith on January 10, 11, 12 and ey resulted in an Immediate 23 related to the facility's nsively assess and effectively ventions which resulted in a arm or death. The IJ which 12, 2016 was removed on at 11:15 a.m.				
		fication of the IJ at F323, an as conducted on January 12				
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are four signature is not required first page of the CMS-2567 fic submission of the POC will ion of compliance.				
F 167 SS=C	on-site revisit of you validate that substa regulations has bee your verification. 483.10(g)(1) RIGHT	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TO SURVEY RESULTS - IBLE	F 16	67		1/14/16
	the most recent sur Federal or State su correction in effect	ight to examine the results of vey of the facility conducted by rveyors and any plan of with respect to the facility.				
	examination and m	ake the results available for ust post in a place readily ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

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

**Electronically Signed** 

02/08/2016

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.

-	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245243	B. WING	<del></del>	01/1	3/2016
	PROVIDER OR SUPPLIER  E MANOR		2	STREET ADDRESS, CITY, STATE, ZIP CODE 150 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	their availability.  This REQUIREMEN	ge 1 ents and must post a notice of  NT is not met as evidenced	F 167			
	review the facility fa manner that was re residents and visito	ion, interview and document iled to post survey results in a adily accessible to all rs. This had the potential to ts residing in the facility and		A Copy of the last survey was place temporarily on the coffee table between the two Manor Neighborhoods adjated from the Therapy room on 1/14/16. additional decorative table was order 1/28/16 to be placed outside the Science of the survey will be building. A copy of the survey will be	veen cent An ered on ocial	
	During observation survey results were bulletin board behin lobby area of the buneeded to be slid of the survey results oviewing. The bullet two drinking fountain the wall, limiting according to the survey results of the	building. A copy of the maintained there whe ation on 1/10/15, at 11:20 a.m. the were observed to be posted on a behind a glass panel in the front he building. The glass panel slid open by hand in order to take  building. A copy of the maintained there whe from Direct Supply. The first survey copy at the Remeeting held on 1/19/ Director of Nursing with maintained there whe from Direct Supply. The maintained there whe from Direct Supply. The first survey copy at the Remeeting held on 1/19/ Director of Nursing with maintained there whe from Direct Supply. The maintained there whe from Direct Supply. The first survey copy at the first survey		maintained there when the table and from Direct Supply. The Residents notified regarding the placement of survey copy at the Resident Council meeting held on 1/19/16 @ 2pm. To Director of Nursing will make sure a is on the designated table by auditing	rives were the il he a copy	
	director of nursing ( would have to slide view the survey res residents who could wheelchairs would survey results as th access to the bullet	1/11/15, at 2:09 p.m. the DON) confirmed residents the glass open in order to ults. The DON confirmed d not stand or were in not be able to access the e water fountains blocked in board. She stated those we to ask for help to access				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR		2	TREET ADDRESS, CITY, STATE, ZIP CODE  50 JORDAN DRIVE  GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 282 SS=D	483.20(k)(3)(ii) SER PERSONS/PER CA The services provided be accordance with eaccare.	RVICES BY QUALIFIED	F 282 F 282			1/14/16
	by: Based on observative review the facility faplan as written for 2 reviewed who had it and 1 of 3 residents health.  Findings include: The quarterly Minin 8/13/15, identified Fincluded Alzheimer bladder, heart failur chronic obstructive The MDS identified impairment, required dressing, toileting, supervision for bed ambulation.  R7's current care pidentified R7 was a injury relate to age, glaucoma, hearing episodes of confus fibrillation, weaknes R7's care plan included.	cion, interview and document tiled to implement the care of 3 residents (R7 and R33) interventions in place for falls is (R7) reviewed for dental of the care of t		On 1/14/16 all Nursing department members were provided education survey deficient practices. For any swho were unable to attend the meemake up written information packet give to them.  The staff were educated on the importance of performing oral care the risks associated with not providing good oral hygiene. We reviewed Reno. 7's care plan and the need for assistance with oral care.  An audit was completed on 2/3/16 of Neighborhood A & B on the AM shift audit was completed on 2/3 of Neighborhood B on the PM shift and Neighborhood A on 2/4 on the PM shadits conducted by the DON and the staffing TMA for completion of oral of Oral care audits will be completed in x 3 months, then it will be incorporated into the monthly Safety Audit - so it is remain on-going. Audits will be completed the above listed employees and LPN completes the Safety audit mo	on the staff ting, a was and ing esident of both t. An donshift. the cares. monthly ted will ipleted S.M. inthly.	

OLIVILI	13 I OIT WEDIOAITE	A MEDICAID SETVICES			0	WID INO.	0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245243	B. WING	<u> </u>		01/1	13/2016
	PROVIDER OR SUPPLIER  MANOR			2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	when completed into frecliner up, (3) powearing shoes, (4) when in bed, (5) and staff, wheelchair to 1-2 staff with all oth (ADL's), able to eat Sign placed on bath exit or enter from the room, and (8) ensure occurs, complete a event and incident and incident incontributing to the finterventions dated identified he needed care.  The nursing assistant sheet for R7 utilized identified R7 as a hinterventions: (1) hindocument, (2) call I (3) body pillow on extended missing documentation che revealed missi	on hourly monitoring sheet tervention, (2) do not put feet rovide gripper socks if not body pillows on each side abulate with assistance of 1-2 follow, (6) assist required of the activities of daily living independently after set up, (7) aroom door so R7 would not be bathroom into his neighbor's re walker within reach. If a fall post fall assessment, a fall report and assess factors all and implement 3/18/15. R7' care plan d staff assist of 1 with oral and (NA) undated assignment d on 1/12/15, at 1:11 p.m. igh fall risk with the following ourly checks at all times, each side when lying down, (4) staff assist of 1-2 for ADL's. assistant reposition and toilet cklist date 12/11/15 to 1/13/16 ocumentation and/or lacked	F:	282	members were provided education regarding the care plan changes at survey deficient practices for Resic 7 and Resident no. 33. For the staf did not attend a make up written painformation was provided to them. [Additional staff education was produring the survey process to remor J deficient practice.]  ON 1/18/16 an email account ground eveloped for all the RN's, LPN's, TMA's and they were all instructed this email when care plan updates changes were made. Education proon how Resident no. 7 is at extrem high risk of injury related to his prefalls and healing fractures and the offer assistance for Resident no. 3 related to her high fall risk at the stimeeting on 1/14/16.  A Interdisciplinary Fall Committee been developed and the first meetineld on 2/3/16. The goals of the Ptoen developed and the first meetineld on 2/3/16. The goals of the Ptoen developed and the first meetineld on 2/3/16. The goals of the Ptoen developed and the first meetineld on 2/3/16 are also reviewed Any resident who has 2 falls in a 30 window of time or has a fall with significant injury will have a complete events/incidents are also reviewed Any resident who has 2 falls in a 30 window of time or has a fall with significant injury will have a complete care plant findings. These will be audited monthly and findings.  An audit tool was developed and S LPN performed a complete care plant and a significant care sheet audited monthly and a significant care sheet audited m	nd the lent no. If who acket of wided we the o was and to use / ovided ely wious need to 3 aff as DSA will the lent no day the "Fall opport no 7 y at the etion	

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL		SURVEY PLETED				
		245243	B. WING			01/1	3/2016
	PROVIDER OR SUPPLIER  E MANOR			25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE RANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	unattended sitting i with the footrest eledirectly on the footrecovered by a white cannula, neck brack and appeared to be entered R7's room to use the toilet, he repositioned R7's let the footrest of the reboth of R7's feet reexited R7's room.  During interview or reported she was a with serious injury, he had any falls from R7 was to be offered frequent checks, a conly two intervention NA-B stated there are related to the reclination Upon reviewing the interventions were the recliner. NA-B footrest for R7 afteroffered him the bed if he wanted his feet confirmed she had cares for R7. NA-B in to administer R7 left to answer other back to complete the R7 required assistate to the completed two to the complete the complete the completed two to the complete the complete the complete the completed two to the complete the comp	in his recliner chair in his room evated, both feet were resting rest. R7's lower body was blanket, oxygen on via nasal se was on, eyes were closed e sleeping. Observed NA-B At 1:58 p.m., she offered, R7 refused, then NA-B eft arm with a pillow. NA-B left recliner chair elevated with recliner chair elevated with resting on the foot rest, then at 1/12/16, at 1:50 p.m. NA-B aware of R7's previous falls she stated she was unsure if our the recliner. NA-B stated ed toileting every hour, and then stated those were the rous she knew of off hand. Were "no specific guidelines" are chair and the footrest. And assignment sheet, no listed regarding the footrest of confirmed she elevated the relunch on 1/12/16 and had dor recliner, and had asked R7 et up or down. NA-B also not returned later provide oral a reported the nurse had come "s nebulizer treatment, she had reall lights and never went the oral cares. NA-B confirmed ance for oral cares and should	F 2	282	2/1-2/4/16. She will be doing this on monthly basis to check for accuracy the nursing assistant care sheets. The frequency will be monthly audits x 3 months and it may move to quarterly dependent on the number of change identified during the monthly audits. continue to find more then 5 change will continue to monitor this monthly indefinite basis. Resident no. 33 had overall change in condition and she required staff assistances with trans and ambulation. She is using her cat and asking for assistance. As her condition improves her care plan and sheets will be adjusted.	on he s If we es we on an d an has fers	

-	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		245243	B. WING		01	/13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	the care plan. LPN was put into the corcare plan, but was nursing assignmen  On 1/13/16, at 10:4 (RN)-B confirmed t get updated onto the assignment sheet. required staff assis was to be provided  On 1/13/16, at 12:2 (DON) expected stainterventions, including recliner down, document of the DON also completion and reading the DON also confit to provide oral care electronic heath recincluded: difficulty in chronic obstructive atrial fibrillation, spimellitus, anemia, Manxiety disorder, por rheumatica and eder for falls due to: his was in her home, copotential for weaking COPD and diabete.	il-B confirmed the intervention immunication book and the never transcribed onto the tasheet.  6 p.m. registered nurse he footrest intervention did not be nursing assistant RN-B also confirmed R7 tance of one for oral care and twice per day.  8 p.m., the director of nursing aff to implement identified fall ding to keep the footrest of ament the hourly checks after assessment after each fall. Firmed staff would be expected a per the care plan.  d on 10/25/13 and the cord (EHR) diagnoses in walking, repeated falls, pulmonary disease(COPD), nal stenosis, type 2 diabetes lajor depressive disorder, olyneuropathy, polymyalgia ema.  d 3/9/15, identified R33 at risk tory of frequent falls when she ontinued risk for falls and less related to diagnoses of s.	F 282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		245243	B. WING			01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR			2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	follow; uses the bat independently in ro able; and will need weakness, increase or tiredness.  (2.) Remain in room bathroom; inform from the room completed her bath strongly encourage transfers/assist to phas been explained transfers; however such as transfers in calling for staff assidecisions even with risks and benefits.  (3.) Attempt to assidecisions even with risks and benefits.  (3.) Attempt to asside with R33 about assist/and or not us help with walking a realizes she is not at that her feet do cat she walks. R33 is rinvolved if she show because she declinassistance with transfers. R33 decided like to continue to the room without calling after the above risk is alert and oriented.	and wheel chair (w/c) to throom; able to ambulate om and to/from bathroom as assistance when displaying in shortness of breath (SOB) in while R33 is in the R33 you will be around the and to alert staff when she has aroom task. All staff need to use of the call light for prevent falls. R33 is aware and it to allow staff assist with all recontinues to complete tasks independently at times, without ist. Continues to make her own in her understanding of the distance. Discussion it not waiting for staff sing call light when she needs always steady on her feet and ch on the floor at times when made aware of the risks always steady on her feet and ch on the floor at times when made aware of the potential for east this time that she would ransfer/walk on her own in her gor waiting for assist, even as were explained to her. She dix 3 and is able to make need the release from	F 2	282			

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245243	B. WING		<del> </del>	01/ <sup>-</sup>	13/2016
	PROVIDER OR SUPPLIER  E MANOR			2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	wheeled herself ou wheelchair with her noted to become S wheeling the w/c. (NA)-A noted R33's and transported R3 and transported R3 and transported R3 and transported R3 completion of the eherself from the diffect to propel the whoecame SOB with difficulty and wheel opened the bedroor room, closed the dwith the door close return later to checassistance was offed on 1/11/16, at 6:29 seated in her reclinheavily and sweatintime, R33 stated shall the recliner and incomplete the wheelchair possible with the brakes on questioned why shassistance, R33 rethem to come and when interviewed registered nurse (Finurse (LPN)-A state to get assistance wand/or transfer as sign-A and LPN-A wand/or transfer as sign-A and L	on 1/11/16, at 5:29 p.m. R33 to fher room by propelling her refeet and arms. R33 was to B and struggled with At 5:31 p.m. nursing assistant addifficulty with self-wheeling R3 to the dining room table.  B p.m. it was noted that upon evening meal, R33 wheeled hing room using her hands and the activity. NA-A noticed the led R33 to her room. NA-A am door, wheeled R33 into the loor and left R33 in her room d. NA-A indicated she would k on R33. No further lered.  D p.m. R33 was observed her in her room breathing high when interviewed at this he had transferred herself into dicated it was difficult. R33 had itioned in front of her recliner the chair locked. When led did not ask staff for plied, "It takes too long for	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245243	B. WING _		01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	alone in the room w supper meal, LPN-/ have offered to ass recliner. LPN-A stat decline the help but RN-A verified the cawritten and reiterate R33 assistance ever will at times accept. The facility's Care Findicated a personal care would be dever multi-disciplinary teresident restorative goals and coordinate towards meeting the 483.25(a)(3) ADL CDEPENDENT RES. A resident who is undaily living receives maintain good nutriand oral hygiene.	in by staff and then left her with the door closed after the A responded that staff should list R33 transfer into her led R33 would probably a she should still be offered. The list is should offer to assist the should offer th	F 28			1/14/16
	review the facility fa of 1 resident (R7) re upon staff for groon Findings include:	ion, interview and document iled to provide oral cares for 1 eviewed who was dependent ning and personal cares.		On 1/14/16 all Nursing department members were provided education survey deficient practices. For any who were unable to attend the mean make up written information packet give to them.  The staff were educated on the	on the staff eting, a t was	
	n/ s quarterly Minir	num Data Set (MDS) dated		importance of performing oral care	and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245243	B. WING		01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR		:	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETION DATE
F 312	8/13/15, identified of Alzheimer's disease chronic obstructive The MDS identified impairment and receivith personal hygie R7's admission assidentified R7 had not condition. The oral some missing nature R7's care plan revier R7 required staff as grooming, including nursing assignment own teeth and required care.  During observation from 7:05 a.m. to 7 (NA)-B assisted R7 included washing heares and dressing was not assisted with for completion of orwere observed with between them.  During interview on confirmed she had cares for R7 earlier had completed all of exception of oral cares and never went back NA-B confirmed R7	diagnoses which included e, anxiety, depression and pulmonary disease (COPD).  R7 had moderate cognitive puired extensive assistance	F 312	the risks associated with not proving good oral hygiene. We reviewed Fino. 7's care plan and the need for assistance with oral care.  An audit was completed on 2/3/16 Neighborhood A & B on the AM shaudit was completed on 2/3 of Neighborhood B on the PM shift a Neighborhood A on 2/4 on the PM Audits conducted by the DON and staffing TMA for completion of ora Oral care audits will be completed x 3 months, then it will be incorpor into the monthly Safety Audit - so i remain on-going. Audits will be coby the above listed employees and LPN completes the Safety audit miles.	of both ift. An on shift. the cares. monthly ated t will mpleted is S.M.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/	13/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 312	Continued From pa	ge 10 1/12/16, at 2:12 p.m. licensed	F 3	112			
	practical nurse (LPI	N)-B confirmed R7 required or oral cares and is expected					
	During interview on 1/13/16, at 11:08 a.m., registered nurse (RN)-B confirmed R7 required staff assist of one for oral cares and was to be provided daily as he did have natural teeth missing.						
	director of nursing (R7 from his recliner assisted him to the confirmed she had and verified R7 requestion complete oral caresto have been provided The DON stated should be to make sure caresto.	1/12/16, at 11:03 a.m., the DON) confirmed she helped to his wheelchair and breakfast table. The DON not provided oral cares for R7, uired staff assistance to and would expect the cares ded before or after breakfast. e would have to remind staff were completed for R7 before or other places after breakfast.					
F 323 SS=J	approved on 12/03, receive appropriate		F3	23		1/14/16	
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY PLETED
		245243	B. WING _		01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP C 250 JORDAN DRIVE GRANITE FALLS, MN 56241	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 11	F 32	23		
	by: Based on observareview, the facility fassess and ensure interventions were for 1 of 1 resident (sustained multiple immediate jeopardy serious harm, injury resident in immediate oensure interventifalls, with the potentimmediate jeopardy (R33) reviewed with The IJ began on 1/was observed to be recliner in his room recliner footrest. The was notified of the p.m. on 1/12/16. The removed on 1/13/19 non-compliance reseverity level Discaptual harm with potential harm with potential harm that is not important that is not impor	12/16, at 1:11 p.m. when R7 e seated unattended in the with both feet elevated on the he director of nursing (DON) immediate jeopardy at 4:03 ne immediate jeopardy was 6, at 11:15 a.m. but mained at the lower scope and plated, which indicated no otential for more than minimal		On 1/14/16 all the Manor N members were provided ed regarding the care plan cha survey deficient practices for 7 & Resident no. 33 and the for all Residents r/t falls. A written make up packet of was provided to any staff th to attend the meeting. [2 mewere provided with over 90°s [Additional staff education with during the survey process to IJ deficient practice.] On 1/18/16 an email accourdeveloped for all the RN's, ITMA's and they were all insthis email when care plan upon the care plan upon how Resident no. 7 is at high risk of injury related to falls and healing fractures a offer assistance for Resider related to her high risk at the held on 1/14/16. A Interdisciplinary Fall Combeen developed and the first held on 2/3/16. The goals of be to have a reduction in fall no falls with major injury. The will meet prior to the Safety monthly meeting where all revents/incidents are also re Any resident who has 2 falls window of time or has a fall	ucation anges and or Resident No. e potential risk of information at were unable eeting times at tending.] was provided or remove the ant group was LPN's, and tructed to use pdates / on provided extremely his previous and the need to at no. 33 e staff meeting was f the PDSA will alls monthly and his committee committee resident viewed.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR		2	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	moderate cognitive extensive assistant personal hygiene, a bed mobility, transf subsequent quarter indicated R7 requirall activities of daily R7's Care Area Ass 2/26/15, indicated R5 short term and long had diagnoses which dementia, hearing lischemic attack (TI fibrillation (irregular contributed to R7's due to R7's memor to call for assistant device. The CAA in been identified for I him meet goals and R7's current care pridentified R7 was a injury relate to age, glaucoma, hearing episodes of confus fibrillation, weaknes R7's care plan incluinterventions: (1) Holleting, document when intervention of recliner up, (3) pwearing shoes, (4) when in bed, (5) an staff, wheelchair to 1-2 staff with all oth (ADL's), able to eat	impairment, required be with dressing, toileting, and and needed supervision for ers and ambulation. A rely MDS dated 12/15/15, ed extensive assistance with a living (ADL's) except eating.  Sessment (CAA) dated R7 was at risk for falls, had a term memory impairment, the included Alzheimer's coss, glaucoma, transient A), heart disease and atrial and the heartbeat) which all fall risk. The CAA indicated and interventions had R7 and were in place to help disprevent falls with injuries.  Ilan, last reviewed on 11/24/15, trisk for falls with potential for Alzheimer's disease, TIA, loss, urinary incontinence, ion and forgetfulness, atrial as, and new environment.	F 323	significant injury will have a composervation" completed by the SRN or the Case Manager RN with days. These will be audited mont Fall Committee meeting for compand findings.  An audit tool was developed and LPN performed a complete care nursing assistant care sheet audi 2/1-2/4/16. She will be doing this monthly basis to check for accurathe nursing assistant care sheets frequency will be monthly audits months and it may move to quart dependent on the number of charidentified during the monthly audicontinue to find more then 5 charwill continue to monitor this mont indefinite basis. Resident no. 33 loverall change in conditionand shrequired staff assistances with train ambulation. She is using her and asking for assistance. As her condition improves her care plan sheets will be adjusted.	upport nin 7 nly at the pletion  S.M. plan to t on on a acy on . The c 3 erly nges ts. If we nges we nly on an nad an ne has ansfers call light	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	room, and (8) ensu addition, the plan in staff were to compl fall event, and to co assess factors contimplement interven.  The undated nursing sheets in use on 1/ for R7: high fall rist interventions: (1) high document, (2) call I (3) body pillow on experienced fadecreased strength incontinence of uring Although the facility interventions post for were not always addid not always receimplementation.  Review of the fall shad occurred with the 2/27/15, 6/3/15, 6/8 12/13/15. However, had experienced madexperienced	athroom into his neighbor's re walker within reach. In adicated that if a fall occurred, ete a post fall assessment, a amplete an incident report and tributing to the fall, and tions dated 3/18/15.  In gassistant (NA) assignment 12/16, indicated the following	F 323	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245243	B. WING	<del></del>	01.	/13/2016
-	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	his body and hit his not wearing his glast the time, R7 had re retrieve his walker, intervention: keep was the resident had so side of his head and right forearm, and had the right upper extraction the emergency room he'd hit his head and Coumadin (a blood record dated 8/17/11 the cervical spine Counties of significal line of the cervical spine Counties and the elevated indicated R7 had be on his buttocks with elevated foot rest afloor from a left wrist post fall assessment on, walker within rehad his glasses on, he was attempting the bathroom and how to put the foot get out of the chair tipped. Additionally R7 had reported he and that visual assessment centimeter (cm) x 1 head. The docume applied an ice pack	head on the floor. R7 was sees at the time of the fall. At ported that when attempting to he felt dizzy and fell. New valker within range of resident. Ustained bruising to the right delbow, a small skin tear to had complained of mild pain to emity. R7 had been sent to m (ER) for evaluation because and because he was on thinner medication). The ER 5, revealed the head CT and CT were both negative, with no	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY IPLETED
		245243	B. WING			01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			25	REET ADDRESS, CITY, STATE, ZIP CODE 0 JORDAN DRIVE RANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	to treat atrial fibrillar indicated R7 had be lower the foot rest of his recliner, the runable to stop hims weakness. As a re intervention had be legs of recliner, sign rest of recliner, lam The fall summary for lays in bed during the and indicated use of departments the leg. Incident documentation. According to the been left in the bed walks around in the R7 had sustained at 1.5 cm to his right to included: frequent round to the left included: frequent round to the left cause of the fall was unsteady at times at intervention to previnitiate every half her and sustained at 1.5 cm to his right to included: frequent round to the left cause of the fall was unsteady at times at intervention to previnitiate every half her and sustained at 1.5 cm to his right to include the fall was unsteady at times at intervention to previnitiate every half her and sustained at 1.5 cm to his right to include the fall was unsteady at times at intervention to previnitiate every half her and the following the fall was unsteady at times at intervention to previnitiate every half her and the following the fall was unsteady at times at intervention to previnitiate every half her and the following the fall was unsteady at times at intervention to previnitiate every half her and the following the fall was unsteady at times at intervention to previnitiate every half her and the following the fol	tion. The fall summary also been unable to figure out how to be finis recliner, tried to get out ecliner had tipped and R7 was self from falling due to sult of this incident, a new en identified: do not elevate in stating (do not elevate leg inated and placed on recliner. The indicated R7 usually the day and elevates his legs, of the sign would notify all grest was to be left down.  Attion indicated on 12/11/15 at been found on the bathroom the report, R7's walker had room and R7 had stated he room without it all the time. It skin tear measuring 0.1 cm x humb. A new intervention eminders to use walker and R7 while in the bathroom; has attion indicated on 12/12/15 at been found on the floor near is left side. The cated R7 had sustained a 5 side of his head. The root is identified to include and recent new room. The ent futher incident included: bur checks by staff.	F3	323			
		n orders, due to the resident's creased weakness to his legs.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	on 12/15/15 at 3:45 himself to the bathrindicated R7 had be had been found lay his pants down, on towards the showe shoe on and one slurine around the to noted to the right si indicated R7 had obut had slurred speconversation. The assistant (NA) had minutes prior. Root without assistance. 1 hour, night staff understanding the fall dispeech and increas subsequently been (emergency room) up nursing progres admitted to the hos radiology report darfollowing injuries: a fracture of right claright 9th and 10th root T2. The CT of cerv non-displaced fract hospital history and for the hospitalization 12/18/15 revealed: required, advised to weeks. Was admit falls with a C2 com retention, cardiac and towards and the standards and the	indicated R7 had fallen again in a.m., when he'd taken froom. The documentation een heard yelling "help" and ing on the bathroom floor with his right side with his head r. Details indicated R7 had one noe off, the floor was wet with liet base, and R7 had a lump de of his head. Documentation ffered no complaints of pain				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245243	B. WING			01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE BRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	left pleural effusion, non-displaced fraction The facility's nursing 12/18/15 to 12/26/1 to the nursing home brace at all times. It is staff had implement hour to one hour the A physician's progressidentified R7 was at falls. The physician done everything to indicated the C2 sp shifted nor moved), documented an ord and Coumadin.  Although the facility numerous intervent monitoring of R7, at p.m., indicated R7 if floor. The report incomposed to the elevation of pain or bruising repense had sustained no in of pain or bruising repense here with the footrest in trecliner chair had tip off the end and onto the floor.	stable cardiomegaly and ures of right clavicle. " g progress notes from 5, indicated R7 had returned a 12/18/15, wearing a neck in addition the notes indicated ted frequent checks (every 1/2)	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245243	B. WING		0	1/13/2016	
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	about this fall indica R7 had been attem been unable to low Interventions devel- incident included: I footrest of recliner in related to ask for he and dycem (an anti- seat.	ated that at the time of the fall, pting to self transfer and had er the footrest on his own. oped as a result of the 6/3/15 owered footrest, and maintain n low position, 1:1 discussion elp when needing assistance -slip pad) added to the recliner	F 3.	23			
	1:11 p.m. to 2:12 p. unattended in his re the footrest elevate directly on the footr covered by a white cannula, neck brac appeared to be slee entered the room to NA-B repositioned the footrest of the r	observation on 1/12/16 from m. R7 was observed sitting ecliner chair in his room with d, both feet were resting est. R7's lower body was blanket, oxygen on via nasal e was on, eyes closed and eping. At 1:58 p.m. NA-B offer toileting but R7 refused. R7's left arm with a pillow, left ecliner chair elevated with sting on the foot rest and					
	reported she was a with serious injury to falls had occurred the only two interverses hourly toileting and she didn't think their guidelines" related of the footrest. NA-nursing assignment interventions were footrest on the reclinelevated the footrest 1/12/16, and that serious injury to serious interventions.	1/12/16, at 1:50 p.m. NA-B ware of R7's previous falls but was unsure whether any rom the recliner. NA-B stated ntions for R7 included offering frequent checks. NA-B stated re were any "specific to the recliner chair or the use -B then reviewed the current t sheet and confirmed no listed regarding the use of the ner. NA-B confirmed she had st for R7 after lunch on he had offered him the choice the bed or in the recliner.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245243	B. WING _		01	/13/2016		
NAME OF PROVIDER OR SUPPLIER  GRANITE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  250 JORDAN DRIVE  GRANITE FALLS, MN 56241					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 323	NA-B also verified sabout whether to have or down. NA-B sof specific resident interventions by the which is available to each shift, and by the which is available to each shift, and by the NA-B stated nursing access to the formation of the state of the	she had given R7 a choice ave the footrest on the recliner stated staff were made aware needs or any new facility's communication book to be read at the beginning of the NA assignment sheets. It is gassistants did not have all resident care plans.  I on 1/12/16, at 2:03 p.m., he ify whether he'd experienced	F 3:	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING			01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR			25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE RANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLÉTION	
F 323	When interviewed on ursing assistant (I awareness of R7's with the footrest elestaff continue to put footrest elevated w stated the recliner I supposed to be pin from operating the made aware of cur by checking the coassignment sheet at the beginning of easaid she reviews of comparing interview on registered nurse (Fexperienced multip including out of his elevated (most recording the communication made to the reside assignment sheets sheets are updated 1/13/16, at 10:46 a intervention to keep originally initiated 6 on the NA assignment should missed. The DON the communication of the recliner or assessment should missed. The DON	on 1/12/16, at 2:24 p.m. NA)-D confirmed an previous falls from the recliner evated. However, NA-D stated t R7 in his recliner with the hen he is tired. NA-D further has an electric remote which is ned out of reach to prevent R7 chair. NA-D stated she is rent fall intervention revisions mmunication book, the nursing and checking with the nurse at ch shift. In addition, NA-D hanges with the previous staff.  1/12/15, at 2:32 p.m. NN)-B confirmed R7 had le falls while at the facility, recliner with the footrest ently on 1/2/16). RN-B stated not supposed to be elevated. At after the completion of a fall eloped intervention is placed in book, and revisions are nt's care plan and NA. RN-B also said the NA weekly on Fridays. On .m. RN-B confirmed the other foot rest down for R7, /8/15, had never been updated	F3	323			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01	/13/2016	
NAME OF PROVIDER OR SUPPLIER  GRANITE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241			
(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 CORRE ( (EACH CORRECTIVE ACTION SH: CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245243	B. WING			01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			25	REET ADDRESS, CITY, STATE, ZIP CODE 0 Jordan Drive Ranite Falls, MN 56241	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	was removed on 1. could be verified by with staff, the facilit comprehensive poremoved from the sign was placed or footrest down, nurbeen updated, the an hourly safety fall and implemented, conducted on ever safety falls checklis non compliance reseverity of a D, no more than minimal failed to ensure on	pardy that began on 1/12/16, /13/16, at 11:15 a.m. when it y record review and interviews ty had completed a st fall reassessment, R7 was recliner with feet elevated, an R7's recliner to leave the sing assignment sheets had care plan had been updated, alls checklist had been created and staff audits had been y shift to ensure the hourly st was implemented. However, mained at the lower scope and actual harm with potential for harm, because the facility going staff compliance with ons to maintain resident	F3	23			
	the resident had be diagnoses includin falls, chronic obstrudisease(COPD), at type 2 diabetes medepressive disorder polyneuropathy, poedema.  The quarterly Minimassessment, dated had sustained one MDS assessment significant change	ealth record (EHR) indicated een admitted on 10/25/13 with g: difficulty in walking, repeated active pulmonary trial fibrillation, spinal stenosis, ellitus, anemia, major er, anxiety disorder, elymyalgia rheumatica and mum Data Set (MDS) 11/12/15, identified that R33 fall since the last quarterly dated 8/26/15. R33's MDS assessment dated ified the resident had sustained					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245243	B. WING			01/-	13/2016
	PROVIDER OR SUPPLIER  E MANOR			25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE RANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	one fall since prior for falling. The Cardocumentation for condition indicated related to use of an weakness at times with activity, obesity anemia. The MDS continue her currer identified indicated assistance with sor living (ADL) when stired, and identified experience episode R33's care plan darfor falls due to: his her home, continue for weakness related diabetes. The care 1.) Assist with amb assist with gait belt follow; uses the bar ambulate independent bathroom as able; displaying weakness breath (SOB) or tire 2.) Remain in room inform R33 you will room and to alert sher bathroom task. encourage her to utransfers/assist to phas been explained assist with all trans to complete tasks sat times, without casign a waiver. She	assessment and was at risk re Area Assessment (CAA) the significant change in R33 was at risk for falls at i-depressant medications, shortness of breath (SOB) y, diabetes, hypertension and further identified staff should at care plan. Interventions R33 needed and received me of her activities of daily she was feeling SOB, weak, or she had potential to be of pain and discomfort.  Ited 3/9/15, identified R33's risk tory of frequent falls when at ead risk for falls, and potential end to diagnoses of COPD and to plan interventions included: ulation on the unit, 1-2 staff and wheel chair (w/c) to throom in her room; able to lently in room and to/from and will need assistance when se, increase in shortness of endness.  In while R33 is in the bathroom; be around the corner in the taff when she has completed All staff need to strongly	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01	/13/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 250 JORDAN DRIVE GRANITE FALLS, MN 56241		, 10, 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 323	to call for assist. She decisions regarding with her understand 3.) Attempt to assist her to use call light held with R33 about assist/and or not us help with walking or realizes she is not at that her feet do cat she walks. R33 is rinvolved if she show because she declinit transfers and walki walks to and from heathroom. R33 is mot to have staff as ambulation she has occur. We talked a could happen such fractures-and these talked about skin to have refused protect her door way. She would like to contin in her room without even after the above She is alert and oridecisions. R33 sign responsibility form. her chart; 4.) Raise table moved to right place in reach next wheelchair in the heand encouraged to Staff also check to nightlight/light in bar	and to death if she chooses not the continues to make her owning when she will transfer, even ding of the risks and benefits. It with all transfers/encourage for assistance. Discussion to the transfers in her room. R33 always steady on her feet and chon the floor at times when made aware of the risks all fall and lose her balance her to ask for assistance with mag in her room. Frequently her chair/bed into her made aware that if she chooses sist her with transfers and as the potential for injures to bout the potential injuries that as head injuries, a could lead to death. We also hears and bruising. R33 also her transfer/walk on her own a calling or waiting for assist, we risks were explained to her.	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	maintained foot we frequently used iter  During observation propelled herself in with the use of her to become SOB an w/c. At 5:31 p.m. N self-wheeling and troom table. Followi was observed to hadining room, using the w/c. It was note the activity. Again, wheeled R33 to helbedroom door, wheeled her heavily a interviewed at that transferred herself been "difficult". It wheelchair position the brakes on the own why she hadn't ask replied, "It takes to I'm impatient".  When interviewed that it is to I'm impatient.  When interviewed that it is to I'm impatient.  When interviewed that it is to I'm impatient.	ar. Keep personal items and ms within R33's reach.  on 1/11/16, at 5:29 p.m. R33 the wheelchair from her room feet and arms. R33 was noted d struggled with wheeling the JA-A noted R33's difficulty with ransported R33 to the dining mg supper, at 6:18 p.m. R33 are wheeled herself from the her hands and feet to propel d that R33 became SOB with NA-A noticed the difficulty and room. NA-A opened the seled R33 into the room, d left R33 in her room with the indicated she would return 33. No further assistance was at 6:29 p.m. R33 was observed er located in her room; and sweating. When time, R33 stated she had into the recliner and that it had was observed that R33 had the ed in front of her recliner with thair locked. When questioned ed staff for assistance R33 to long for them to come and the following day, on 1/12/16, as seated in her room in her so very SOB and breathing she had been in the bathroom ause staff came in and saw her getting onto the toilet. She is terrible today, and that she'd SOB and weak when	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING		0-	1/13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE 250 JORDAN DRIVE GRANITE FALLS, MN 5624	, ZIP CODE	
(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 C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 323	entered the room s not always ask for of the fall risks but herself as possible R33 indicated the f the fault of the staff indicated she would felt she needed ass the call light.	R33 stated if staff had not he may have fallen as she did help. R 33 stated she is aware desires to do as much for to maintain her independence. alls she experienced were not i; "I'm a bit stubborn." R33 dutilize the call light when she sistance but usually did not use	F 3	23		
	had experienced that 1) 1/9/16, at 3:15 pthe toilet and had in caused the floor to tear. The nursing p 05:04 p.m. identified urine, which caused indicated R33 had she was in a hurry, tear to the left thum required three staff a full lift. Document initially denied pain					
	2) 9/24/15 a progress note from 11:56 a.m. indicated when an NA had gone to check R33's menu selection, R33 had been found on the floor near her door. R33 indicated she was going to get her walker to go to the bathroom and had fallen. Documentation indicated R33 sustained multiple bruises and a small skin tear to her right middle finger, and had been sent to the hospital due to complaints of shoulder pain on her left side. Fractures were ruled out and R33 returned to the facility.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245243	B. WING _		01	/13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	indicated R33 was When staff entered the floor lying on he her head out into he hematoma (bruise) gone to the hospital identified. An intervindicated R33 was help by using the cathat R33 had agree 4) 7/6/15, at 8:35 athat R33 had actival staff entered the rofloor with her legs of indicated R33 had supper right arm on 3.5 x 2.5 cm. R33 position easily with 5) 7/1/15 at 6:45 p. R33 had been foun in a puddle of urine documentation indicated on the high-rissustained a bump athe right of the midl The notes indicated neurological checks irregularities had be when interviewed and LPN-A stated siget assistance whe and/or transfer as sign-A and LPN-A with the right of the midles and the sign of t	is p.m. a progress note heard calling out "Help!" If the room, R33 had been on er back in the bathroom with er room. R33 had sustained a to her left hip and elbow, had I, but no fractures were ention developed post fall encouraged by staff to ask for all light when transferring, and add.  I.m. a progress note identified ated her call light and when om R33 was sitting on the crossed. Documentation sustained a skin tear to her the lateral aspect measuring was assisted to a standing 3 staff and gait belt.  Im., a progress note identified d on the floor in her bathroom at 3:10 p.m. that day. The cated R33 had bumped her se on the toilet, and had about the size of a golf ball to ine on the back of her head. It staff had implemented at the time of the fall, but no	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245243	B. WING			01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 JORDAN DRIVE FRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=E	been wheeled to he and left alone with the responded that staff R33 with transferring stated R33 would period help, but it still show verified the care play and reiterated staff assistance because sometimes she will 483.60(b), (d), (e) ELABEL/STORE DR.  The facility must end a licensed pharmacon of records of receip controlled drugs in accurate reconcilitate records are in order controlled drugs is reconciled.  Drugs and biological abeled in accordant professional princip appropriate accessing instructions, and the applicable.  In accordance with facility must store a locked compartment controls, and perminance access to the the control of the	er room by staff after supper, the door closed, LPN-A f should have offered to assist ag into her recliner. LPN-A robably have declined the alld have been offered. RN-A an was not followed as written should offer to provide R33 e although she may decline, accept the assistance. DRUG RECORDS, UGS & BIOLOGICALS and disposition of all sufficient detail to enable antion; and determines that drug and that an account of all maintained and periodically als used in the facility must be not accept the assistance. State and Federal laws, the lad drugs and biologicals in the sunder proper temperature at only authorized personnel to	F 3	323			1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING	·····	01/	13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 431	Control Act of 1976 abuse, except when package drug distriquantity stored is more be readily detected.  This REQUIREMED by:	ug Abuse Prevention and and other drugs subject to not the facility uses single unit bution systems in which the ninimal and a missing dose can but the single that the single	F 4	On 1/14/16 education was p	provided to all	
	by: Based on observation, interview and document review, the facility failed to maintain labeled medications according to safe and acceptable standards of practice for 8 of 45 residents (R5, R10, R17, R24, R26, R42, R44, R48) whose medications were reviewed during medication storage.  Findings include:  Wing A's medication cart was observed on 1/13/16, at 8:47 a.m. with registered nurse (RN)-B in attendance and licensed practical nurse (LPN)-B administering the ordered medications. The following was noted:  (1.) R17's signed physician orders indicated Lantus Insulin (glargine) 100 units/milliliter (ml) 14 units subcutaneous (SQ) every (Q) evening. The most recent date of administration from this medication was documented as 1/12/16, at 8:44 p.m. The date written on the label appeared as 12/?/15. RN-B and LPN-B both confirmed the opened date was not legible and were uncertain when this medication had originally been opened. The Medication Expiration Dating document provided by the Consultant Pharmacist Inc. indicated Lantus Insulin had an expiration date of 28 days after opening.			the Nurses and TMA's regar survey finding and deficient pany staff unable to attend a with the educational materials we them individually.  Staff were instructed to check medications, insulin bottles, topical medications prior to echecking for expiration dates. The two medication carts we 2/1/16 and 2/2/16 by our school. J.B. Only one medication was on an expiration date so that was reordered and the expir medication will be disposed policy and procedure.  The medication carts will be monthly by J.B. TMA and the pharmacist will also do a momedication cart audit on a mas well.  Any medication found to be close to expiring will be disposed pharmacy. Audits will continuindefinitely.	ding the oractices. For written copy of ere given to ek all "PRN" and other each use, so ere audited on reduling TMA as coming up a medication ing of per facility audited e consulting re thorough onthly basis expired or osed of per and the different to the company of the different the company of the different the company of the different to the different to the consulting are thorough onthly basis expired or osed of per and the different to the consulting are thorough onthly basis expired or osed of per and the different to the consulting are thorough onthly basis expired or osed of per and the different to the consulting are thorough on the consulting are the consulting are the consulting are the consulting are th	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245243	B. WING _		01/	13/2016
_	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  250 JORDAN DRIVE  GRANITE FALLS, MN 56241	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	
F 431	sliding scale and la 8:44 p.m. The pack 12/5/15 and the explays after opening confirmed the mediexpiration, had bee have been replaced (3.) R42 had signe Flexpen sliding scale medication was veradministered 1/13/1 an opened date of confirmed the morn administered from the was indicated as 28 Both RN-B and LPN was administered as 1 and 1 capsule QD and 2 capsule QD and 3 capsule QD and 3 capsule QD and 3 capsule QD and 4 capsule QD and 5 capsule QD and 5 capsule QD and 6 capsule	olog Flexpen-signed order for st administered 1/12/16, at tage was dated as opened biration was indicated as 28 RN-B and LPN-B both cation was past the date of n administered and should d.  d MD orders for Novolog le four times daily. This iffied as last being 16, at 6:56 a.m. The label had 11/24/15, and LPN-B hing dose of insulin was this package. Expiration date 3 days after opening for use. N-B confirmed this medication after the expiration date.  The MD order for Colace 100 is needed for constipation. For administered 8/16/15. The was not legible for instructions and in addition the bottle was an red substance and surface and the medication should have here was no way to know when been opened nor the date of or ther stated she thought this nat had been brought from	F 43	1		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245243	B. WING _	· · · · · · · · · · · · · · · · · · ·	01	/13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	not this medication Wing-B's medication 1/13/16, at 9:30 a.n and LPN-C administ medications. The f (1.) R26 had a sign mg 1 tablet by mou Hours as needed (I of administration was 12/24/15, at 4:30 printed on the phar LPN-A&C verified t administered after the control of the properties of the control of the phar LPN-A&C verified the phar LPN-A&C verified the phar LPN-A&C verified the control of the phar LPN-A&C verified the phar LPN	PN-B were aware whether or had last been administered.  In cart was observed on in. with LPN-A in attendance stering the ordered ollowing was noted: ned MD order for Oxycodone 5 th (PO) every (Q) six (6) PRN). The most recent date as documented on the MAR in a.m The date of expiration macy label was 9/22/15. The most recent date of expiration was the date of expiration.  In ed MD order for Alpralozam in the most recent of administration was 12/23/15, inted expiration date on the interest administered after the date of expiration date on the interest administered after the date of unknown. The most recent date of unknown. The printed he label was 12/26/15.  The d MD order for Robitussin AC easpoons PO Q4H PRN. Last on was unknown. The printed is 12/26/15.  The most recent date of unknown. The printed he label was 12/26/15.  The most recent date of unknown. The printed is 12/26/15.		1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245243	B. WING			01/13/2016	
	PROVIDER OR SUPPLIER  E MANOR			2	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	also reviewed by the during the monthly observed the above confirmed they were have been administ.  On 1/13/16, at 11:1 pharmacist (CP) was and stated his most 12/4/15. It was vert A&B, in addition to were reviewed. The legible on the medic review if the date disacceptable time frame, not possible to determine usable time frame, not possible, the medication administered past the and it was the expected expiration date administration.  When interviewed of stated she had considered the expiration date was of the facility policy. Of Medications, approported approached the insuling the procedure of the procedure. (1.) check the control of the procedure: (1.) check the above control of the procedure of the above control of the above control of the procedure of the above control of the above control of the procedure of the above control of the above control of the	d in the medication carts were e consultant pharmacist spot review. The DON e listed medications and e outdated and should not tered per facility policy.  2 a.m. the consultant as interviewed via telephone trecent facility visit was on ified that both medication carts individual resident records e CP stated if a date is not cation label, staff should ispensed was within an me and see whether it is ne if the medication is within a The CP indicated if this was edication should be replaced. ulin should not be he labeled expiration date. Extation that nursing staff attes prior to drug  on 1/13/16, at 1:34 p.m. RN-D tacted the local pharmacy dications to the facility and on dates printed on packages ate of expiration. She further cottle with the unreadable ver the 28 day usage date.  Checking outdated val dated 12/04, indicated that ns will be removed to prevent	F	131			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245243	B. WING	<del></del>	01	/13/2016
	PROVIDER OR SUPPLIER  E MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 431	medication pass. Exprocedure.  The facility policy, Manspections, approportions of medications of the labeling.  Medication contains excessively soiled.  Medication labeling medications are not been re-ordered after 1 medications are discreported of the medications of the medication of the medicat	Medication Inventory ved on 1/05, indicated unused ion doses will be discarded. edication inventory shall be by the TD nurse and spot y the Consultant Pharmacist. Hould be removed from ched the expiration date listed ers are unstable, damaged, or is soiled and non-legible. longer ordered and have not been	F 4:	31		



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered February 4, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

RE: Project Number S5343027

Dear Mr. Kooiman:

On November 24, 2015, a standard survey was completed at your facility by the Minnesota Department of 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Printed: 12/15/2015 FORM APPROVED OMB NO. 0938-0391

11/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MUNICIPAL HOSPITAL & **GRANITE MANOR** 

(X3) DATE SURVEY COMPLETED

245243

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

#### **MUNICIPAL HOSP & GRANITE MANOR 345 TENTH AVENUE**

WONICIFAL HOSP & GRANITE MANOR		GRANITE FALLS, MN 56241					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)	DED BY FULL REGULATORY PREFIX		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS		K 000				
	FIRE SAFETY						
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Division, on November 24, the time of this survey, Building 02 of Mu Hospital & Granite Manor Nursing Home found to be in compliance with the requifor participation in Medicare/Medicaid at Subpart 483.70(a), Life Safety from Fire, 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life S Code (LSC), Chapter 18 New Health Call Occupancies.	State 2015. At nicipal was rements 42 CFR, and the					
	Building 02 of Municipal Hospital & Gran Nursing Home consists of a 2015 buildin replacement, and is one-story in height, basement, is fully fire sprinkler protected determined to be of Type V(111) construc-	g has no and was					
	The facility has a fire alarm system with a detection in the corridors and spaces oper corridors which is monitored for automat department notification. The facility has a capacity of 48 beds and was not occupied of the survey.	en to the ic fire					
	The requirement at 42 CFR, Subpart 483 MET as evidenced by:	3.70(a) is					
						5	
ADODATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEI	ITATINE O CIONA	TUDE.	TITLE		(X6) DATE	

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

TITLE

(X6) DATE

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



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted January 29, 2016

Mr. Thomas Kooiman, Administrator Granite Manor 250 Jordan Drive Granite Falls, MN 56241

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5243027

Dear Mr. Kooiman:

The above facility was surveyed on January 10, 2016 through January 13, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Granite Manor January 28, 2016 Page 3

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 contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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.

Please feel free to call me with any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Granite Manor January 28, 2016 Page 3

PRINTED: 02/08/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•		
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the Minnesota for the minnesota	nether a violation has been					
	When a rule contain comply with any of the lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are					

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

02/08/16 **Electronically Signed** 

TITLE

STATE FORM 6899 KNY311 If continuation sheet 1 of 35

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GRANIT	E MANOR		AN DRIVE FALLS, MN	EC041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm On January 10, 11, this Department's sand the following conflicted in your correction that you and identify the date Minnesota Department State Licensing federal software. To assigned to Minnesota Nursing Homes.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the ment of Health.  12 & 13, 2016 surveyors of taff, visited the above provider correction orders are issued. Our electronic plan of have reviewed these orders, when they will be completed. The ent of Health is documenting correction Orders using any numbers have been ota state statutes/rules for	2 000			
	statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow	Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	13/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRANIT	E MANOR		DAN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/14/16
		omprehensive plan of care personnel involved in the				
	by: Based on observati review the facility fa plan as written for 2 reviewed who had i	ent is not met as evidenced on, interview and document alled to implement the care 2 of 3 residents (R7 and R33) nterventions in place for falls is (R7) reviewed for dental		Corrected.		
	Findings include:					
	8/13/15, identified Fincluded Alzheimer' bladder, heart failur chronic obstructive The MDS identified impairment, required ressing, toileting, page 13/15.	num Data Set (MDS) dated R7 had diagnoses which is disease, neurogenic re, anxiety, depression and pulmonary disease (COPD). R7 had moderate cognitive and extensive assistance with personal hygiene and needed mobility, transfers and				
		lan, last reviewed on 11/24/15, t risk for falls with potential for				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 3 of 35

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SUBVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDANITI	E MANOR	250 JORD	AN DRIVE			
GRANIII	EWANON	GRANITE	FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	'	ge 3 Alzheimer's disease, TIA,	2 565			
	glaucoma, hearing episodes of confusi fibrillation, weaknes R7's care plan incluinterventions: (1) Hoileting, document when completed into frecliner up, (3) powearing shoes, (4) when in bed, (5) am staff, wheelchair to 1-2 staff with all oth (ADL's), able to eat Sign placed on bath exit or enter from the room, and (8) ensuroccurs, complete a event and incident in contributing to the finterventions dated	loss, urinary incontinence, on and forgetfulness, atrial is, and new environment. Ided the following lourly checks and hourly on hourly monitoring sheet ervention, (2) do not put feet rovide gripper socks if not body pillows on each side abulate with assistance of 1-2 follow, (6) assist required of er activities of daily living independently after set up, (7) aroom door so R7 would not be bathroom into his neighbor's re walker within reach. If a fall post fall assessment, a fall report and assess factors				
	sheet for R7 utilized identified R7 as a h interventions: (1) h document, (2) call li (3) body pillow on e	ant (NA) undated assignment of on 1/12/15, at 1:11 p.m. igh fall risk with the following ourly checks at all times-and ight within reach at all times, ach side when lying down, (4) staff assist of 1-2 for ADL's.				
	documentation che	assistant reposition and toilet cklist date 12/11/15 to 1/13/16 ocumentation and/or lacked provided.				
	(NA)-B provided R7	a.m., nursing assistant with his morning cares. ould be back when his				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 4 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. Boilbing.			
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	nebulizer treatment R7 stated ok.  During continuous of 1:11 p.m. to 2:12 p. unattended sitting in with the footrest eledirectly on the footr covered by a white cannula, neck brack and appeared to be entered R7's room to use the toilet, he repositioned R7's let the footrest of the reboth of R7's feet reexited R7's room.  During interview on reported she was a with serious injury, he had any falls from R7 was to be offered frequent checks, are only two intervention NA-B stated there we related to the reclin Upon reviewing the interventions were I the recliner. NA-B footrest for R7 after offered him the bed if he wanted his feet	ge 4  was done to brush his teeth,  bbservation on 1/12/16 from m. R7 was observed h his recliner chair in his room evated, both feet were resting est. R7's lower body was blanket, oxygen on via nasal e was on, eyes were closed sleeping. Observed NA-B At 1:58 p.m., she offered, R7 refused, then NA-B eft arm with a pillow. NA-B left ecliner chair elevated with sting on the foot rest, then  1/12/16, at 1:50 p.m. NA-B ware of R7's previous falls she stated she was unsure if m the recliner. NA-B stated ed toileting every hour, hd then stated those were the hs she knew of off hand. Here "no specific guidelines" er chair and the footrest. NA assignment sheet, no isted regarding the footrest of confirmed she elevated the lunch on 1/12/16 and had or recliner, and had asked R7 to up or down. NA-B also not returned later provide oral	2 565	DEFICIENCY)		
	in to administer R7' left to answer other back to complete th	reported the nurse had come s nebulizer treatment, she had call lights and never went he oral cares. NA-B confirmed ince for oral cares and should imes per day.				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 5 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRANIT	E MANOR		DAN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	(LPN)-B confirmed elevated with use o the care plan. LPN was put into the cor	p.m. licensed practical nurse R7's legs were not to be f the footrest as identified on -B confirmed the intervention munication book and the never transcribed onto the t sheet.				
	(RN)-B confirmed the get updated onto the assignment sheet.	RN-B also confirmed R7 tance of one for oral care and				
	(DON) expected sta interventions, include recliner down, docu completion and rea	8 p.m., the director of nursing aff to implement identified fall ding to keep the footrest of ment the hourly checks after ssessment after each fall. irmed staff would be expected per the care plan.				
	electronic heath red included: difficulty in chronic obstructive atrial fibrillation, spin mellitus, anemia, M	I on 10/25/13 and the cord (EHR) diagnoses in walking, repeated falls, pulmonary disease(COPD), nal stenosis, type 2 diabetes ajor depressive disorder, olyneuropathy, polymyalgia ema.				
	for falls due to: hist was in her home, co	d 3/9/15, identified R33 at risk tory of frequent falls when she ontinued risk for falls and less related to diagnoses of s.				
	The care plan interv	ventions included:				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 6 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE	56041		
	OLIMANA DV. OTA		FALLS, MN		ON	0.650
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	assist with gait belt follow; uses the bat independently in roo able; and will need weakness, increase or tiredness.	oulation on the unit 1-2 staff and wheel chair (w/c) to hroom; able to ambulate om and to/from bathroom as assistance when displaying e in shortness of breath (SOB)				
	(2.) Remain in room while R33 is in the bathroom; inform R33 you will be around the corner in the room and to alert staff when she has completed her bathroom task. All staff need to strongly encourage use of the call light for transfers/assist to prevent falls. R33 is aware and has been explained to allow staff assist with all transfers; however, continues to complete tasks such as transfers independently at times, without calling for staff assist. Continues to make her own decisions even with her understanding of the risks and benefits.					
	her to use call light held with R33 abour assist/and or not use help with walking ar realizes she is not a that her feet do cate she walks. R33 is m involved if she shout because she declin assistance with tran room. R33 is made injuries. R33 decide like to continue to tr room without calling after the above risk is alert and oriented	ist with all transfers/encourage for assistance. Discussion t not waiting for staff sing call light when she needs adways steady on her feet and ch on the floor at times when nade aware of the risks ald fall and lose her balance es to always ask for asfers and walking in her aware of the potential for es at this time that she would cansfer/walk on her own in her g or waiting for assist, even as were explained to her. She is a she to make led the release from				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 7 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
	NAME OF PROVIDER OR SUPPLIER  GRANITE MANOR  250 JOH GRANIT			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	responsibility form.  During observation wheeled herself out wheelchair with her noted to become So wheeling the w/c. A (NA)-A noted R33's and transported R3  On 1/11/16, at 6:18 completion of the etherself from the din feet to propel the wheeled to propel the wheeled to propel the whole opened the bedroor room, closed the dowith the door closed return later to check assistance was offer the whole of the down the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed return later to check assistance was offer the whole opened the bedroor room, closed the down the door closed the down the door closed the down the door closed the down the down the down the door closed the down the do	on 1/11/16, at 5:29 p.m. R33 of her room by propelling her feet and arms. R33 was OB and struggled with At 5:31 p.m. nursing assistant difficulty with self-wheeling to the dining room table.  p.m. it was noted that upon wening meal, R33 wheeled ing room using her hands and color was noted that R33 he activity. NA-A noticed the ed R33 to her room. NA-A m door, wheeled R33 into the for and left R33 in her room d. NA-A indicated she would to on R33. No further ered.  p.m. R33 was observed er in her room breathing g. When interviewed at this e had transferred herself into icated it was difficult. R33 had tioned in front of her recliner the chair locked. When ed did not ask staff for olied, "It takes too long for	2 565			

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 8 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRANITI	GRANITE MANOR 250 JOH GRANIT			56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	alone in the room we supper meal, LPN-have offered to assorecliner. LPN-A state decline the help but RN-A verified the cawritten and reiterate R33 assistance ever will at times accept. The facility's Care Findicated a personal care would be dever multi-disciplinary teresident restorative goals and coordinate towards meeting the SUGGESTED MET. The facility could refor providing cares and provide educate to the content of the develop and implemensure on-going contents.	m by staff and then left her with the door closed after the A responded that staff should ist R33 transfer into her led R33 would probably a she should still be offered. The plan was not followed as led staff should offer to assist an though she may decline and the assistance.  Plan policy revised 1/15, alized integrated written plan of eloped for each resident by a lam in order to evaluate the potential, establish attainable the staff and resident efforts one goals.  THOD OF CORRECTION: wiew policies and procedures as directed by the care plan ion to nursing staff pertaining to care plan. The facility could ment an auditing system to	2 565			
2 830	, ,	O Subp. 1 Adequate and re; General	2 830			1/14/16
	receive nursing car- custodial care, and individual needs an the comprehensive	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and				

Minnesota Department of Health

PRINTED: 02/08/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00725	B. WING	<del></del>	01/1	3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRANITE	MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	of bed as much as written order from the resident must remain prefers to remain in the second of the	ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.  ent is not met as evidenced on, interview and document ailed to comprehensively adequate supervision and mplemented to prevent falls R7) reviewed who had alls with injury, resulting in an of (IJ) with the potential risk of or or death. In addition to the te jeopardy, the facility failed ons were followed to reduce tial for harm that is not or for 1 of 3 additional residents	2 830	Corrected		

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 10 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/1	0/2010
			AN DRIVE	57/11 COBE		
GRANIT	E MANOR		FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	2/26/15, indicated F short term and long had diagnoses which dementia, hearing I ischemic attack (TL fibrillation (irregular contributed to R7's due to R7's memorate to call for assistance device. The CAA in been identified for F him meet goals and R7's current care pridentified R7 was a injury relate to age, glaucoma, hearing episodes of confusifibrillation, weaknes R7's care plan incluinterventions: (1) Hoileting, document when intervention of recliner up, (3) proposed for the plan in staff, wheelchair to 1-2 staff with all oth (ADL's), able to eat Sign placed on bath or enter from the baroom, and (8) ensu addition, the plan in staff were to complifall event, and to contribute the contribute of the plan in staff were to complifall event, and to contribute the contribute of the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in staff were to complifall event, and to contribute the plan in the plan	lourly checks and hourly on hourly monitoring sheet ompleted, (2) do not put feet rovide gripper socks if not body pillows on each side abulate with assistance of 1-2 follow, (6) assist required of er activities of daily living independently after set up, (7) proom door so R7 will not exit athroom into his neighbor's re walker within reach. In dicated that if a fall occurred, ete a post fall assessment, a implete an incident report and ributing to the fall, and				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00725		B. WING		01/13/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE	50044		
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	FALLS, MN	PROVIDER'S PLAN OF CORRECTION	DNI .	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	sheets in use on 1/for R7: high fall risl interventions: (1) h document, (2) call I (3) body pillow on e toilet hourly and (5). Review of R7's eve assessments from had experienced fadecreased strength incontinence of urin Although the facility interventions post fawere not always ad	ng assistant (NA) assignment 12/16, indicated the following ourly checks at all times-and ight within reach at all times, each side when lying down, (4) staff assist of 1-2 for ADL's.  Int reports and post fall 2/27/15 to 1/2/16 revealed he lls related to impulsivity, improperly fitting shoes, he and poor memory. It staff had developed alls, necessary interventions ded to the care plan and staff ive adequate instruction on				
	Review of the fall summaries indicated no injury had occurred with the falls that occurred on 2/27/15, 6/3/15, 6/8/15, 12/1/15, 12/6/15 and 12/13/15. However documentation indicated C7 had experienced minor to significant injuries with the following falls:					
	at 2:00 p.m., activity his room when R7 is up and attempting a across the room. It his body and hit his not wearing his glass the time, R7 had regretrieve his walker, intervention: keep with the resident had so side of his head an right forearm, and it	nt documentation, on 8/17/15 y staff had witnessed R7 fall in ost his balance after getting self-transfer to his walker R7 landed on the right side of head on the floor. R7 was sees at the time of the fall. At ported that when attempting to he felt dizzy and fell. New walker within range of resident. Ustained bruising to the right delbow, a small skin tear to had complained of mild pain to emity. R7 had been sent to				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 12 of 35

PRINTED: 02/08/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00725	B. WING		01/13/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
	the emergency room he'd hit his head an Coumadin (a blood record dated 8/17/1 the cervical spine C evidence of signific	m (ER) for evaluation because d because he was on thinner medication). The ER 5, revealed the head CT and CT were both negative, with no ant head injury.				
	Incident documentation indicated on 12/2/15 at 11:40 a.m., R7 had fallen because his recliner chair had tipped forward when R7 attempted to self transfer out of the recliner while the foot rest was in the elevated position. The documentation indicated R7 had been found seated on the floor on his buttocks with his back resting against the elevated foot rest and described blood on the floor from a left wrist skin tear. A documented					
	on, walker within re had his glasses on, he was attempting the bathroom and how to put the foot get out of the chair	nt indicated R7 had his shoes ach, call light activated and but indicated R7 had stated to get out of his chair to go to ladn't been able to figure out rest down so had attempted to with it up and the chair had				
	R7 had reported he and that visual asse centimeter (cm) x 1 head. The document applied an ice pack	the documentation indicated do hit his head on the left side, essment had revealed a 3 cm lump to the left side of his nation indicated staff had and had initiated monitoring as continued use of Coumadin				
	to treat atrial fibrillar indicated R7 had be lower the foot rest of of his recliner, the r unable to stop hims	tion. The fall summary also een unable to figure out how to of his recliner, tried to get out ecliner had tipped and R7 was self from falling due to				
	intervention had be legs of recliner, sign rest of recliner) lam	sult of this incident, a new en identified: do not elevate n stating (do not elevate leg inated and placed on recliner. urther indicated R7 usually				

Minnesota Department of Health

00725 B. WING 01/13/2016	016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GRANITE MANOR 250 JORDAN DRIVE GRANITE FALLS, MN 56241	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) OMPLETE DATE
lays in bed during the day and elevates his legs, and indicated use of the sign would notify all departments the leg rest was to be left down.  Incident documentation indicated on 12/11/15 at 10:20 p.m., R7 had been found on the bathroom floor. According to the report, R7 's walker had been left in the bed room and R7 had stated he walks around in the room without it all the time. R7 had sustained a skin tear measuring 0.1 cm x 1.5 cm to his right thumb. A new intervention included: frequent reminders to use walker and NA's to remain with R7 while in the bathroom; has UTI.  Incident documentation indicated on 12/12/15 at 5:19 p.m., R7 had been found on the floor near the toilet, lying on his left side. The documentation indicated R7 had sustained a 5 cm bump to the left side of his head. The root cause of the fall was identified to include unsteady at times and recent new room. The intervention to prevent futher incident included: initiate every half hour checks by staff.  A nurse's progress note dated 12/14/15, indicated R7 had been evaluated by the physician who had modified medication orders, due to the resident's multiple falls and increased weakness to his legs.  Fall documentation indicated R7 had fallen again on 12/15/15 at 3-35 a.m., when he'd taken himself to the bathroom. The documentation indicated R7 had been heard yelling 'help' and had been found laying on the bathroom floor with his pants down, on his right side with his head towards the shower. Details indicated R7 had one shoe of, the floor was wet with urine around the toilet base, and R7 had a lump noted to the right side of his head. Documentation	

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 14 of 35

PRINTED: 02/08/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00725 B. WING 01/13/20		3/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	but had slurred speconversation. The assistant (NA) had minutes prior. Root without assistance. 1 hour, night staff ut 12/15/15, the nurse regarding the fall dispeech and increas subsequently been (emergency room) up nursing progress admitted to the hos radiology report dat following injuries: a fracture of right clavinght 9th and 10th ritter. The CT of cervinon-displaced fract hospital history and for the hospitalization 12/18/15 revealed: required, advised to weeks. Was admit falls with a C2 compretention, cardiac a reason for falling. (left pleural effusion non-displaced fract The facility's nursin 12/18/15 to 12/26/1 to the nursing home brace at all times. staff had implemen hour to one hour th	ifered no complaints of pain ech and rambled notes indicated the nursing checked on R7 just 10 cause: up to bathroom  New intervention: toilet every pdated. At 9:41 a.m. on had contacted R7's physician are to R7 experiencing slurred ed confusion. R7 had transferred to the local ER for further evaluation. Follow is notes indicated R7 had been pital on 12/15/15, and a red 12/16/15, identified the asmall left pleural effusion, vicle, right scapula, posterior bs and superior endplate of cal spine identified a ure of C2, CT negative. The physical/discharge summary on period of 12/15/15 to "surgical intervention was not of wear a hard C-collar for 6 ted to hospital after multiple pression fracture, CHF, urinary rrhythmia, and unknown Chest x-ray showed chronic astable cardiomegaly and ures of right clavicle."  If a progress notes from 5, indicated R7 had returned as 12/18/15, wearing a neck an addition the notes indicated ted frequent checks (every 1/2)	2 830			

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 15 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/13/2016	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GRANITI	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	falls. The physiciar done everything to indicated the C2 sp shifted nor moved),	n note also indicated staff had try to prevent falls, and ine fracture was stable (not and the physician had ler for R7 to remain off Digoxin				
	Although the facility staff had implemented numerous interventions and had increased monitoring of R7, an incident from 1/2/16 at 2:11 p.m., indicated R7 had again been found on the floor. The report indicated R7 had reported he'd slipped to the elevated foot rest of his recliner and then onto the floor. The documentation indicated R7 had been able to get himself up from the floor, had sustained no injuries, and had no complaints of pain or bruising noted. However, there had been no post fall assessment conducted.					
	at 6:17 p.m. R7 had room. The docume stated he was attenwith the footrest in recliner chair had ti off the end and onto occurred. Additionabout this fall indica R7 had been attembeen unable to low Interventions develoring the contract of recliner in related to ask for he and dycem (an antiseat.	falls revealed that on 6/3/15, d been found on the floor in his ntation indicated R7 had applying to get out of the recliner the up position, that the pped forward, and R7 had slid to the floor. No injuries had all information documented ated that at the time of the fall, pting to self transfer and had er the footrest on his own. Oped as a result of the 6/3/15 owered footrest, and maintain in low position, 1:1 discussion elp when needing assistance -slip pad) added to the recliner				
	1:11 p.m. to 2:12 p.	observation on 1/12/16 from m. R7 was observed sitting ecliner chair in his room with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	directly on the footr covered by a white cannula, neck brace appeared to be sleed entered the room to NA-B repositioned the footrest of the rooth of R7's feet reexited R7's room.  During interview on reported she was a with serious injury to falls had occurred the only two interverses hourly toileting and she didn't think their guidelines" related of the footrest. NA-nursing assignment interventions were footrest on the reclicelevated the footrest 1/12/16, and that sof whether to lay in NA-B also verified sabout whether to have of specific resident interventions by the which is available to each shift, and by the NA-B stated nursing access to the formatics.	d, both feet were resting est. R7's lower body was blanket, oxygen on via nasal e was on, eyes closed and eping. At 1:58 p.m. NA-B offer toileting but R7 refused. R7's left arm with a pillow, left ecliner chair elevated with sting on the foot rest and 1/12/16, at 1:50 p.m. NA-B ware of R7's previous falls but was unsure whether any rom the recliner. NA-B stated ntions for R7 included offering frequent checks. NA-B stated re were any "specific to the recliner chair or the use B then reviewed the current at sheet and confirmed no isted regarding the use of the ner. NA-B confirmed she had st for R7 after lunch on he had offered him the choice the bed or in the recliner. She had given R7 a choice the bed or in the recliner stated staff were made aware needs or any new facility's communication book of the NA assignment sheets. It is assistants did not have all resident care plans.	2 830				

PRINTED: 02/08/2016 FORM APPROVED

Minnesota Department of Health

Minnesota Department of Health							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
00725		B. WING		01/13/2016			
NAME OF	PROVIDER OR SUPPLIER	CTDEET ADI	ODECC CITY O	TATE ZID CODE	-		
NAIVIE OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRANIT	E MANOR		AN DRIVE	EC041			
	T		FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 17	2 830		ļ		
	During interview on practical nurse (LPI experienced prior fastated he was not selevated. The survicheck R7's position entered R7's room which were elevate recliner, should not immediately lowere and asked him whe into his bed. LPN-B interventions in place the communication a note dated 12/2/1 communication boofeet of recliner up, fwith feet up. LPN-B intervention had be it had not been transasignment sheets LPN-B confirmed R previous falls, and hospitalization for in When interviewed on ursing assistant (Nawareness of R7's with the footrest elevated who stated the recliner resupposed to be pin from operating the made aware of curby checking the corassignment sheet as stageness of the corassignment sheet as the corassig	1/12/16, at 2:06 p.m. licensed N)-B confirmed R7 had alls from the recliner chair and supposed to have the footrest eyor then asked LPN-B to in his room. At 2:11 p.m. and confirmed R7's legs, d with the footrest of the have been elevated. LPN-B d the footrest and R7's feet of the have been elevated. LPN-B d the footrest and R7's feet of the have been elevated. LPN-B d the footrest and R7's feet of the have been elevated. LPN-B d the footrest and R7's feet of the have been elevated. LPN-B delice which are documented in book. LPN-B confirmed that 5, was documented in the look updating staff: do not put fell trying to get out of chair as stated although the en updated on R7's care plan, scribed onto the NA so staff would be aware. Thad received injuries from had most recently required injuries sustained from a fall.					

6899

PRINTED: 02/08/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00725			B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	During interview on registered nurse (Rexperienced multiple including out of his elevated (most recent RN-B explained that report, a newly devithe communication made to the resider assignment sheets sheets are updated 1/13/16, at 10:46 a. intervention to keep originally initiated 6 on the NA assignment buring interview on director of nursing (assessment had be from the recliner or assessment should missed. The DON of R7's fall from the was aware of falls interventions, which footrest of the recline further verified that transcribed onto the During additional in 1/13/16 at 12:28 p. I condition was very sustained multiple in 12/15/15. The DON still very fragile with remained at high ris	1/12/15, at 2:32 p.m.  N)-B confirmed R7 had le falls while at the facility, recliner with the footrest ently on 1/2/16). RN-B stated not supposed to be elevated. It after the completion of a fall eloped intervention is placed in book, and revisions are nt's care plan and NA RN-B also said the NA weekly on Fridays. On m. RN-B confirmed the to the foot rest down for R7, /8/15, had never been updated	2 830			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
	PROVIDER OR SUPPLIER	250 JORD	DRESS, CITY, S  OAN DRIVE  FALLS, MN	STATE, ZIP CODE  56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	fractures and has to A post fall assessm completed on 1/12/DON. The assess of the fall as: confusimpairment, R7 trar and the footrest wa the time of the fall. included: add dycer prevent from slippir No foot rests on the recliner to be kept of laminated sign attain not to bring up the finursing staff updatin updates.  The facility's Fall Pr 10/14, indicated ear assessed for their resided with the resident had be diagnoses including falls, chronic obstruction disease (COPD), attype 2 diabetes med depressive disorder polyneuropathy, polyn	ent for the 1/2/16 fall was 16 after interview with the nent indicated the root cause sion and severe cognitive asferred without assistance is elevated on the recliner at Intervention modifications in under the cushion to ag. Additional interventions: wheelchair, footrest on the down, hourly checks by staff, a ched to R7's recliner stating ootrest, and a memo to all ang them on the care plan evention Policy revised on the resident would be isk of falling and interventions ted to meet the individual ints.  alth record (EHR) indicated en admitted on 10/25/13 with greated ctive pulmonary rial fibrillation, spinal stenosis, litus, anemia, major	2 830			

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 20 of 35

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00725	B. WING		01/1	3/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ODANUTE MANOR	250 JORE	OAN DRIVE			
GRANITE MANOR	GRANITE	FALLS, MN	56241		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
for falling. The Care documentation for the condition indicated Frelated to use of antiweakness at times, swith activity, obesity, anemia. The MDS fucontinue her current identified indicated Fassistance with som living (ADL) when shired, and identified sexperience episodes.  R33's care plan date for falls due to: history history history history weakness related diabetes. The care plan in follow; uses the bath ambulate independent bathroom as able; and displaying weakness breath (SOB) or tired 2.) Remain in room inform R33 you will be room and to alert state her bathroom task, encourage her to us transfers/assist to propose the complete tasks suat times, without call sign a waiver. She is injuries that could re	assessment and was at risk a Area Assessment (CAA) he significant change in R33 was at risk for falls i-depressant medications, shortness of breath (SOB), diabetes, hypertension and arther identified staff should a care plan. Interventions R33 needed and received he of her activities of daily he was feeling SOB, weak, or she had potential to sof pain and discomfort.  Bed 3/9/15, identified R33's risk for falls, and potential dot diagnoses of COPD and plan interventions included: alation on the unit, 1-2 staff and wheel chair (w/c) to proom in her room; able to ently in room and to/from and will need assistance when so, increase in shortness of dness.  While R33 is in the bathroom; be around the corner in the aff when she has completed All staff need to strongly				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 21 of 35

iviinnesc	<u>ita Department of He</u>	aith				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00725	B. WING	<del> </del>	01/1	3/2016
NAME OF		OTDEET AD		OTATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE	50044		
	ı		FALLS, MN	56241		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
1710		,	I/(G	DEFICIENCY)		
2 830	Continued From no	ac 01	2 830			
2 030	Continued From page 21		2 030			
	to call for assist. Sh	e continues to make her own				
	decisions regarding	when she will transfer, even				
	with her understand	ling of the risks and benefits.				
		st with all transfers/encourage				
		for assistance. Discussion				
		t not waiting for staff				
		sing call light when she needs				
		transfers in her room. R33				
	realizes she is not always steady on her feet and					
		ch on the floor at times when				
		nade aware of the risks				
		ald fall and lose her balance es to ask for assistance with				
		ng in her room. Frequently				
		ner chair/bed into her				
		nade aware that if she chooses				
		sist her with transfers and				
		the potential for injures to				
		oout the potential injuries that				
	could happen such					
		could lead to death. We also				
	talked about skin te	ars and bruising. R33 also				
	has refused protect	ive foam from being placed in				
	her door way. She	decides at this time that she				
		ue to transfer/walk on her own				
		calling or waiting for assist,				
		e risks were explained to her.				
		ented x 3 and is able to make				
	decisions. R33 sign					
		See form which is placed into				
		ed edge mattress; 5.) Bedside				
		t side of the bed; 6.) Walker to bed and chair; Keeps				
		all just outside her doorway;				
		keep this wheelchair locked.				
		make sure it's locked. 7.) Use				
		throom as R33 requests to				
		eded. Provide proper and well				
		ar. Keep personal items and				
		ns within R33's reach.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/13/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		<u></u>
GRANITI	E MANOR		AN DRIVE			
			FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 830	Continued From page 22		2 830			
	propelled herself in with the use of her to become SOB and w/c. At 5:31 p.m. No self-wheeling and to room table. Following was observed to had dining room, using the w/c. It was note the activity. Again, Nowheeled R33 to her bedroom door, wheeled had to closed. NA-A is later to check on R3 offered by NA-A. A seated in her recline breathing heavily an interviewed at that to transferred herself is been "difficult". It was wheelchair positions the brakes on the cowhy she hadn't ask replied, "It takes to I'm impatient".	ime, R33 stated she had nto the recliner and that it had as observed that R33 had the ed in front of her recliner with hair locked. When questioned ed staff for assistance R33 o long for them to come and				
	When interviewed the following day, on 1/12/16, at 5:17 p.m. R33 was seated in her room in her wheelchair and was very SOB and breathing heavy. R33 stated she had been in the bathroom and was lucky because staff came in and saw her having a hard time getting onto the toilet. She stated her SOB was terrible today, and that she'd become extremely SOB and weak when attempting to toilet. R33 stated if staff had not entered the room she may have fallen as she did not always ask for help. R 33 stated she is aware					

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 23 of 35

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WING			
		00725	B. WING		01/1	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRANITI	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	herself as possible R33 indicated the fath fault of the staff indicated she would felt she needed assist the call light.  Review of the medinad experienced that 1) 1/9/16, at 3:15 pthe toilet and had incaused the floor to tear. The nursing procession of the caused indicated R33 had as he was in a hurry, tear to the left thum required three staff a full lift. Document initially denied pain p.m. had requested shoulder pain.  2) 9/24/15 a progresindicated when an Imenu selection, R3 near her door. R33 get her walker to go fallen. Documentati multiple bruises and middle finger, and indue to complaints of side. Fractures were to the facility.	desires to do as much for to maintain her independence. alls she experienced were not; "I'm a bit stubborn." R33 d utilize the call light when she sistance but usually did not use cal record identified that R33	2 830			
	indicated R33 was	heard calling out "Help! " the room, R33 had been on				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 24 of 35

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRANITE N	MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
the hold in ho	er head out into he ematoma (bruise) one to the hospital dentified. An intervendicated R33 was ealp by using the capat R33 had agreed) 7/6/15, at 8:35 a. The task and task and activated the rocoor with her legs condicated R33 had supper right arm on the street of the rocoor with her legs condicated R33 had supper right arm on the street as a supper right arm on the street as a supper right arm on the supper right arm on the supper right arm on the supper right of the midlicated on the high-risustained a bump and right of the midlicated eurological checks are gularities had be when interviewed on the high-risustained a bump and the right of the midlicated eurological checks are gularities had be when interviewed on the high-risustained a bump and LPN-A stated sight. A and LPN-A we wening observation een wheeled to he and left alone with the sponded that staff as with transferring the staff and the staff as with transferring the staff and the staff as with transferring the staff and the staff as with transferring the staff as a sta	r back in the bathroom with er room. R33 had sustained a to her left hip and elbow, had, but no fractures were ention developed post fall encouraged by staff to ask for all light when transferring, and d.  m. a progress note identified the her call light and when the massed. Documentation sustained a skin tear to her the lateral aspect measuring was assisted to a standing a staff and gait belt.  m., a progress note identified the don the floor in her bathroom at 3:10 p.m. that day. The cated R33 had bumped her the on the toilet, and had bout the size of a golf ball to the on the back of her head. Staff had implemented at the time of the fall, but no	2 830			

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00725	B. WING		01/13/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		5, = 5 1 5
GRANITE MANOR			AN DRIVE FALLS, MN	56241		
(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
2 830	help, but it still show verified the care pla and reiterated staff assistance because sometimes she will SUGGESTED MET director of nurses (I staff on the importaresident has experideveloped to ensurand interventions a resident safety. The quality assurance	alld have been offered. RN-A in was not followed as written should offer to provide R33 e although she may decline, accept the assistance.  HOD OF CORRECTION: The DON) could inservice nursing nce of re-assessment after a enced a fall. An audit could be the appropriate assessment re implemented to ensure e results could be reported to	2 830			
2 855	Proper Nursing Car  Subp. 2. Criteria for proper care. The cadequate and proper E. Assistance as not keep the mouth, tead Measures must be lips  This MN Requirement by: Based on observation review the facility factor of 1 resident (R7) recupon staff for groom Findings include:	or determining adequate and criteria for determining	2 855	Corrected		1/14/16

6899

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF I				STATE ZID CODE	01/1	3/2010
	PROVIDER OR SUPPLIER		DRESS, CITT, S	STATE, ZIP CODE		
GRANITE MANOR		FALLS, MN	56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 855	Continued From page 26		2 855			
	Alzheimer's disease chronic obstructive The MDS identified impairment and requith personal hygie R7's admission assidentified R7 had nate condition. The oral some missing natur R7's care plan revier R7 required staff as grooming, including nursing assignment	diagnoses which included e, anxiety, depression and pulmonary disease (COPD). R7 had moderate cognitive juired extensive assistance ne.  Dessment dated 2/19/15, atural teeth and in poor assessment identified R7 had ral teeth and several fillings.  Dewed on 11/24/15, identified esistance of one with juiling oral care. R7's undated, at sheet indicated he had his ired assist of one to provide				
	During observation of morning cares on 1/12/16, from 7:05 a.m. to 7:35 a.m. nursing assistant (NA)-B assisted R7 with personal cares which included washing his face, toileting, perineal cares and dressing. During the observation, R7 was not assisted with nor offered the opportunity for completion of oral cares. R7's natural teeth were observed with areas of white matter build up between them.					
	During interview on 1/12/16, at 1:50, NA-B confirmed she had not returned to provide oral cares for R7 earlier in the day, and confirmed she had completed all of his daily cares with the exception of oral care. NA-B reported the nurse had come in to administer R7's nebulizer treatment, she had left to answer other call lights and never went back to complete the oral cares. NA-B confirmed R7 required assistance for oral cares and should be completed two times per day.					

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00725	B. WING		01/1	3/2016
	PROVIDER OR SUPPLIER	250 JORD	DRESS, CITY, S AN DRIVE FALLS, MN	STATE, ZIP CODE <b>56241</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 855	During interview on practical nurse (LPI staff assist of one for to be completed da.  During interview on registered nurse (R staff assist of one for provided daily as he missing.  During interview on director of nursing (R7 from his recliner assisted him to the confirmed she had and verified R7 requestionary to have been provided to make sure cares to have been provided to make sure cares he went to therapy of the DON stated she went to therapy of the providing cares he went to the providing cares and the providing cares needs of residents and the plan. The facility could refor providing cares needs of residents and the plan. The facility compliance.	1/12/16, at 2:12 p.m. licensed N)-B confirmed R7 required or oral cares and is expected	2 855			

6899

(21) days.
Minnesota Department of Health
STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00725	B. WING	<del></del>	01/1	3/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRANITI	MANOR		AN DRIVE FALLS, MN	56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 855	Continued From page 28		2 855				
21615	MN Rule 4658.1340 Preparation Area;S	Subp. 2 MedicineCabinet & cheduleII	21615			1/14/16	
	Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain labeled medications according to safe and acceptable standards of practice for 8 of 45 residents (R5, R10, R17, R24, R26, R42, R44, R48) whose medications were reviewed during medication storage.			Corrected			
	Findings include:						
	1/13/16, at 8:47 a.m (RN)-B in attendance (LPN)-B administer. The following was recent units subcutaneous most recent date of medication was doop.m. The date writt 12/?/15. RN-B and opened date was necessary.	n cart was observed on n. with registered nurse ce and licensed practical nurse ing the ordered medications. noted: hysician orders indicated gine) 100 units/milliliter (ml) 14 (SQ) every (Q) evening. The administration from this cumented as 1/12/16, at 8:44 en on the label appeared as LPN-B both confirmed the ot legible and were uncertain on had originally been opened.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRANITI	GRANITE MANOR 250 JORI GRANITE			56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21615	Continued From page 29		21615				
	The Medication Expiration Dating document provided by the Consultant Pharmacist Inc. indicated Lantus Insulin had an expiration date of 28 days after opening.						
	(2.) R17 had a Novolog Flexpen-signed order for sliding scale and last administered 1/12/16, at 8:44 p.m. The package was dated as opened 12/5/15 and the expiration was indicated as 28 days after opening. RN-B and LPN-B both confirmed the medication was past the date of expiration, had been administered and should have been replaced.						
	(3.) R42 had signed MD orders for Novolog Flexpen sliding scale four times daily. This medication was verified as last being administered 1/13/16, at 6:56 a.m. The label had an opened date of 11/24/15, and LPN-B confirmed the morning dose of insulin was administered from this package. Expiration date was indicated as 28 days after opening for use. Both RN-B and LPN-B confirmed this medication was administered after the expiration date.						
	(4.) R48 had a signed MD order for Colace 100 mg 1 capsule QD as needed for constipation. The order had a start date of 11/10/14, and was last documented as administered 8/16/15. The label on the bottle was not legible for instructions or date of expiration. In addition the bottle was soiled with a dried on red substance and surface soil. RN-B indicated the medication should have been replaced as there was no way to know when the medication had been opened nor the date of expiration. RN-B further stated she thought this was a medication that had been brought from home when R48 was admitted.  (5.) R10 was noted to have a bottle of Mintox						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRANIT	E MANOR		AN DRIVE FALLS, MN	56241		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21615	medication order we labeled with an exp Neither RN-B or LP not this medication  Wing-B's medication  Wing-B's medication  Wing-B's medication  Wing-B's medication  Wing-B's medication  Wing-B's medication  Ming-B's medication  The final sign and LPN-C administ medications. The final final sign and LPN-G had a sign as 12/24/15, at 4:30 printed on the phane LPN-A&C verified the documented after the sign of the properties of	a the label indicating the as filled 11/20/13, and was iration date of 11/20/14. N-B were aware whether or had last been administered.  In cart was observed on a with LPN-A in attendance stering the ordered ollowing was noted: Indeed MD order for Oxycodone 5 th (PO) every (Q) six (6) PRN). The most recent date as documented on the MAR of a.m The date of expiration macy label was 9/22/15. In medication was the date of expiration.  Indeed MD order for Alpralozam and the most recent for administration was 12/23/15, inted expiration date on the Both LPN A&C confirmed and administered after the date of the MD order for Codiene/Gen PRN. The most recent date of unknown. The printed the label was 12/26/15.  Indeed MD order for Robitussin AC easpoons PO Q4H PRN. Last on was unknown. The printed of 12/26/15.	21615			
		n. and stated facility policy eck the medication carts on a				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00725	B. WING		01/1	3/2016
			DRESS, CITY, S	STATE, ZIP CODE	-	
GRANITI	E MANOR		AN DRIVE	50044		
040.15	CUIMMA DV CTA		FALLS, MN		NI	(X5)
(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 SHOUL CROSS-REFERENCED TO THE APPROF	'E ACTION SHOULD BE D TO THE APPROPRIATE	
21615	Continued From page 31		21615			
	monthly basis and that LPN-A was responsible for this task. The DON also indicated the medications located in the medication carts were also reviewed by the consultant pharmacist during the monthly spot review. The DON observed the above listed medications and confirmed they were outdated and should not have been administered per facility policy.  On 1/13/16, at 11:12 a.m. the consultant pharmacist (CP) was interviewed via telephone and stated his most recent facility visit was on 12/4/15. It was verified that both medication carts A&B, in addition to individual resident records were reviewed. The CP stated if a date is not legible on the medication label, staff should review if the date dispensed was within an acceptable time frame and see whether it is possible to determine if the medication is within a usable time frame. The CP indicated if this was not possible, the medication should be replaced. The CP verified insulin should not be administered past the labeled expiration date. and it was the expectation that nursing staff check expiration dates prior to drug administration.					
	stated she had con- which provides med verified the expiration were the correct da verified the insulin b	on 1/13/16, at 1:34 p.m. RN-D tacted the local pharmacy dications to the facility and on dates printed on packages te of expiration. She further pottle with the unreadable wer the 28 day usage date.				
	outdated medication administration of ex	val dated 12/04, indicated that ns will be removed to prevent				

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 32 of 35

Minnesota Department of Health							
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.				
		00725	B. WING		01/1	3/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRANITE MANOR			AN DRIVE FALLS, MN	56241			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21615	Continued From pa	ge 32	21615				
	during medication passes. (2.) Remove any outdated medications during each routine medication pass. Dispose of them according to procedure.						
	Inspections, approportions of medicat Procedure: (1.) Medications of medicat Procedure: (1.) Medications of the labeling of th	continued and have not been nonth. at a resident brings from separate bag, labeled with ot in use. These are reviewed on discharge and destroyed if entative is in agreement with o longer needed or are  THOD OF CORRECTION: sing or designee could educate members on the processes. sing or designee could develop					
	•	R CORRECTION: Seven (7)					

Minnesota Department of Health

STATE FORM 6899 KNY311 If continuation sheet 33 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BOILDING.	<del></del>				
00725		B. WING		01/13/2016				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GRANITE	GRANITE MANOR 250 JORDAN DRIVE GRANITE FALLS, MN 56241							
(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		
21975	Continued From page 33		21975					
21975	MN St. Statute 144A.10 Subd. 3 Inspection; Commissioner of Health; Fines		21975			1/14/16		
	Subd. 3. Reports; posting. A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under section 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing home after its most recent inspection or re-inspection shall be posted in a conspicuous and readily accessible place in the nursing home. All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued. Confidential information protected by section 13.05 or 13.46, shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13.							
	by: Based on observati review the facility fa manner that was re residents and visito	ent is not met as evidenced on, interview and document illed to post survey results in a adily accessible to all rs. This had the potential to its residing in the facility and		Corrected				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00725	B. WING		01/1	3/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRANIT	GRANITE MANOR 250 JORDAN DRIVE GRANITE FALLS, MN 56241						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
21975	Continued From page 34		21975				
	Findings include:						
	survey results were behind glass in the glass panel needed order to take the suboard for viewing. above two drinking from the wall, limiting were wheelchair both director of nursing (view the survey result and not be able to the water fountains board, and stated the for help to get them SUGGESTED MET The administrator of staff to assure the faccessibile to all redesignee could more	on 1/10/15, at 11:20 a.m. the noted in a bulletin board front of the building. The to be slid open by hand in any results off the bulletin. The bulletin board was located fountains which projected outing access to residents who and and unable to stand.  1/11/15, at 2:09 p.m. the (DON) stated residents could ults by sliding the glass open. It is a cress the survey results as blocked access to the bulleting residents would have to ask to out.  THOD OF CORRECTION: The administrator or note for continued compliance.  RECORRECTION: Twenty-one					

6899