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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KNY3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245243**

2. STATE VENDOR OR MEDICAID NO. (L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRANITE MANOR**
(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Joseph Garvey, HFE NE II 02/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 03/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/06/1981** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

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 S5343024

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
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245243 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	01/14/2016	LSC	01/14/2016	LSC	01/14/2016
ID Prefix F0323	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.60(b), (d), (e)	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	3/8/2016	22113	2/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/13/2016

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

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00725 Y1	A. Building 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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20830	Correction	ID Prefix 20855	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 2 E.	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 4658.1340 Subp. 2	Completed	Reg. # MN St. Statute 144A.10 Subd. 3	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	3/8/2016	22113	02/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/13/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KNY3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245243**

2. STATE VENDOR OR MEDICAID NO. (L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRANITE MANOR**
(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date : Joseph Garvey, HFE NE II 02/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 03/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/06/1981** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 03/08/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

Removal of Immediate Jeopardy - 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;

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on January 10, 11, 12 and 13, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess and effectively implement fall interventions which resulted in a high potential for harm or death. The IJ which began on January 12, 2016 was removed on January 13, 2016, at 11:15 a.m. As a result of identification of the IJ at F323, an extended survey was conducted on January 12 and 13, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily	F 167		1/14/16

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

Electronically Signed | 02/08/2016

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F 167	Continued From page 1 accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post survey results in a manner that was readily accessible to all residents and visitors. This had the potential to affect all 45 residents residing in the facility and visitors. Findings include: During observation on 1/10/15, at 11:20 a.m. the survey results were observed to be posted on a bulletin board behind a glass panel in the front lobby area of the building. The glass panel needed to be slid open by hand in order to take the survey results off the bulletin board for viewing. The bulletin board was located above two drinking fountains which projected out from the wall, limiting access to residents or visitors who were wheelchair bound and/or unable to stand. During interview on 1/11/15, at 2:09 p.m. the director of nursing (DON) confirmed residents would have to slide the glass open in order to view the survey results. The DON confirmed residents who could not stand or were in wheelchairs would not be able to access the survey results as the water fountains blocked access to the bulletin board. She stated those residents would have to ask for help to access the survey results.	F 167	A Copy of the last survey was placed temporarily on the coffee table between the two Manor Neighborhoods adjacent from the Therapy room on 1/14/16. An additional decorative table was ordered on 1/28/16 to be placed outside the Social Services office - on your way into the building. A copy of the survey will be maintained there when the table arrives from Direct Supply. The Residents were notified regarding the placement of the survey copy at the Resident Council meeting held on 1/19/16 @ 2pm. The Director of Nursing will make sure a copy is on the designated table by auditing this on a weekly basis.	

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F 282	Continued From page 2	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the care plan as written for 2 of 3 residents (R7 and R33) reviewed who had interventions in place for falls and 1 of 3 residents (R7) reviewed for dental health. Findings include: The quarterly Minimum Data Set (MDS) dated 8/13/15, identified R7 had diagnoses which included Alzheimer's disease, neurogenic bladder, heart failure, anxiety, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R7 had moderate cognitive impairment, required extensive assistance with dressing, toileting, personal hygiene and needed supervision for bed mobility, transfers and ambulation. R7's current care plan, last reviewed on 11/24/15, identified R7 was at risk for falls with potential for injury relate to age, Alzheimer's disease, TIA, glaucoma, hearing loss, urinary incontinence, episodes of confusion and forgetfulness, atrial fibrillation, weakness, and new environment. R7's care plan included the following interventions: (1) Hourly checks and hourly	F 282	On 1/14/16 all Nursing department staff members were provided education on the survey deficient practices. For any staff who were unable to attend the meeting, a make up written information packet was give to them. The staff were educated on the importance of performing oral care and the risks associated with not providing good oral hygiene. We reviewed Resident no. 7's care plan and the need for assistance with oral care. An audit was completed on 2/3/16 of both Neighborhood A & B on the AM shift. An audit was completed on 2/3 of Neighborhood B on the PM shift and on Neighborhood A on 2/4 on the PM shift. Audits conducted by the DON and the staffing TMA for completion of oral cares. Oral care audits will be completed monthly x 3 months, then it will be incorporated into the monthly Safety Audit - so it will remain on-going. Audits will be completed by the above listed employees and S.M. LPN completes the Safety audit monthly. On 1/14/16 all the Manor Nursing staff	1/14/16

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F 282	Continued From page 3 toileting, document on hourly monitoring sheet when completed intervention, (2) do not put feet of recliner up, (3) provide gripper socks if not wearing shoes, (4) body pillows on each side when in bed, (5) ambulate with assistance of 1-2 staff, wheelchair to follow, (6) assist required of 1-2 staff with all other activities of daily living (ADL's), able to eat independently after set up, (7) Sign placed on bathroom door so R7 would not exit or enter from the bathroom into his neighbor's room, and (8) ensure walker within reach. If a fall occurs, complete a post fall assessment, a fall event and incident report and assess factors contributing to the fall and implement interventions dated 3/18/15. R7' care plan identified he needed staff assist of 1 with oral care. The nursing assistant (NA) undated assignment sheet for R7 utilized on 1/12/15, at 1:11 p.m. identified R7 as a high fall risk with the following interventions: (1) hourly checks at all times-and document, (2) call light within reach at all times, (3) body pillow on each side when lying down, (4) toilet hourly and (5) staff assist of 1-2 for ADL's. Review of nursing assistant reposition and toilet documentation checklist date 12/11/15 to 1/13/16 revealed missing documentation and/or lacked the time cares were provided. On 1/12/16, at 7:05 a.m., nursing assistant (NA)-B provided R7 with his morning cares. NA-B told R7 she would be back when his nebulizer treatment was done to brush his teeth, R7 stated ok. During continuous observation on 1/12/16 from 1:11 p.m. to 2:12 p.m. R7 was observed	F 282	members were provided education regarding the care plan changes and the survey deficient practices for Resident no. 7 and Resident no. 33. For the staff who did not attend a make up written packet of information was provided to them. [Additional staff education was provided during the survey process to remove the IJ deficient practice.] ON 1/18/16 an email account group was developed for all the RN's, LPN's, and TMA's and they were all instructed to use this email when care plan updates / changes were made. Education provided on how Resident no. 7 is at extremely high risk of injury related to his previous falls and healing fractures and the need to offer assistance for Resident no. 33 related to her high fall risk at the staff meeting on 1/14/16. A Interdisciplinary Fall Committee has been developed and the first meeting was held on 2/3/16. The goals of the PDSA will be to have a reduction in falls monthly and no falls with major injury. This committee will meet prior to the Safety committee monthly meeting where all resident events/incidents are also reviewed. Any resident who has 2 falls in a 30 day window of time or has a fall with significant injury will have a complete "Fall Observation" completed by the Support RN or the Case Manager RN within 7 days. These will be audited monthly at the Fall Committee meeting for completion and findings. An audit tool was developed and S.M. LPN performed a complete care plan to nursing assistant care sheet audit on	

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F 282	Continued From page 4 unattended sitting in his recliner chair in his room with the footrest elevated, both feet were resting directly on the footrest. R7's lower body was covered by a white blanket, oxygen on via nasal cannula, neck brace was on, eyes were closed and appeared to be sleeping. Observed NA-B entered R7's room At 1:58 p.m., she offered, R7 to use the toilet, he refused, then NA-B repositioned R7's left arm with a pillow. NA-B left the footrest of the recliner chair elevated with both of R7's feet resting on the foot rest, then exited R7's room. During interview on 1/12/16, at 1:50 p.m. NA-B reported she was aware of R7's previous falls with serious injury, she stated she was unsure if he had any falls from the recliner. NA-B stated R7 was to be offered toileting every hour, frequent checks, and then stated those were the only two interventions she knew of off hand. NA-B stated there were "no specific guidelines" related to the recliner chair and the footrest. Upon reviewing the NA assignment sheet, no interventions were listed regarding the footrest of the recliner. NA-B confirmed she elevated the footrest for R7 after lunch on 1/12/16 and had offered him the bed or recliner, and had asked R7 if he wanted his feet up or down. NA-B also confirmed she had not returned later provide oral cares for R7. 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. On 1/12/16, at 2:12 p.m. licensed practical nurse (LPN)-B confirmed R7's legs were not to be elevated with use of the footrest as identified on	F 282	2/1-2/4/16. She will be doing this on a monthly basis to check for accuracy on 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 changes identified during the monthly audits. If we continue to find more then 5 changes we will continue to monitor this monthly on an indefinite basis. Resident no. 33 had an overall change in condition and she has required staff assistances with transfers and ambulation. She is using her call light and asking for assistance. As her condition improves her care plan and care sheets will be adjusted.	

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F 282	Continued From page 5	F 282		

the care plan. LPN-B confirmed the intervention was put into the communication book and the care plan, but was never transcribed onto the nursing assignment sheet.

On 1/13/16, at 10:46 p.m. registered nurse (RN)-B confirmed the footrest intervention did not get updated onto the nursing assistant assignment sheet. RN-B also confirmed R7 required staff assistance of one for oral care and was to be provided twice per day.

On 1/13/16, at 12:28 p.m., the director of nursing (DON) expected staff to implement identified fall interventions, including to keep the footrest of recliner down, document the hourly checks after completion and reassessment after each fall. The DON also confirmed staff would be expected to provide oral care per the care plan.

.
R33's was admitted on 10/25/13 and the electronic heath record (EHR) diagnoses included: difficulty in walking, repeated falls, chronic obstructive pulmonary disease(COPD), atrial fibrillation, spinal stenosis, type 2 diabetes mellitus, anemia, Major depressive disorder, anxiety disorder, polyneuropathy, polymyalgia rheumatica and edema.

The care plan dated 3/9/15, identified R33 at risk for falls due to: history of frequent falls when she was in her home, continued risk for falls and potential for weakness related to diagnoses of COPD and diabetes.

The care plan interventions included:

(1.) Assist with ambulation on the unit 1-2 staff

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F 282	Continued From page 6 assist with gait belt and wheel chair (w/c) to follow; uses the bathroom; able to ambulate independently in room and to/from bathroom as able; and will need assistance when displaying weakness, increase in shortness of breath (SOB) or tiredness. (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. (3.) Attempt to assist with all transfers/encourage her to use call light for assistance. Discussion held with R33 about not waiting for staff assist/and or not using call light when she needs help with walking and transfers in her room. R33 realizes she is not always steady on her feet and that her feet do catch on the floor at times when she walks. R33 is made aware of the risks involved if she should fall and lose her balance because she declines to always ask for assistance with transfers and walking in her room. R33 is made aware of the potential for injuries. R33 decides at this time that she would like to continue to transfer/walk on her own in her room without calling or waiting for assist, even after the above risks were explained to her. She is alert and oriented x 3 and is able to make decisions. R33 signed the release from responsibility form.	F 282		

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F 282	Continued From page 7 During observation on 1/11/16, at 5:29 p.m. R33 wheeled herself out of her room by propelling her wheelchair with her feet and arms. R33 was noted to become SOB and struggled with wheeling the w/c. At 5:31 p.m. nursing assistant (NA)-A noted R33's difficulty with self-wheeling and transported R33 to the dining room table. On 1/11/16, at 6:18 p.m. it was noted that upon completion of the evening meal, R33 wheeled herself from the dining room using her hands and feet to propel the w/c. It was noted that R33 became SOB with the activity. NA-A noticed the difficulty and wheeled R33 to her room. NA-A opened the bedroom door, wheeled R33 into the room, closed the door and left R33 in her room with the door closed. NA-A indicated she would return later to check on R33. No further assistance was offered. On 1/11/16, at 6:29 p.m. R33 was observed seated in her recliner in her room breathing heavily and sweating. When interviewed at this time, R33 stated she had transferred herself into the recliner and indicated it was difficult. R33 had the wheelchair positioned in front of her recliner with the brakes on the chair locked. When questioned why she did not ask staff for assistance, R33 replied, " It takes too long for them to come and I am impatient". When interviewed on 1/13/16, at 8:38 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-A stated staff should encourage R33 to get assistance when she needed to toilet and/or transfer as stated in the care plan. When RN-A and LPN-A were questioned about the evening observation on 1/11/16, when R33 was	F 282		

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F 282	Continued From page 8 wheeled to her room by staff and then left her alone in the room with the door closed after the supper meal, LPN-A responded that staff should have offered to assist R33 transfer into her recliner. LPN-A stated R33 would probably decline the help but she should still be offered. RN-A verified the care plan was not followed as written and reiterated staff should offer to assist R33 assistance even though she may decline and will at times accept the assistance. The facility's Care Plan policy revised 1/15, indicated a personalized integrated written plan of care would be developed for each resident by a multi-disciplinary team in order to evaluate the resident restorative potential, establish attainable goals and coordinate staff and resident efforts towards meeting those goals.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral cares for 1 of 1 resident (R7) reviewed who was dependent upon staff for grooming and personal cares. Findings include: R7's quarterly Minimum Data Set (MDS) dated	F 312	On 1/14/16 all Nursing department staff members were provided education on the survey deficient practices. For any staff who were unable to attend the meeting, a make up written information packet was give to them. The staff were educated on the importance of performing oral care and	1/14/16

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F 312	Continued From page 9 8/13/15, identified diagnoses which included Alzheimer's disease, anxiety, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R7 had moderate cognitive impairment and required extensive assistance with personal hygiene. R7's admission assessment dated 2/19/15, identified R7 had natural teeth and in poor condition. The oral assessment identified R7 had some missing natural teeth and several fillings. R7's care plan reviewed on 11/24/15, identified R7 required staff assistance of one with grooming, including oral care. R7's undated, nursing assignment sheet indicated he had his own teeth and required assist of one to provide oral care. 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	F 312	the risks associated with not providing good oral hygiene. We reviewed Resident no. 7's care plan and the need for assistance with oral care. An audit was completed on 2/3/16 of both Neighborhood A & B on the AM shift. An audit was completed on 2/3 of Neighborhood B on the PM shift and on Neighborhood A on 2/4 on the PM shift. Audits conducted by the DON and the staffing TMA for completion of oral cares. Oral care audits will be completed monthly x 3 months, then it will be incorporated into the monthly Safety Audit - so it will remain on-going. Audits will be completed by the above listed employees and S.M. LPN completes the Safety audit monthly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 day. During interview on 1/12/16, at 2:12 p.m. licensed practical nurse (LPN)-B confirmed R7 required staff assist of one for oral cares and is expected to be completed daily. 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. During interview on 1/12/16, at 11:03 a.m., the director of nursing (DON) confirmed she helped R7 from his recliner to his wheelchair and assisted him to the breakfast table. The DON confirmed she had not provided oral cares for R7, and verified R7 required staff assistance to complete oral cares and would expect the cares to have been provided before or after breakfast. The DON stated she would have to remind staff to make sure cares were completed for R7 before he went to therapy or other places after breakfast. The facility's Oral Hygiene policy revised and approved on 12/03, indicated residents would receive appropriate oral hygiene needed to maintain or improve oral hygiene status.	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		1/14/16

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and ensure adequate supervision and interventions were implemented to prevent falls for 1 of 1 resident (R7) reviewed who had sustained multiple falls with injury, resulting in an immediate jeopardy (IJ) with the potential risk of serious harm, injury or death. In addition to the resident in immediate jeopardy, the facility failed to ensure interventions were followed to reduce falls, with the potential for harm that is not immediate jeopardy for 1 of 3 additional residents (R33) reviewed with falls. The IJ began on 1/12/16, at 1:11 p.m. when R7 was observed to be seated unattended in the recliner in his room with both feet elevated on the recliner footrest. The director of nursing (DON) was notified of the immediate jeopardy at 4:03 p.m. on 1/12/16. The immediate jeopardy was removed on 1/13/16, at 11:15 a.m. but non-compliance remained at the lower scope and severity level D- isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/13/15, identified diagnoses which included: Alzheimer's disease, neurogenic bladder, heart failure, anxiety, depression and chronic obstructive pulmonary disease (COPD). That same quarterly MDS also indicated R7 had	F 323	On 1/14/16 all the Manor Nursing staff members were provided education regarding the care plan changes and survey deficient practices for Resident No. 7 & Resident no. 33 and the potential risk for all Residents r/t falls. A written make up packet of information was provided to any staff that were unable to attend the meeting. [2 meeting times were provided with over 90% attending.] [Additional staff education was provided during the survey process to remove the IJ deficient practice.] On 1/18/16 an email account group was developed for all the RN's, LPN's, and TMA's and they were all instructed to use this email when care plan updates / changes are made. Education provided on how Resident no. 7 is at extremely high risk of injury related to his previous falls and healing fractures and the need to offer assistance for Resident no. 33 related to her high risk at the staff meeting held on 1/14/16. A Interdisciplinary Fall Committee has been developed and the first meeting was held on 2/3/16. The goals of the PDSA will be to have a reduction in falls monthly and no falls with major injury. This committee will meet prior to the Safety committee monthly meeting where all resident events/incidents are also reviewed. Any resident who has 2 falls in a 30 day window of time or has a fall with	

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F 323	Continued From page 12 moderate cognitive impairment, required extensive assistance with dressing, toileting, and personal hygiene, and needed supervision for bed mobility, transfers and ambulation. A subsequent quarterly MDS dated 12/15/15, indicated R7 required extensive assistance with all activities of daily living (ADL's) except eating. R7's Care Area Assessment (CAA) dated 2/26/15, indicated R7 was at risk for falls, had short term and long term memory impairment, had diagnoses which included Alzheimer's dementia, hearing loss, glaucoma, transient ischemic attack (TIA), heart disease and atrial fibrillation (irregular heartbeat) which all contributed to R7's fall risk. The CAA indicated due to R7's memory impairment he would forget to call for assistance or to use his assistive device. The CAA indicated interventions had been identified for R7 and were in place to help him meet goals and prevent falls with injuries. R7's current care plan, last reviewed on 11/24/15, identified R7 was at risk for falls with potential for injury relate to age, Alzheimer's disease, TIA, glaucoma, hearing loss, urinary incontinence, episodes of confusion and forgetfulness, atrial fibrillation, weakness, and new environment. R7's care plan included the following interventions: (1) Hourly checks and hourly toileting, document on hourly monitoring sheet when intervention completed, (2) do not put feet of recliner up, (3) provide gripper socks if not wearing shoes, (4) body pillows on each side when in bed, (5) ambulate with assistance of 1-2 staff, wheelchair to follow, (6) assist required of 1-2 staff with all other activities of daily living (ADL's), able to eat independently after set up, (7) Sign placed on bathroom door so R7 will not exit	F 323	significant injury will have a complete "Fall Observation" completed by the Support RN or the Case Manager RN within 7 days. These will be audited monthly at the Fall Committee meeting for completion and findings. An audit tool was developed and S.M. LPN performed a complete care plan to nursing assistant care sheet audit on 2/1-2/4/16. She will be doing this on a monthly basis to check for accuracy on 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 changes identified during the monthly audits. If we continue to find more then 5 changes we will continue to monitor this monthly on an indefinite basis. Resident no. 33 had an overall change in conditionand she has required staff assistances with transfers and ambulation. She is using her call light and asking for assistance. As her condition improves her care plan and care sheets will be adjusted.	

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or enter from the bathroom into his neighbor's room, and (8) ensure walker within reach. In addition, the plan indicated that if a fall occurred, staff were to complete a post fall assessment, a fall event, and to complete an incident report and assess factors contributing to the fall, and implement interventions dated 3/18/15.

The undated nursing assistant (NA) assignment sheets in use on 1/12/16, indicated the following for R7: high fall risk with the following interventions: (1) hourly checks at all times-and document, (2) call light within reach at all times, (3) body pillow on each side when lying down, (4) toilet hourly and (5) staff assist of 1-2 for ADL's.

Review of R7's event reports and post fall assessments from 2/27/15 to 1/2/16 revealed he had experienced falls related to impulsivity, decreased strength, improperly fitting shoes, incontinence of urine and poor memory. Although the facility staff had developed interventions post falls, necessary interventions were not always added to the care plan and staff did not always receive adequate instruction on implementation.

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:

According to incident documentation, on 8/17/15 at 2:00 p.m., activity staff had witnessed R7 fall in his room when R7 lost his balance after getting up and attempting self-transfer to his walker across the room. R7 landed on the right side of

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his body and hit his head on the floor. R7 was not wearing his glasses at the time of the fall. At the time, R7 had reported that when attempting to retrieve his walker, he felt dizzy and fell. New intervention: keep walker within range of resident. The resident had sustained bruising to the right side of his head and elbow, a small skin tear to right forearm, and had complained of mild pain to the right upper extremity. R7 had been sent to the emergency room (ER) for evaluation because he'd hit his head and because he was on Coumadin (a blood thinner medication). The ER record dated 8/17/15, revealed the head CT and the cervical spine CT were both negative, with no evidence of significant 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 post fall assessment indicated R7 had his shoes on, walker within reach, call light activated and had his glasses on, but indicated R7 had stated he was attempting to get out of his chair to go to the bathroom and hadn't been able to figure out how to put the foot rest down so had attempted to get out of the chair with it up and the chair had tipped. Additionally, the documentation indicated R7 had reported he'd hit his head on the left side, and that visual assessment had revealed a 3 centimeter (cm) x 1 cm lump to the left side of his head. The documentation indicated staff had applied an ice pack and had initiated monitoring for bruising due R7's continued use of Coumadin

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to treat atrial fibrillation. The fall summary also indicated R7 had been unable to figure out how to lower the foot rest of his recliner, tried to get out of his recliner, the recliner had tipped and R7 was unable to stop himself from falling due to weakness. As a result of this incident, a new intervention had been identified: do not elevate legs of recliner, sign stating (do not elevate leg rest of recliner) laminated and placed on recliner. The fall summary further indicated R7 usually 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.

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Fall documentation indicated R7 had fallen again on 12/15/15 at 3:45 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 on and one shoe off, the floor was wet with urine around the toilet base, and R7 had a lump noted to the right side of his head. Documentation indicated R7 had offered no complaints of pain but had slurred speech and rambled conversation. The notes indicated the nursing assistant (NA) had checked on R7 just 10 minutes prior. Root cause: up to bathroom without assistance. New intervention: toilet every 1 hour, night staff updated. At 9:41 a.m. on 12/15/15, the nurse had contacted R7's physician regarding the fall due to R7 experiencing slurred speech and increased confusion. R7 had subsequently been transferred to the local ER (emergency room) for further evaluation. Follow up nursing progress notes indicated R7 had been admitted to the hospital on 12/15/15, and a radiology report dated 12/16/15, identified the following injuries: a small left pleural effusion, fracture of right clavicle, right scapula, posterior right 9th and 10th ribs and superior endplate of T2. The CT of cervical spine identified a non-displaced fracture of C2, CT negative. The hospital history and physical/discharge summary for the hospitalization period of 12/15/15 to 12/18/15 revealed: " surgical intervention was not required, advised to wear a hard C-collar for 6 weeks. Was admitted to hospital after multiple falls with a C2 compression fracture, CHF, urinary retention, cardiac arrhythmia, and unknown reason for falling. Chest x-ray showed chronic

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left pleural effusion, stable cardiomegaly and non-displaced fractures of right clavicle. "

The facility's nursing progress notes from 12/18/15 to 12/26/15, indicated R7 had returned to the nursing home 12/18/15, wearing a neck brace at all times. In addition the notes indicated staff had implemented frequent checks (every 1/2 hour to one hour throughout the night).

A physician's progress note dated 12/22/15, identified R7 was at risk for further injury and falls. The physician note also indicated staff had done everything to try to prevent falls, and indicated the C2 spine fracture was stable (not shifted nor moved), and the physician had documented an order for R7 to remain off Digoxin and Coumadin.

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.

Review of previous falls revealed that on 6/3/15, at 6:17 p.m. R7 had been found on the floor in his room. The documentation indicated R7 had stated he was attempting to get out of the recliner with the footrest in the up position, that the recliner chair had tipped forward, and R7 had slid off the end and onto the floor. No injuries had occurred. Additional information documented

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about this fall indicated that at the time of the fall, R7 had been attempting to self transfer and had been unable to lower the footrest on his own. Interventions developed as a result of the 6/3/15 incident included: lowered footrest, and maintain footrest of recliner in low position, 1:1 discussion related to ask for help when needing assistance and dycem (an anti-slip pad) added to the recliner seat.

During continuous observation on 1/12/16 from 1:11 p.m. to 2:12 p.m. R7 was observed sitting unattended in his recliner chair in his room with the footrest elevated, both feet were resting directly on the footrest. R7's lower body was covered by a white blanket, oxygen on via nasal cannula, neck brace was on, eyes closed and appeared to be sleeping. At 1:58 p.m. NA-B entered the room to offer toileting but R7 refused. NA-B repositioned R7's left arm with a pillow, left the footrest of the recliner chair elevated with both of R7's feet resting on the foot rest and exited R7's room.

During interview on 1/12/16, at 1:50 p.m. NA-B reported she was aware of R7's previous falls with serious injury but was unsure whether any falls had occurred from the recliner. NA-B stated the only two interventions for R7 included offering hourly toileting and frequent checks. NA-B stated she didn't think there were any "specific guidelines" related to the recliner chair or the use of the footrest. NA-B then reviewed the current nursing assignment sheet and confirmed no interventions were listed regarding the use of the footrest on the recliner. NA-B confirmed she had elevated the footrest for R7 after lunch on 1/12/16, and that she had offered him the choice of whether to lay in the bed or in the recliner.

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F 323	Continued From page 19 NA-B also verified she had given R7 a choice about whether to have the footrest on the recliner up or down. NA-B stated staff were made aware of specific resident needs or any new interventions by the facility's communication book which is available to be read at the beginning of each shift, and by the NA assignment sheets. NA-B stated nursing assistants did not have access to the formal resident care plans. R7 was interviewed on 1/12/16, at 2:03 p.m., he was unable to identify whether he'd experienced any falls from his recliner. During interview on 1/12/16, at 2:06 p.m. licensed practical nurse (LPN)-B confirmed R7 had experienced prior falls from the recliner chair and stated he was not supposed to have the footrest elevated. The surveyor then asked LPN-B to check R7's position in his room. At 2:11 p.m. entered R7's room and confirmed R7's legs, which were elevated with the footrest of the recliner, should not have been elevated. LPN-B immediately lowered the footrest and R7's feet and asked him whether he would like to move into his bed. LPN-B reported R7 has multiple fall interventions in place which are documented in the communication book. LPN-B confirmed that a note dated 12/2/15, was documented in the communication book updating staff: do not put feet of recliner up, fell trying to get out of chair with feet up. LPN-B stated although the intervention had been updated on R7's care plan, it had not been transcribed onto the NA assignment sheets so staff would be aware. LPN-B confirmed R7 had received injuries from previous falls, and had most recently required hospitalization for injuries sustained from a fall.	F 323		

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When interviewed on 1/12/16, at 2:24 p.m. nursing assistant (NA)-D confirmed an awareness of R7's previous falls from the recliner with the footrest elevated. However, NA-D stated staff continue to put R7 in his recliner with the footrest elevated when he is tired. NA-D further stated the recliner has an electric remote which is supposed to be pinned out of reach to prevent R7 from operating the chair. NA-D stated she is made aware of current fall intervention revisions by checking the communication book, the nursing assignment sheet and checking with the nurse at the beginning of each shift. In addition, NA-D said she reviews changes with the previous staff.

During interview on 1/12/15, at 2:32 p.m. registered nurse (RN)-B confirmed R7 had experienced multiple falls while at the facility, including out of his recliner with the footrest elevated (most recently on 1/2/16). RN-B stated R7's footrest were not supposed to be elevated. RN-B explained that after the completion of a fall report, a newly developed intervention is placed in the communication book, and revisions are made to the resident's care plan and NA assignment sheets. RN-B also said the NA sheets are updated weekly on Fridays. On 1/13/16, at 10:46 a.m. RN-B confirmed the intervention to keep the foot rest down for R7, originally initiated 6/8/15, had never been updated on the NA assignment sheet.

During interview on 1/12/16, at 4:23 p.m. the director of nursing (DON) confirmed no post fall assessment had been completed after R7's fall from the recliner on 1/2/16. The DON stated the assessment should have been done but was missed. The DON also stated she was not aware of R7's fall from the recliner on 6/3/15; however,

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was aware of falls involving the recliner on 12/2/15 and 1/2/16. The DON confirmed staff were expected to implement all identified interventions, which for R7 included keeping the footrest of the recliner in the down position. She further verified that intervention had not been transcribed onto the NA assignment sheet.

During additional interview with the DON on 1/13/16 at 12:28 p.m., the DON stated R7's condition was very compromised because he'd sustained multiple injuries due to a fall on 12/15/15. The DON further confirmed R7 was still very fragile with many co-morbidities, and remained at high risk for falls and injury. The DON stated R7 continues to have healing fractures and has to wear a cervical collar.

A post fall assessment for the 1/2/16 fall was completed on 1/12/16 after interview with the DON. The assessment indicated the root cause of the fall as: confusion and severe cognitive impairment, R7 transferred without assistance and the footrest was elevated on the recliner at the time of the fall. Intervention modifications included: add dycem under the cushion to prevent from slipping. Additional interventions: No foot rests on the wheelchair, footrest on the recliner to be kept down, hourly checks by staff, a laminated sign attached to R7's recliner stating not to bring up the footrest, and a memo to all nursing staff updating them on the care plan updates.

The facility's Fall Prevention Policy revised on 10/14, indicated each resident would be assessed for their risk of falling and interventions would be implemented to meet the individual needs of the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 The immediate jeopardy that began on 1/12/16, was removed on 1/13/16, at 11:15 a.m. when it could be verified by record review and interviews with staff, the facility had completed a comprehensive post fall reassessment, R7 was removed from the recliner with feet elevated, a sign was placed on R7's recliner to leave the footrest down, nursing assignment sheets had been updated, the care plan had been updated, an hourly safety falls checklist had been created and implemented, and staff audits had been conducted on every shift to ensure the hourly safety falls checklist was implemented. However, non compliance remained at the lower scope and severity of a D, no actual harm with potential for more than minimal harm, because the facility failed to ensure ongoing staff compliance with identified interventions to maintain resident safety. R33's electronic health record (EHR) indicated the resident had been admitted on 10/25/13 with diagnoses including: difficulty in walking, repeated falls, chronic obstructive pulmonary disease(COPD), atrial fibrillation, spinal stenosis, type 2 diabetes mellitus, anemia, major depressive disorder, anxiety disorder, polyneuropathy, polymyalgia rheumatica and edema. The quarterly Minimum Data Set (MDS) assessment, dated 11/12/15, identified that R33 had sustained one fall since the last quarterly MDS assessment dated 8/26/15. R33's significant change MDS assessment dated 6/12/15, also identified the resident had sustained	F 323		

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	245243	A. BUILDING _____ B. WING _____	01/13/2016

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F 323	Continued From page 23 one fall since prior assessment and was at risk for falling. The Care Area Assessment (CAA) documentation for the significant change in condition indicated R33 was at risk for falls related to use of anti-depressant medications, weakness at times, shortness of breath (SOB) with activity, obesity, diabetes, hypertension and anemia. The MDS further identified staff should continue her current care plan. Interventions identified indicated R33 needed and received assistance with some of her activities of daily living (ADL) when she was feeling SOB, weak, or tired, and identified she had potential to experience episodes of pain and discomfort. R33's care plan dated 3/9/15, identified R33's risk for falls due to: history of frequent falls when at her home, continued risk for falls, and potential for weakness related to diagnoses of COPD and diabetes. The care plan interventions included: 1.) Assist with ambulation on the unit, 1-2 staff assist with gait belt and wheel chair (w/c) to follow; uses the bathroom in her room; able to ambulate independently in room and to/from bathroom as able; and will need assistance when displaying weakness, increase in shortness of breath (SOB) or tiredness. 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 her to use the call light for transfers/assist to prevent falls. R33 is aware and has been explained that she should use staff assist with all transfers; however, she continues to complete tasks such as transfer's independent at times, without calling for staff assist-she did sign a waiver. She is aware of the risks such as injuries that could result in hip FX (fracture), head	F 323		

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injuries that can lead to death if she chooses not to call for assist. She continues to make her own decisions regarding when she will transfer, even with her understanding of the risks and benefits. 3.) Attempt to assist with all transfers/encourage her to use call light for assistance. Discussion held with R33 about not waiting for staff assist/and or not using call light when she needs help with walking or transfers in her room. R33 realizes she is not always steady on her feet and that her feet do catch on the floor at times when she walks. R33 is made aware of the risks involved if she should fall and lose her balance because she declines to ask for assistance with transfers and walking in her room. Frequently walks to and from her chair/bed into her bathroom. R33 is made aware that if she chooses not to have staff assist her with transfers and ambulation she has the potential for injures to occur. We talked about the potential injuries that could happen such as head injuries, fractures-and these could lead to death. We also talked about skin tears and bruising. R33 also has refused protective foam from being placed in her door way. She decides at this time that she would like to continue to transfer/walk on her own in her room without calling or waiting for assist, even after the above risks were explained to her. She is alert and oriented x 3 and is able to make decisions. R33 signed a release from responsibility form. See form which is placed into her chart; 4.) Raised edge mattress; 5.) Bedside table moved to right side of the bed; 6.) Walker place in reach next to bed and chair; Keeps wheelchair in the hall just outside her doorway; and encouraged to keep this wheelchair locked. Staff also check to make sure it's locked. 7.) Use nightlight/light in bathroom as R33 requests to use and use as needed. Provide proper and well

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GRANITE MANOR	**250 JORDAN DRIVE GRANITE FALLS, MN 56241**

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maintained foot wear. Keep personal items and frequently used items within R33's reach.

During observation on 1/11/16, at 5:29 p.m. R33 propelled herself in the wheelchair from her room with the use of her feet and arms. R33 was noted to become SOB and struggled with wheeling the w/c. At 5:31 p.m. NA-A noted R33's difficulty with self-wheeling and transported R33 to the dining room table. Following supper, at 6:18 p.m. R33 was observed to have wheeled herself from the dining room, using her hands and feet to propel the w/c. It was noted that R33 became SOB with the activity. Again, NA-A noticed the difficulty and wheeled R33 to her room. NA-A opened the bedroom door, wheeled R33 into the room, closed the door and left R33 in her room with the door closed. NA-A indicated she would return later to check on R33. No further assistance was offered by NA-A. At 6:29 p.m. R33 was observed seated in her recliner located in her room; breathing heavily and sweating. When interviewed at that time, R33 stated she had transferred herself into the recliner and that it had been "difficult". It was observed that R33 had the wheelchair positioned in front of her recliner with the brakes on the chair locked. When questioned why she hadn't asked staff for assistance R33 replied, " It takes too long for them to come and I'm impatient".

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

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F 323	Continued From page 26 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 of the fall risks but desires to do as much for herself as possible to maintain her independence. R33 indicated the falls she experienced were not the fault of the staff; "I'm a bit stubborn." R33 indicated she would utilize the call light when she felt she needed assistance but usually did not use the call light. Review of the medical record identified that R33 had experienced the following falls: 1) 1/9/16, at 3:15 p.m. while attempting to get to the toilet and had incontinence on the floor which caused the floor to be slick. R33 sustained a skin tear. The nursing progress note dated 1/9/16, at 05:04 p.m. identified R33 was incontinent of urine, which caused her to slip and fall, and indicated R33 had not used her walker because she was in a hurry. R33 had sustained a skin tear to the left thumb and index finger, and had required three staff assist into bed with the use of a full lift. Documentation indicated R33 had initially denied pain but at approximately 4:40 p.m. had requested and received Tylenol for right shoulder 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.	F 323		

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3) 7/16/15, at 10:25 p.m. a progress note indicated R33 was heard calling out "Help! " When staff entered the room, R33 had been on the floor lying on her back in the bathroom with her head out into her room. R33 had sustained a hematoma (bruise) to her left hip and elbow, had gone to the hospital, but no fractures were identified. An intervention developed post fall indicated R33 was encouraged by staff to ask for help by using the call light when transferring, and that R33 had agreed.

4) 7/6/15, at 8:35 a.m. a progress note identified that R33 had activated her call light and when staff entered the room R33 was sitting on the floor with her legs crossed. Documentation indicated R33 had sustained a skin tear to her upper right arm on the lateral aspect measuring 3.5 x 2.5 cm. R33 was assisted to a standing position easily with 3 staff and gait belt.

5) 7/1/15 at 6:45 p.m., a progress note identified R33 had been found on the floor in her bathroom in a puddle of urine at 3:10 p.m. that day. The documentation indicated R33 had bumped her head on the high-rise on the toilet, and had sustained a bump about the size of a golf ball to the right of the midline on the back of her head. The notes indicated staff had implemented neurological checks at the time of the fall, but no irregularities had been noted.

When interviewed on 1/13/16, at 8:38 a.m. RN-A and LPN-A stated staff should encourage R33 to get assistance when she needs to use the toilet and/or transfer as stated in the care plan. When RN-A and LPN-A were questioned about the evening observation on 1/11/16, when R33 had

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F 323	Continued From page 28 been wheeled to her room by staff after supper, and left alone with the door closed, LPN-A responded that staff should have offered to assist R33 with transferring into her recliner. LPN-A stated R33 would probably have declined the help, but it still should have been offered. RN-A verified the care plan was not followed as written and reiterated staff should offer to provide R33 assistance because although she may decline, sometimes she will accept the assistance.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		1/14/16

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F 431	Continued From page 29 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This 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. 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.	F 431	On 1/14/16 education was provided to all the Nurses and TMA's regarding the survey finding and deficient practices. For any staff unable to attend a written copy of the educational materials were given to them individually. Staff were instructed to check all "PRN" medications, insulin bottles, and other topical medications prior to each use, checking for expiration dates. The two medication carts were audited on 2/1/16 and 2/2/16 by our scheduling TMA J.B. Only one medication was coming up on an expiration date so that medication was reordered and the expiring medication will be disposed of per facility policy and procedure. The medication carts will be audited monthly by J.B. TMA and the consulting pharmacist will also do a more thorough medication cart audit on a monthly basis as well. Any medication found to be expired or close to expiring will be disposed of per facility policy and procedure and the medication will be re-ordered from the pharmacy. Audits will continue monthly indefinitely.	

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F 431	Continued From page 30 (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 antacid/antigas with the label indicating the medication order was filled 11/20/13, and was labeled with an expiration date of 11/20/14.	F 431		

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F 431	Continued From page 31 Neither RN-B or LPN-B were aware whether or not this medication had last been administered. Wing-B's medication cart was observed on 1/13/16, at 9:30 a.m. with LPN-A in attendance and LPN-C administering the ordered medications. The following was noted: (1.) R26 had a signed MD order for Oxycodone 5 mg 1 tablet by mouth (PO) every (Q) six (6) Hours as needed (PRN). The most recent date of administration was documented on the MAR as 12/24/15, at 4:30 a.m.. The date of expiration printed on the pharmacy label was 9/22/15. LPN-A&C verified this medication was administered after the date of expiration. (2.) R44 had a signed MD order for Alpralozam 0.25 mg 1 PO PRN . The most recent documented date of administration was 12/23/15, at 3:40 a.m. The printed expiration date on the label was 12/21/15. Both LPN A&C confirmed this medication was administered after the date of expiration. (3.) R24 had a signed MD order for Codiene/Gen 5-10 cc PO Q4-6H PRN. The most recent date of administration was unknown. The printed expiration date on the label was 12/26/15. (4.) R5 had a signed MD order for Robitussin AC (with codeine) 1-2 teaspoons PO Q4H PRN. Last date of administration was unknown. The printed expiration date was 12/26/15. The director of nursing (DON) was interviewed on 1/13/16, at 9:14 a.m. and stated facility policy requires staff to check the medication carts on a monthly basis and that LPN-A was responsible for this task. The DON also indicated the	F 431		

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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.

When interviewed on 1/13/16, at 1:34 p.m. RN-D stated she had contacted the local pharmacy which provides medications to the facility and verified the expiration dates printed on packages were the correct date of expiration. She further verified the insulin bottle with the unreadable opened date was over the 28 day usage date.

The facility policy, Checking outdated Medications, approval dated 12/04, indicated that outdated medications will be removed to prevent administration of expired medications. Procedure: (1.) check medications for outdate during medication passes. (2.) Remove any

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F 431	Continued From page 33 outdated medications during each routine medication pass. Dispose of them according to procedure. The facility policy, Medication Inventory Inspections, approved on 1/05, indicated unused portions of medication doses will be discarded. Procedure: (1.) Medication inventory shall be inspected routinely by the TD nurse and spot checked-monthly by the Consultant Pharmacist. (2.) Medications should be removed from storage when: Medication has reached the expiration date listed on the labeling. Medication containers are unstable, damaged, or excessively soiled. Medication labeling is soiled and non-legible. Medications are no longer ordered and have not been re-ordered after 1 month. Medications are discontinued and have not been re-ordered after 1 month. (3.) Medications that a resident brings from home are kept in a separate bag, labeled with their name, when not in use. These are reviewed with the resident upon discharge and destroyed if the resident/representative is in agreement with this, and they are no longer needed or are outdated.	F 431		

MDH
Minnesota Department of Health

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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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	245243	A. BUILDING **02 - MUNICIPAL HOSPITAL & GRANITE MANOR** B. WING _____	**11/24/2015**

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MUNICIPAL HOSP & GRANITE MANOR	**345 TENTH AVENUE GRANITE FALLS, MN 56241**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 24, 2015. At the time of this survey, Building 02 of Municipal Hospital & Granite Manor Nursing Home was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Municipal Hospital & Granite Manor Nursing Home consists of a 2015 building replacement, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and was not occupied at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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

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

MDH
Minnesota Department of Health

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00725	A. BUILDING: _____ B. WING _____	01/13/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 10, 11, 12 & 13, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the care plan as written for 2 of 3 residents (R7 and R33) reviewed who had interventions in place for falls and 1 of 3 residents (R7) reviewed for dental health. Findings include: The quarterly Minimum Data Set (MDS) dated 8/13/15, identified R7 had diagnoses which included Alzheimer's disease, neurogenic bladder, heart failure, anxiety, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R7 had moderate cognitive impairment, required extensive assistance with dressing, toileting, personal hygiene and needed supervision for bed mobility, transfers and ambulation. R7's current care plan, last reviewed on 11/24/15, identified R7 was at risk for falls with potential for	2 565	Corrected.	1/14/16

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2 565	Continued From page 3	2 565		

injury relate to age, Alzheimer's disease, TIA, glaucoma, hearing loss, urinary incontinence, episodes of confusion and forgetfulness, atrial fibrillation, weakness, and new environment. R7's care plan included the following interventions: (1) Hourly checks and hourly toileting, document on hourly monitoring sheet when completed intervention, (2) do not put feet of recliner up, (3) provide gripper socks if not wearing shoes, (4) body pillows on each side when in bed, (5) ambulate with assistance of 1-2 staff, wheelchair to follow, (6) assist required of 1-2 staff with all other activities of daily living (ADL's), able to eat independently after set up, (7) Sign placed on bathroom door so R7 would not exit or enter from the bathroom into his neighbor's room, and (8) ensure walker within reach. If a fall occurs, complete a post fall assessment, a fall event and incident report and assess factors contributing to the fall and implement interventions dated 3/18/15. R7' care plan identified he needed staff assist of 1 with oral care.

The nursing assistant (NA) undated assignment sheet for R7 utilized on 1/12/15, at 1:11 p.m. identified R7 as a high fall risk with the following interventions: (1) hourly checks at all times-and document, (2) call light within reach at all times, (3) body pillow on each side when lying down, (4) toilet hourly and (5) staff assist of 1-2 for ADL's.

Review of nursing assistant reposition and toilet documentation checklist date 12/11/15 to 1/13/16 revealed missing documentation and/or lacked the time cares were provided.

On 1/12/16, at 7:05 a.m., nursing assistant (NA)-B provided R7 with his morning cares. NA-B told R7 she would be back when his

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2 565	Continued From page 4 nebulizer treatment was done to brush his teeth, R7 stated ok. During continuous observation on 1/12/16 from 1:11 p.m. to 2:12 p.m. R7 was observed unattended sitting in his recliner chair in his room with the footrest elevated, both feet were resting directly on the footrest. R7's lower body was covered by a white blanket, oxygen on via nasal cannula, neck brace was on, eyes were closed and appeared to be sleeping. Observed NA-B entered R7's room At 1:58 p.m., she offered, R7 to use the toilet, he refused, then NA-B repositioned R7's left arm with a pillow. NA-B left the footrest of the recliner chair elevated with both of R7's feet resting on the foot rest, then exited R7's room. During interview on 1/12/16, at 1:50 p.m. NA-B reported she was aware of R7's previous falls with serious injury, she stated she was unsure if he had any falls from the recliner. NA-B stated R7 was to be offered toileting every hour, frequent checks, and then stated those were the only two interventions she knew of off hand. NA-B stated there were "no specific guidelines" related to the recliner chair and the footrest. Upon reviewing the NA assignment sheet, no interventions were listed regarding the footrest of the recliner. NA-B confirmed she elevated the footrest for R7 after lunch on 1/12/16 and had offered him the bed or recliner, and had asked R7 if he wanted his feet up or down. NA-B also confirmed she had not returned later provide oral cares for R7. 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.	2 565		

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2 565	Continued From page 5 On 1/12/16, at 2:12 p.m. licensed practical nurse (LPN)-B confirmed R7's legs were not to be elevated with use of the footrest as identified on the care plan. LPN-B confirmed the intervention was put into the communication book and the care plan, but was never transcribed onto the nursing assignment sheet. On 1/13/16, at 10:46 p.m. registered nurse (RN)-B confirmed the footrest intervention did not get updated onto the nursing assistant assignment sheet. RN-B also confirmed R7 required staff assistance of one for oral care and was to be provided twice per day. On 1/13/16, at 12:28 p.m., the director of nursing (DON) expected staff to implement identified fall interventions, including to keep the footrest of recliner down, document the hourly checks after completion and reassessment after each fall. The DON also confirmed staff would be expected to provide oral care per the care plan. R33's was admitted on 10/25/13 and the electronic heath record (EHR) diagnoses included: difficulty in walking, repeated falls, chronic obstructive pulmonary disease(COPD), atrial fibrillation, spinal stenosis, type 2 diabetes mellitus, anemia, Major depressive disorder, anxiety disorder, polyneuropathy, polymyalgia rheumatica and edema. The care plan dated 3/9/15, identified R33 at risk for falls due to: history of frequent falls when she was in her home, continued risk for falls and potential for weakness related to diagnoses of COPD and diabetes. The care plan interventions included:	2 565		

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2 565	Continued From page 6 (1.) Assist with ambulation on the unit 1-2 staff assist with gait belt and wheel chair (w/c) to follow; uses the bathroom; able to ambulate independently in room and to/from bathroom as able; and will need assistance when displaying weakness, increase in shortness of breath (SOB) or tiredness. (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. (3.) Attempt to assist with all transfers/encourage her to use call light for assistance. Discussion held with R33 about not waiting for staff assist/and or not using call light when she needs help with walking and transfers in her room. R33 realizes she is not always steady on her feet and that her feet do catch on the floor at times when she walks. R33 is made aware of the risks involved if she should fall and lose her balance because she declines to always ask for assistance with transfers and walking in her room. R33 is made aware of the potential for injuries. R33 decides at this time that she would like to continue to transfer/walk on her own in her room without calling or waiting for assist, even after the above risks were explained to her. She is alert and oriented x 3 and is able to make decisions. R33 signed the release from	2 565		

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2 565	Continued From page 7 responsibility form. During observation on 1/11/16, at 5:29 p.m. R33 wheeled herself out of her room by propelling her wheelchair with her feet and arms. R33 was noted to become SOB and struggled with wheeling the w/c. At 5:31 p.m. nursing assistant (NA)-A noted R33's difficulty with self-wheeling and transported R33 to the dining room table. On 1/11/16, at 6:18 p.m. it was noted that upon completion of the evening meal, R33 wheeled herself from the dining room using her hands and feet to propel the w/c. It was noted that R33 became SOB with the activity. NA-A noticed the difficulty and wheeled R33 to her room. NA-A opened the bedroom door, wheeled R33 into the room, closed the door and left R33 in her room with the door closed. NA-A indicated she would return later to check on R33. No further assistance was offered. On 1/11/16, at 6:29 p.m. R33 was observed seated in her recliner in her room breathing heavily and sweating. When interviewed at this time, R33 stated she had transferred herself into the recliner and indicated it was difficult. R33 had the wheelchair positioned in front of her recliner with the brakes on the chair locked. When questioned why she did not ask staff for assistance, R33 replied, " It takes too long for them to come and I am impatient". When interviewed on 1/13/16, at 8:38 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-A stated staff should encourage R33 to get assistance when she needed to toilet and/or transfer as stated in the care plan. When RN-A and LPN-A were questioned about the evening observation on 1/11/16, when R33 was	2 565		

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2 565	Continued From page 8 wheeled to her room by staff and then left her alone in the room with the door closed after the supper meal, LPN-A responded that staff should have offered to assist R33 transfer into her recliner. LPN-A stated R33 would probably decline the help but she should still be offered. RN-A verified the care plan was not followed as written and reiterated staff should offer to assist R33 assistance even though she may decline and will at times accept the assistance. The facility's Care Plan policy revised 1/15, indicated a personalized integrated written plan of care would be developed for each resident by a multi-disciplinary team in order to evaluate the resident restorative potential, establish attainable goals and coordinate staff and resident efforts towards meeting those goals. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures for providing cares as directed by the care plan and provide education to nursing staff pertaining to the content of the care plan. The facility could develop and implement an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		1/14/16

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2 830	Continued From page 9 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and ensure adequate supervision and interventions were implemented to prevent falls for 1 of 1 resident (R7) reviewed who had sustained multiple falls with injury, resulting in an immediate jeopardy (IJ) with the potential risk of serious harm, injury or death. In addition to the resident in immediate jeopardy, the facility failed to ensure interventions were followed to reduce falls, with the potential for harm that is not immediate jeopardy for 1 of 3 additional residents (R33) reviewed with falls. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/13/15, identified diagnoses which included: Alzheimer's disease, neurogenic bladder, heart failure, anxiety, depression and chronic obstructive pulmonary disease (COPD). That same quarterly MDS also indicated R7 had moderate cognitive impairment, required extensive assistance with dressing, toileting, and personal hygiene, and needed supervision for bed mobility, transfers and ambulation. A subsequent quarterly MDS dated 12/15/15, indicated R7 required extensive assistance with all activities of daily living (ADL's) except eating.	2 830	Corrected	

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2 830	Continued From page 10 R7's Care Area Assessment (CAA) dated 2/26/15, indicated R7 was at risk for falls, had short term and long term memory impairment, had diagnoses which included Alzheimer's dementia, hearing loss, glaucoma, transient ischemic attack (TIA), heart disease and atrial fibrillation (irregular heartbeat) which all contributed to R7's fall risk. The CAA indicated due to R7's memory impairment he would forget to call for assistance or to use his assistive device. The CAA indicated interventions had been identified for R7 and were in place to help him meet goals and prevent falls with injuries. R7's current care plan, last reviewed on 11/24/15, identified R7 was at risk for falls with potential for injury relate to age, Alzheimer's disease, TIA, glaucoma, hearing loss, urinary incontinence, episodes of confusion and forgetfulness, atrial fibrillation, weakness, and new environment. R7's care plan included the following interventions: (1) Hourly checks and hourly toileting, document on hourly monitoring sheet when intervention completed, (2) do not put feet of recliner up, (3) provide gripper socks if not wearing shoes, (4) body pillows on each side when in bed, (5) ambulate with assistance of 1-2 staff, wheelchair to follow, (6) assist required of 1-2 staff with all other activities of daily living (ADL's), able to eat independently after set up, (7) Sign placed on bathroom door so R7 will not exit or enter from the bathroom into his neighbor's room, and (8) ensure walker within reach. In addition, the plan indicated that if a fall occurred, staff were to complete a post fall assessment, a fall event, and to complete an incident report and assess factors contributing to the fall, and implement interventions dated 3/18/15.	2 830		

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2 830	Continued From page 11 The undated nursing assistant (NA) assignment sheets in use on 1/12/16, indicated the following for R7: high fall risk with the following interventions: (1) hourly checks at all times-and document, (2) call light within reach at all times, (3) body pillow on each side when lying down, (4) toilet hourly and (5) staff assist of 1-2 for ADL's. Review of R7's event reports and post fall assessments from 2/27/15 to 1/2/16 revealed he had experienced falls related to impulsivity, decreased strength, improperly fitting shoes, incontinence of urine and poor memory. Although the facility staff had developed interventions post falls, necessary interventions were not always added to the care plan and staff did not always receive adequate instruction on implementation. 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: According to incident documentation, on 8/17/15 at 2:00 p.m., activity staff had witnessed R7 fall in his room when R7 lost his balance after getting up and attempting self-transfer to his walker across the room. R7 landed on the right side of his body and hit his head on the floor. R7 was not wearing his glasses at the time of the fall. At the time, R7 had reported that when attempting to retrieve his walker, he felt dizzy and fell. New intervention: keep walker within range of resident. The resident had sustained bruising to the right side of his head and elbow, a small skin tear to right forearm, and had complained of mild pain to the right upper extremity. R7 had been sent to	2 830		

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the emergency room (ER) for evaluation because he'd hit his head and because he was on Coumadin (a blood thinner medication). The ER record dated 8/17/15, revealed the head CT and the cervical spine CT were both negative, with no evidence of significant 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 post fall assessment indicated R7 had his shoes on, walker within reach, call light activated and had his glasses on, but indicated R7 had stated he was attempting to get out of his chair to go to the bathroom and hadn't been able to figure out how to put the foot rest down so had attempted to get out of the chair with it up and the chair had tipped. Additionally, the documentation indicated R7 had reported he'd hit his head on the left side, and that visual assessment had revealed a 3 centimeter (cm) x 1 cm lump to the left side of his head. The documentation indicated staff had applied an ice pack and had initiated monitoring for bruising due R7's continued use of Coumadin to treat atrial fibrillation. The fall summary also indicated R7 had been unable to figure out how to lower the foot rest of his recliner, tried to get out of his recliner, the recliner had tipped and R7 was unable to stop himself from falling due to weakness. As a result of this incident, a new intervention had been identified: do not elevate legs of recliner, sign stating (do not elevate leg rest of recliner) laminated and placed on recliner. The fall summary further indicated R7 usually

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2 830	Continued From page 13 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 3:45 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 on and one shoe off, the floor was wet with urine around the toilet base, and R7 had a lump noted to the right side of his head. Documentation	2 830		

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indicated R7 had offered no complaints of pain but had slurred speech and rambled conversation. The notes indicated the nursing assistant (NA) had checked on R7 just 10 minutes prior. Root cause: up to bathroom without assistance. New intervention: toilet every 1 hour, night staff updated. At 9:41 a.m. on 12/15/15, the nurse had contacted R7's physician regarding the fall due to R7 experiencing slurred speech and increased confusion. R7 had subsequently been transferred to the local ER (emergency room) for further evaluation. Follow up nursing progress notes indicated R7 had been admitted to the hospital on 12/15/15, and a radiology report dated 12/16/15, identified the following injuries: a small left pleural effusion, fracture of right clavicle, right scapula, posterior right 9th and 10th ribs and superior endplate of T2. The CT of cervical spine identified a non-displaced fracture of C2, CT negative. The hospital history and physical/discharge summary for the hospitalization period of 12/15/15 to 12/18/15 revealed: " surgical intervention was not required, advised to wear a hard C-collar for 6 weeks. Was admitted to hospital after multiple falls with a C2 compression fracture, CHF, urinary retention, cardiac arrhythmia, and unknown reason for falling. Chest x-ray showed chronic left pleural effusion, stable cardiomegaly and non-displaced fractures of right clavicle. "

The facility's nursing progress notes from 12/18/15 to 12/26/15, indicated R7 had returned to the nursing home 12/18/15, wearing a neck brace at all times. In addition the notes indicated staff had implemented frequent checks (every 1/2 hour to one hour throughout the night).

A physician's progress note dated 12/22/15, identified R7 was at risk for further injury and

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falls. The physician note also indicated staff had done everything to try to prevent falls, and indicated the C2 spine fracture was stable (not shifted nor moved), and the physician had documented an order for R7 to remain off Digoxin and Coumadin.

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.

Review of previous falls revealed that on 6/3/15, at 6:17 p.m. R7 had been found on the floor in his room. The documentation indicated R7 had stated he was attempting to get out of the recliner with the footrest in the up position, that the recliner chair had tipped forward, and R7 had slid off the end and onto the floor. No injuries had occurred. Additional information documented about this fall indicated that at the time of the fall, R7 had been attempting to self transfer and had been unable to lower the footrest on his own. Interventions developed as a result of the 6/3/15 incident included: lowered footrest, and maintain footrest of recliner in low position, 1:1 discussion related to ask for help when needing assistance and dycem (an anti-slip pad) added to the recliner seat.

During continuous observation on 1/12/16 from 1:11 p.m. to 2:12 p.m. R7 was observed sitting unattended in his recliner chair in his room with

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2 830	Continued From page 16 the footrest elevated, both feet were resting directly on the footrest. R7's lower body was covered by a white blanket, oxygen on via nasal cannula, neck brace was on, eyes closed and appeared to be sleeping. At 1:58 p.m. NA-B entered the room to offer toileting but R7 refused. NA-B repositioned R7's left arm with a pillow, left the footrest of the recliner chair elevated with both of R7's feet resting on the foot rest and exited R7's room. During interview on 1/12/16, at 1:50 p.m. NA-B reported she was aware of R7's previous falls with serious injury but was unsure whether any falls had occurred from the recliner. NA-B stated the only two interventions for R7 included offering hourly toileting and frequent checks. NA-B stated she didn't think there were any "specific guidelines" related to the recliner chair or the use of the footrest. NA-B then reviewed the current nursing assignment sheet and confirmed no interventions were listed regarding the use of the footrest on the recliner. NA-B confirmed she had elevated the footrest for R7 after lunch on 1/12/16, and that she had offered him the choice of whether to lay in the bed or in the recliner. NA-B also verified she had given R7 a choice about whether to have the footrest on the recliner up or down. NA-B stated staff were made aware of specific resident needs or any new interventions by the facility's communication book which is available to be read at the beginning of each shift, and by the NA assignment sheets. NA-B stated nursing assistants did not have access to the formal resident care plans. R7 was interviewed on 1/12/16, at 2:03 p.m., he was unable to identify whether he'd experienced any falls from his recliner.	2 830		

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2 830	Continued From page 17 During interview on 1/12/16, at 2:06 p.m. licensed practical nurse (LPN)-B confirmed R7 had experienced prior falls from the recliner chair and stated he was not supposed to have the footrest elevated. The surveyor then asked LPN-B to check R7's position in his room. At 2:11 p.m. entered R7's room and confirmed R7's legs, which were elevated with the footrest of the recliner, should not have been elevated. LPN-B immediately lowered the footrest and R7's feet and asked him whether he would like to move into his bed. LPN-B reported R7 has multiple fall interventions in place which are documented in the communication book. LPN-B confirmed that a note dated 12/2/15, was documented in the communication book updating staff: do not put feet of recliner up, fell trying to get out of chair with feet up. LPN-B stated although the intervention had been updated on R7's care plan, it had not been transcribed onto the NA assignment sheets so staff would be aware. LPN-B confirmed R7 had received injuries from previous falls, and had most recently required hospitalization for injuries sustained from a fall. When interviewed on 1/12/16, at 2:24 p.m. nursing assistant (NA)-D confirmed an awareness of R7's previous falls from the recliner with the footrest elevated. However, NA-D stated staff continue to put R7 in his recliner with the footrest elevated when he is tired. NA-D further stated the recliner has an electric remote which is supposed to be pinned out of reach to prevent R7 from operating the chair. NA-D stated she is made aware of current fall intervention revisions by checking the communication book, the nursing assignment sheet and checking with the nurse at the beginning of each shift. In addition, NA-D said she reviews changes with the previous staff.	2 830		

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2 830	Continued From page 18 During interview on 1/12/15, at 2:32 p.m. registered nurse (RN)-B confirmed R7 had experienced multiple falls while at the facility, including out of his recliner with the footrest elevated (most recently on 1/2/16). RN-B stated R7's footrest were not supposed to be elevated. RN-B explained that after the completion of a fall report, a newly developed intervention is placed in the communication book, and revisions are made to the resident's care plan and NA assignment sheets. RN-B also said the NA sheets are updated weekly on Fridays. On 1/13/16, at 10:46 a.m. RN-B confirmed the intervention to keep the foot rest down for R7, originally initiated 6/8/15, had never been updated on the NA assignment sheet. During interview on 1/12/16, at 4:23 p.m. the director of nursing (DON) confirmed no post fall assessment had been completed after R7's fall from the recliner on 1/2/16. The DON stated the assessment should have been done but was missed. The DON also stated she was not aware of R7's fall from the recliner on 6/3/15; however, was aware of falls involving the recliner on 12/2/15 and 1/2/16. The DON confirmed staff were expected to implement all identified interventions, which for R7 included keeping the footrest of the recliner in the down position. She further verified that intervention had not been transcribed onto the NA assignment sheet. During additional interview with the DON on 1/13/16 at 12:28 p.m., the DON stated R7's condition was very compromised because he'd sustained multiple injuries due to a fall on 12/15/15. The DON further confirmed R7 was still very fragile with many co-morbidities, and remained at high risk for falls and injury. The DON stated R7 continues to have healing	2 830		

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2 830	Continued From page 19 fractures and has to wear a cervical collar. A post fall assessment for the 1/2/16 fall was completed on 1/12/16 after interview with the DON. The assessment indicated the root cause of the fall as: confusion and severe cognitive impairment, R7 transferred without assistance and the footrest was elevated on the recliner at the time of the fall. Intervention modifications included: add dycem under the cushion to prevent from slipping. Additional interventions: No foot rests on the wheelchair, footrest on the recliner to be kept down, hourly checks by staff, a laminated sign attached to R7's recliner stating not to bring up the footrest, and a memo to all nursing staff updating them on the care plan updates. The facility's Fall Prevention Policy revised on 10/14, indicated each resident would be assessed for their risk of falling and interventions would be implemented to meet the individual needs of the residents. R33's electronic health record (EHR) indicated the resident had been admitted on 10/25/13 with diagnoses including: difficulty in walking, repeated falls, chronic obstructive pulmonary disease(COPD), atrial fibrillation, spinal stenosis, type 2 diabetes mellitus, anemia, major depressive disorder, anxiety disorder, polyneuropathy, polymyalgia rheumatica and edema. The quarterly Minimum Data Set (MDS) assessment, dated 11/12/15, identified that R33 had sustained one fall since the last quarterly MDS assessment dated 8/26/15. R33's significant change MDS assessment dated 6/12/15, also identified the resident had sustained	2 830		

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2 830	Continued From page 20 one fall since prior assessment and was at risk for falling. The Care Area Assessment (CAA) documentation for the significant change in condition indicated R33 was at risk for falls related to use of anti-depressant medications, weakness at times, shortness of breath (SOB) with activity, obesity, diabetes, hypertension and anemia. The MDS further identified staff should continue her current care plan. Interventions identified indicated R33 needed and received assistance with some of her activities of daily living (ADL) when she was feeling SOB, weak, or tired, and identified she had potential to experience episodes of pain and discomfort. R33's care plan dated 3/9/15, identified R33's risk for falls due to: history of frequent falls when at her home, continued risk for falls, and potential for weakness related to diagnoses of COPD and diabetes. The care plan interventions included: 1.) Assist with ambulation on the unit, 1-2 staff assist with gait belt and wheel chair (w/c) to follow; uses the bathroom in her room; able to ambulate independently in room and to/from bathroom as able; and will need assistance when displaying weakness, increase in shortness of breath (SOB) or tiredness. 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 her to use the call light for transfers/assist to prevent falls. R33 is aware and has been explained that she should use staff assist with all transfers; however, she continues to complete tasks such as transfer's independent at times, without calling for staff assist-she did sign a waiver. She is aware of the risks such as injuries that could result in hip FX (fracture), head injuries that can lead to death if she chooses not	2 830		

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2 830	Continued From page 21 to call for assist. She continues to make her own decisions regarding when she will transfer, even with her understanding of the risks and benefits. 3.) Attempt to assist with all transfers/encourage her to use call light for assistance. Discussion held with R33 about not waiting for staff assist/and or not using call light when she needs help with walking or transfers in her room. R33 realizes she is not always steady on her feet and that her feet do catch on the floor at times when she walks. R33 is made aware of the risks involved if she should fall and lose her balance because she declines to ask for assistance with transfers and walking in her room. Frequently walks to and from her chair/bed into her bathroom. R33 is made aware that if she chooses not to have staff assist her with transfers and ambulation she has the potential for injures to occur. We talked about the potential injuries that could happen such as head injuries, fractures-and these could lead to death. We also talked about skin tears and bruising. R33 also has refused protective foam from being placed in her door way. She decides at this time that she would like to continue to transfer/walk on her own in her room without calling or waiting for assist, even after the above risks were explained to her. She is alert and oriented x 3 and is able to make decisions. R33 signed a release from responsibility form. See form which is placed into her chart; 4.) Raised edge mattress; 5.) Bedside table moved to right side of the bed; 6.) Walker place in reach next to bed and chair; Keeps wheelchair in the hall just outside her doorway; and encouraged to keep this wheelchair locked. Staff also check to make sure it's locked. 7.) Use nightlight/light in bathroom as R33 requests to use and use as needed. Provide proper and well maintained foot wear. Keep personal items and frequently used items within R33's reach.	2 830		

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2 830	Continued From page 22 During observation on 1/11/16, at 5:29 p.m. R33 propelled herself in the wheelchair from her room with the use of her feet and arms. R33 was noted to become SOB and struggled with wheeling the w/c. At 5:31 p.m. NA-A noted R33's difficulty with self-wheeling and transported R33 to the dining room table. Following supper, at 6:18 p.m. R33 was observed to have wheeled herself from the dining room, using her hands and feet to propel the w/c. It was noted that R33 became SOB with the activity. Again, NA-A noticed the difficulty and wheeled R33 to her room. NA-A opened the bedroom door, wheeled R33 into the room, closed the door and left R33 in her room with the door closed. NA-A indicated she would return later to check on R33. No further assistance was offered by NA-A. At 6:29 p.m. R33 was observed seated in her recliner located in her room; breathing heavily and sweating. When interviewed at that time, R33 stated she had transferred herself into the recliner and that it had been "difficult". It was observed that R33 had the wheelchair positioned in front of her recliner with the brakes on the chair locked. When questioned why she hadn't asked staff for assistance R33 replied, " It takes too long for them to come and I'm impatient". 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	2 830		

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	00725	A. BUILDING: _____ B. WING _____	01/13/2016

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2 830	Continued From page 23 of the fall risks but desires to do as much for herself as possible to maintain her independence. R33 indicated the falls she experienced were not the fault of the staff; "I'm a bit stubborn." R33 indicated she would utilize the call light when she felt she needed assistance but usually did not use the call light. Review of the medical record identified that R33 had experienced the following falls: 1) 1/9/16, at 3:15 p.m. while attempting to get to the toilet and had incontinence on the floor which caused the floor to be slick. R33 sustained a skin tear. The nursing progress note dated 1/9/16, at 05:04 p.m. identified R33 was incontinent of urine, which caused her to slip and fall, and indicated R33 had not used her walker because she was in a hurry. R33 had sustained a skin tear to the left thumb and index finger, and had required three staff assist into bed with the use of a full lift. Documentation indicated R33 had initially denied pain but at approximately 4:40 p.m. had requested and received Tylenol for right shoulder 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. 3) 7/16/15, at 10:25 p.m. a progress note indicated R33 was heard calling out "Help! " When staff entered the room, R33 had been on	2 830		

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2 830	Continued From page 24 the floor lying on her back in the bathroom with her head out into her room. R33 had sustained a hematoma (bruise) to her left hip and elbow, had gone to the hospital, but no fractures were identified. An intervention developed post fall indicated R33 was encouraged by staff to ask for help by using the call light when transferring, and that R33 had agreed. 4) 7/6/15, at 8:35 a.m. a progress note identified that R33 had activated her call light and when staff entered the room R33 was sitting on the floor with her legs crossed. Documentation indicated R33 had sustained a skin tear to her upper right arm on the lateral aspect measuring 3.5 x 2.5 cm. R33 was assisted to a standing position easily with 3 staff and gait belt. 5) 7/1/15 at 6:45 p.m., a progress note identified R33 had been found on the floor in her bathroom in a puddle of urine at 3:10 p.m. that day. The documentation indicated R33 had bumped her head on the high-rise on the toilet, and had sustained a bump about the size of a golf ball to the right of the midline on the back of her head. The notes indicated staff had implemented neurological checks at the time of the fall, but no irregularities had been noted. When interviewed on 1/13/16, at 8:38 a.m. RN-A and LPN-A stated staff should encourage R33 to get assistance when she needs to use the toilet and/or transfer as stated in the care plan. When RN-A and LPN-A were questioned about the evening observation on 1/11/16, when R33 had been wheeled to her room by staff after supper, and left alone with the door closed, LPN-A responded that staff should have offered to assist R33 with transferring into her recliner. LPN-A stated R33 would probably have declined the	2 830		

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2 830	Continued From page 25 help, but it still should have been offered. RN-A verified the care plan was not followed as written and reiterated staff should offer to provide R33 assistance because although she may decline, sometimes she will accept the assistance. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could inservice nursing staff on the importance of re-assessment after a resident has experienced a fall. An audit could be developed to ensure the appropriate assessment and interventions are implemented to ensure resident safety. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral cares for 1 of 1 resident (R7) reviewed who was dependent upon staff for grooming and personal cares. Findings include: R7's quarterly Minimum Data Set (MDS) dated	2 855	Corrected	1/14/16

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2 855	Continued From page 26 8/13/15, identified diagnoses which included Alzheimer's disease, anxiety, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R7 had moderate cognitive impairment and required extensive assistance with personal hygiene. R7's admission assessment dated 2/19/15, identified R7 had natural teeth and in poor condition. The oral assessment identified R7 had some missing natural teeth and several fillings. R7's care plan reviewed on 11/24/15, identified R7 required staff assistance of one with grooming, including oral care. R7's undated, nursing assignment sheet indicated he had his own teeth and required assist of one to provide oral care. 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.	2 855		

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2 855	Continued From page 27 During interview on 1/12/16, at 2:12 p.m. licensed practical nurse (LPN)-B confirmed R7 required staff assist of one for oral cares and is expected to be completed daily. 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. During interview on 1/12/16, at 11:03 a.m., the director of nursing (DON) confirmed she helped R7 from his recliner to his wheelchair and assisted him to the breakfast table. The DON confirmed she had not provided oral cares for R7, and verified R7 required staff assistance to complete oral cares and would expect the cares to have been provided before or after breakfast. The DON stated she would have to remind staff to make sure cares were completed for R7 before he went to therapy or other places after breakfast. The facility's Oral Hygiene policy revised and approved on 12/03, indicated residents would receive appropriate oral hygiene needed to maintain or improve oral hygiene status. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures for providing cares as directed by the assessed needs of residents and provide education to nursing staff to follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 855		

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2 855	Continued From page 28 .	2 855		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII 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. 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.	21615	Corrected	1/14/16

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21615	Continued From page 29 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	21615		

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21615	Continued From page 30	21615		

antacid/antigas with the label indicating the medication order was filled 11/20/13, and was labeled with an expiration date of 11/20/14. Neither RN-B or LPN-B were aware whether or not this medication had last been administered.

Wing-B's medication cart was observed on 1/13/16, at 9:30 a.m. with LPN-A in attendance and LPN-C administering the ordered medications. The following was noted:
(1.) R26 had a signed MD order for Oxycodone 5 mg 1 tablet by mouth (PO) every (Q) six (6) Hours as needed (PRN). The most recent date of administration was documented on the MAR as 12/24/15, at 4:30 a.m.. The date of expiration printed on the pharmacy label was 9/22/15. LPN-A&C verified this medication was administered after the date of expiration.

(2.) R44 had a signed MD order for Alpralozam 0.25 mg 1 PO PRN . The most recent documented date of administration was 12/23/15, at 3:40 a.m. The printed expiration date on the label was 12/21/15. Both LPN A&C confirmed this medication was administered after the date of expiration.

(3.) R24 had a signed MD order for Codiene/Gen 5-10 cc PO Q4-6H PRN. The most recent date of administration was unknown. The printed expiration date on the label was 12/26/15.

(4.) R5 had a signed MD order for Robitussin AC (with codeine) 1-2 teaspoons PO Q4H PRN. Last date of administration was unknown. The printed expiration date was 12/26/15.

The director of nursing (DON) was interviewed on 1/13/16, at 9:14 a.m. and stated facility policy requires staff to check the medication carts on a

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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.

When interviewed on 1/13/16, at 1:34 p.m. RN-D stated she had contacted the local pharmacy which provides medications to the facility and verified the expiration dates printed on packages were the correct date of expiration. She further verified the insulin bottle with the unreadable opened date was over the 28 day usage date.

The facility policy, Checking outdated Medications, approval dated 12/04, indicated that outdated medications will be removed to prevent administration of expired medications. Procedure: (1.) check medications for outdate

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during medication passes. (2.) Remove any outdated medications during each routine medication pass. Dispose of them according to procedure.

The facility policy, Medication Inventory Inspections, approved on 1/05, indicated unused portions of medication doses will be discarded. Procedure: (1.) Medication inventory shall be inspected routinely by the TD nurse and spot checked-monthly by the Consultant Pharmacist. (2.) Medications should be removed from storage when:
Medication has reached the expiration date listed on the labeling.
Medication containers are unstable, damaged, or excessively soiled.
Medication labeling is soiled and non-legible.
Medications are no longer ordered and have not been re-ordered after 1 month.
Medications are discontinued and have not been re-ordered after 1 month.
(3.) Medications that a resident brings from home are kept in a separate bag, labeled with their name, when not in use. These are reviewed with the resident upon discharge and destroyed if the resident/representative is in agreement with this, and they are no longer needed or are outdated.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

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21975	Continued From page 33	21975		
21975	MN St. Statute 144A.10 Subd. 3 Inspection; Commissioner of Health; Fines 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to post survey results in a manner that was readily accessible to all residents and visitors. This had the potential to affect all 45 residents residing in the facility and visitors.	21975	Corrected	1/14/16

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21975	Continued From page 34 Findings include: During observation on 1/10/15, at 11:20 a.m. the survey results were noted in a bulletin board behind glass in the front of the building. The glass panel needed to be slid open by hand in order to take the survey results off the bulletin board for viewing. The bulletin board was located above two drinking fountains which projected out from the wall, limiting access to residents who were wheelchair bound and unable to stand. During interview on 1/11/15, at 2:09 p.m. the director of nursing (DON) stated residents could view the survey results by sliding the glass open. The DON confirmed residents in wheelchairs would not be able to access the survey results as the water fountains blocked access to the bulletin board, and stated the residents would have to ask for help to get them out. SUGGESTED METHOD OF CORRECTION: The administrator or designee could re-eduate staff to assure the facility survey results are accessibile to all residents. The administrator or designee could monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21975		