DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MED</b>	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY	ID: KT3D Facility ID: 00477
1. MEDICARE/MEDICAID PROVID (L1) 245537 2.STATE VENDOR OR MEDICAID N (L2) 328542100	ER NO.	3. NAME AND AI	DDRESS OF FAC SKA COMMU STREET, PO	CILITY I <b>NITY HE</b> A	ALTH SERVICES (L6) 56381	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/24 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	<ul><li>43 (L18)</li><li>43 (L17)</li></ul>	Complianc 1. A B. Not in Con		gram	And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A, 8	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO		105	шъ		15. FACILITY MEETS	(L15)
18 SNF 18/19 SNF 43	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(E13)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lyla Burkman, Unit Sup			02/07/2017	(L19)	Net20299993	, Enforcement Specialist 04/06/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RF	EGIONAI	LOFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBII</li> <li><u>X</u></li> <li>1. Facility is Eligible to F</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	<b>MENT</b>	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>07/27/1989</b>	BEGINNING		ENDING DA		VOLUNTARY         00           01-Merger, Closure         00	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	e
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE		
	(L32)	01/25/2017		(L33)	DETERMINATION APPE	ROVAL

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

CCN: 24 5537

Minnewaska Community Health Services was not in substantial compliance with Federal participation requirements at the time of the December 8, 2016 standard survey. On January 24, 2017, a Post Certification Revisit (PCR) Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed December 8, 2016, effective January 10, 2017.

Effective January 10, 2107, the facility is certified for 45 skilled nursing facility beds.

The facility's request for a continuing waiver involving the health deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Approval of the waiver has been recommended.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245537 February 10, 2017

Mr. Christopher Knoll, Administrator Minnewaska Community Health Services 605 Main Street, P.O. Box 40 Starbuck, MN 56381

Dear Mr. Knoll:

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 10, 2017 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

Your request for waiver of F458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Please contact me if you have any questions.

An equal opportunity employer.

Minnewaska Community Health Services February 10, 2017 Page 2

Sincerely,

ate Comston X

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 7, 2017

Mr. Christopher Knoll, Administrator Minnewaska Community Health Services 605 Main Street, PO Box 40 Starbuck, Minnesota 56381

RE: Project Number S5537028

Dear Mr.. Knoll:

On December 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On January 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 10, 2017 and therefore remedies outlined in our letter to you dated December 21, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Sincerely,

#### Mark meath

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

# **POST-CERTIFICATION REVISIT REPORT**

			DATE OF REVISIT	
	A. Building B. Wing	Y2	1/24/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEWASKA COMMUNITY HEALTH SERVICES		605 MAIN STREET, PO BOX 40		
		STARBUCK, MN 56381		

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

ITE	м	DATE	ITEM			DATE	ITEM		DATE
Y4		Y5	Y4			Y5	Y4		Y5
ID Prefix	F0156 483.10(d)(3)(g)(1	Correction	ID Prefix Reg. #		c)(2)(i-ii,iv,v)		ID Prefix Reg. #	F0282 483.21(b)(3)(ii)	Correction
Reg. #	(13)(16)-(18)	Completed 01/10/2017		(3),483.	.21(b)(2)	Completed 	Ū		01/10/2017
LSC		01/10/2017	LSC				LSC		01/10/2017
ID Prefix	F0312	Correction	ID Prefix	F0314		Correction	ID Prefix	F0431	Correction
Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(	b)(1)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed
LSC		01/10/2017	LSC			01/10/2017	LSC		01/10/2017
ID Prefix	F0441	Correction	ID Prefix	F0465		Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4	)(e)(f) Completed	Reg. #	483.90(	h)(5)	Completed	Reg. #		Completed
LSC		01/10/2017	LSC			01/10/2017	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		
REVIEWE STATE AG		REVIEWED BY (INITIALS) LB/mm	<b>DATE</b> 02/07/2	017	SIGNATURE OF	SURVEYOR 2803	5	DA 0	te 1/24/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE			DA	TE
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						YES NO	

DEPARTMENT OF HEALT	HAND HUMA	N SERVICES			<b>CENTERS FOR MED</b>	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: KT3D
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00477
1. MEDICARE/MEDICAID PROVIDE (L1) 245537     2.STATE VENDOR OR MEDICAID N (L2) 328542100		(L4) 605 MAIN S	SKA COMMU STREET, PO	NITY HEA	ALTH SERVICES (L6) 56381	4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW
		(L5) STARBUCK	K, MN			5. Validation 6. Complaint 7. On-Site Visit 9. Other
8. ACCREDITATION STATUS:	2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	05 HHA 06 PRTF 07 X-Ray	09 ESRD 10 NF 11 ICF/IID		8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/51
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> </ul>	43 (L18) 43 (L17)	Compliance 1. A X B. Not in Con	ance With equirements the Based On: Acceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: <b>B</b> , <b>8</b>	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF 43	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Denise Erickson, HFE N	EII	0	01/03/2017	(L19)	Mark Meath, Er	nforcement Specialist 01/24/2017 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBIL</li> <li>X 1. Facility is Eligible to P</li> <li>2. Facility is not Eligible</li> </ol>			MPLIANCE WIT HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) ; :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>07/27/1989</b>	BEGINNINC	G DATE	ENDING DA	TE	VOLUNTARY     00       01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	6
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change
(L27)		n of Admissions: uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: KT3D PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00477

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

Effective June 15, 2016, eight beds, previously on layaway status, were relicensed and then a total of 30 beds were immediately transferred to CG Care Center, LLC. The 30 beds will be licensed and certified at CG Care Center LLC. The transfer of beds was accomplished in accordance with the terms of a cost neutral bed relocaton, as summarized in the letter dated February 2, 2016 to Mr. Daniel A. Lindh, President, Presbyterian Homes and Services from Susan Winkelmann, Assistant Director, Health Regulation Division, Minnesota Department of Health.

At the time of the December 8, 2016 recertification survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections are required.

The facility's request for a continuing waiver involving the health deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. The facility's compliance is based on pending CMS approval of your request for waiver.

Refer to the providers letter of waiver request dated December 26, 2016, CMS 2567 for both health and life safety code, and plan of correction for health. Post Certification Revisit (PCR) to follow.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 21, 2016

Mr. Christopher Knoll, Administrator Minnewaska Community Health Services 605 Main Street, Po Box 40 Starbuck, Minnesota 56381

RE: Project Number S5537028

Dear Mr.. Knoll:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Minnewaska Community Health Services December 21, 2016 Page 2

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

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

#### DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A

Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

#### 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.

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

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Minnewaska Community Health Services December 21, 2016 Page 4

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

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

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

# Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 8, 2017 (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

Minnewaska Community Health Services December 21, 2016 Page 5 issued. This mandatory denial of payment is i

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 June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely, Mark Meath

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
		245537	B. WING		12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	0		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 156 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(d)(3)(g)(1)(4	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES	F 15	6		1/10/17
	remains informed c of contacting the ph	nust ensure that each resident of the name, specialty, and way nysician and other primary care onsible for his or her care.				
	(1) The resident hat his or her rights and	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.				
	notices orally (mean	has the right to receive ning spoken) and in writing a format and a language he a, including:				
	The facility must fur	s as specified in this section. rnish to each resident a written rights which includes -				
	Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 12/28/2016

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

PRINTED: 01/03/2017

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING	i		12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY F	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	<ul> <li>(A) A description of personal funds, und section;</li> <li>(B) A description of procedures for estaincluding the right to resources under see Security Act.</li> <li>(C) A list of names, email), and telephone State regulatory and resident advocacy of Survey Agency, the State Long-Term Caprotection and advocservices where state in long-term care far agency for informatic community and the and</li> <li>(D) A statement that complaint with the Sconcerning any susfederal nursing facinot limited to reside exploitation, misappin the facility, non-c directives requirement information regarding (ii) Information and and local advocacy not limited to the State Cong-Term Care Or State Security Act.</li> </ul>	the manner of protecting der paragraph (f)(10) of this the requirements and ablishing eligibility for Medicaid, o request an assessment of ection 1924(c) of the Social addresses (mailing and ne numbers of all pertinent d informational agencies, groups such as the State e State licensure office, the are Ombudsman program, the ocacy agency, adult protective te law provides for jurisdiction acilities, the local contact tion about returning to the Medicaid Fraud Control Unit; at the resident may file a State Survey Agency spected violation of state or lity regulations, including but	F	156			

If continuation sheet Page 2 of 47

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245537	B. WING		12	2/08/2016
NAME OF	PROVIDER OR SUPPLIER	·	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP	CODE	
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 156	Americans Act of 1 U.S.C. 3001 et seq advocacy system (i as established und Disabilities Assistan 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) w November 28, 2017 (iii) Information reg eligibility and cover [§483.10(g)(4)(iii) w November 28, 2017 (iv) Contact informat Disability Resource Section 202(a)(20) Act); or other No W [§483.10(g)(4)(iv) w November 28, 2017 (v) Contact informat Control Unit; and [§483.10(g)(4)(iv) w November 28, 2017 (v) Contact informat Control Unit; and [§483.10(g)(4)(v) w November 28, 2017 (vi) Information and grievances or comp suspected violation facility regulations, resident abuse, neg misappropriation of facility, non-complia directives requirem information regardi (g)(5) The facility m	965, as amended 2016 (42 ) and the protection and as designated by the state, and er the Developmental nce and Bill of Rights Act of 5001 et seq.) ill be implemented beginning 7 (Phase 2)] arding Medicare and Medicaid age; vill be implemented beginning 7 (Phase 2)] ation for the Aging and e Center (established under (B)(iii) of the Older Americans frong Door Program; vill be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud vill be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud vill be implemented beginning 7 (Phase 2)] ation for the Medicaid Fraud vill be implemented beginning 7 (Phase 2)] at contact information for filing plaints concerning any of state or federal nursing including but not limited to	F 1	56		

If continuation sheet Page 3 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 156	(i) A list of names, a	representatives: addresses (mailing and email),	F 1	156			
	agencies and advoc Survey Agency, the protective services jurisdiction in long-t of the State Long-To program, the protect home and commun and the Medicaid F	bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for term care facilities, the Office form Care Ombudsman ction and advocacy network, hity based service programs, raud Control Unit; and					
	complaint with the s concerning any sus federal nursing facil limited to resident a misappropriation of facility, and non-cor directives requirem	t the resident may file a State Survey Agency spected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning					
	written information, applicants for admis information about h Medicare and Medi	must display in the facility and provide to residents and ssion, oral and written low to apply for and use caid benefits, and how to previous payments covered by					
	and services to the	must provide a notice of rights resident prior to or upon ng the resident's stay.					
		inform the resident both orally anguage that the resident					

If continuation sheet Page 4 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/0	08/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	understands of his regulations governii responsibilities duri (ii) The facility must the State-developed obligations, if any. (iii) Receipt of such amendments to it, r writing; (g)(17) The facility r (i) Inform each Med writing, at the time of facility and when the Medicaid of- (A) The items and s nursing facility serv for which the reside (B) Those other iter facility offers and for charged, and the ar services; and (ii) Inform each Med changes are made specified in paragra this section. (g)(18) The facility r before, or at the tim periodically during t available in the faci	or her rights and all rules and ng resident conduct and ing the stay in the facility. It also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in	F 1	56			

		& MEDICAID SERVICES	[		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245537	B. WING _		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 156		dicare/ Medicaid or by the	F 15	56		
	and services cover Medicaid State plan	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.				
	items and services facility must inform	Where changes are made to charges for othe ms and services that the facility offers, the cility must inform the resident in writing at least days prior to implementation of the change.				
(i tı fa d p rv fa d (i rv t	transferred and doo facility must refund representative, or e deposit or charges per diem rate, for the resided or reserved	es or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's he days the resident actually d or retained a bed in the of any minimum stay or equirements.				
	resident representa	st refund to the resident or ative any and all refunds due 30 days from the resident's rom the facility.				
	behalf of an individ facility must not con these regulations. This REQUIREME	admission contract by or on ual seeking admission to the nflict with the requirements of NT is not met as evidenced				
	facility failed to pro- two-day notice of d	v and document review, the vide documentation of a enial of Medicare benefits for 1 ) whose liability notices were		Resident R47 has since discharg the facility. It is the policy of Minnewaska Luth Home that all residents will be pro	neran	

Facility ID: 00477

If continuation sheet Page 6 of 47

		AND HUMAN SERVICES			F	ORM	01/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		245537	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 156	Continued From pa	ge 6	F 1	56			
	reviewed.				with a proper liability and appeal rights notice in a timely manner prior to	;	
	Findings include:				termination of Medicare skilled service The Case Manager RN's have been	es.	
	11/11/16, indicated 10/24/16, through 1	nimum Data Set (MDS) dated R47 received skilled therapy 1/10/16. The medical record ce of discharge from Medicare			educated on the requirements to provi proper liability and appeal rights notice a timely manner prior to termination of Medicare. Monitoring to ensure compliance will b conducted by the Director of Nursing of	e in e	
	R47 had received n stay at the facility.	6 a.m. the MDS nurse verified nedicare benefits during her The MDS Nurse verified R47 ication of denial form in her und elsewhere.			designee through monthly audits. Res of the audits will be presented at QA ir March, 2017 for review. Correction date: 1/10/2017		
	(DON) verified R47	6 p.m. the director of nursing did not receive a medicare uired and should have.					
F 280 SS=D	483.10(c)(2)(i-ii,iv,v	policy was not provided. )(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80			1/10/17
	and implementation	participate in the development of his or her person-centered ing but not limited to:					
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care.					
		icipate in establishing the I outcomes of care, the type,					

Facility ID: 00477

If continuation sheet Page 7 of 47

	-	AND HUMAN SERVICES			FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245537	B. WING		12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		605 MAIN STREET,PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 7	F 280			
	amount, frequency,	, and duration of care, and any d to the effectiveness of the				
	(iv) The right to reco included in the plan	eive the services and/or items of care.				
		the care plan, including the gnificant changes to the plan				
	right to participate in	nall inform the resident of the n his or her treatment and sident in this right. The nust				
	(i) Facilitate the incl resident representa	lusion of the resident and/or ative.				
	(ii) Include an asses strengths and need	ssment of the resident's ls.				
		resident's personal and s in developing goals of care.				
	483.21 (b) Comprehensive	Care Plans				
	(2) A comprehensiv	/e care plan must be-				
	(i) Developed within the comprehensive	n 7 days after completion of assessment.				
	(ii) Prepared by an includes but is not l	interdisciplinary team, that imited to				
	(A) The attending p	hysician.				

If continuation sheet Page 8 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		ONSTRUCTION		E SURVEY PLETED
		245537	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER	HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ace 8	F 28	80			
		rse with responsibility for the					
	(C) A nurse aide wi resident.	th responsibility for the					
	<ul> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> </ul>						
		te staff or professionals in mined by the resident's needs the resident.					
	team after each as comprehensive and assessments.	revised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced					
	Based on observa- review, the facility f care plan to include reducing boot for 1 for pressure ulcers	tion, interview and document ailed to accurately revise the the use of a pressure of 3 residents (R43) reviewed and had a physician order uled use of a pressure device.		re a st T d	The Care Plan for resident R43 h eviewed to ensure that it continue ccurately reflect the resident's cu tatus and current physician's ord 'he Care Plans for all residents etermined to be at risk for skin reakdown will be reviewed to en- heir Care Plans accurately reflect	es to irrent ers. sure that	
	11/30/16, indicated	d physician order dated R43 was to wear a pressure e left foot during daytime		re pl O re	esident's current status and accu hysician's orders. On admission, Significant Change esident status, and as residents of ue for their next MDS (Minimum	rate e in come	

Facility ID: 00477

If continuation sheet Page 9 of 47

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 1				0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245537	B. WING			12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIOI DATE
F 280	Continued From pa	ige 9	F 2	80			
	R43 had severe co required extensive care plan also indic developing pressur developed a bluish 2.5 cm fluid filled bl care plan directed s needs and to follow care plan further id ordered a pressure the boot was to be Treatment record fo on 11/24/16, a press worn during night ti physician order direct time hours. On 2/07/16, at 11:3 seated in her whee her TV. R43 had s left arm of her whee cushion under her I wheelchair. R43 wo low, half back acros was off the back of wearing a pressure A pressure reducing room. -At 12:40 p.m. follo nursing assistant (fi	dated on 11/30/16, indicated gnitive impairment and assistance with ADLs. The cated R43 was at risk for e ulcers and on 10/21/16, had /purple, 4.5 centimeters (cm) x lister on her left inner heel. The staff to anticipate all of R43's / facility wound protocol. The entified R43's physician ereducing boot and indicated worn at night only. R43's or December 2016, indicated asure reducing boot was to be me hours. However, R43's ected the use during the day 8 a.m. R43 was observed lchair, in her room, in front of heep skin which covered the elchair and a black foam bottom in the seat of her ore gray, no-tie shoes with a ss her left heel. R43's left heel the footrest and she was not e reducing boot on her left foot. g boot was not observed in her wing lunch in the dining room, NA)-F wheeled R43 into her . R43's left foot was off the foot			Set) assessment, resident's care pla will be reviewed to ensure the care p continues to accurately reflect the resident's status and current physici orders. By January 10, 2017, licensed nursi staff will attend an in-service. The Director of Nursing or designee will conduct the in-service. The in-servi cover: " A review of the regulations, " Review of the statement of deficiencies, " Review of the plan of correction " Care Plan development, " Revision and updating of care p as needed. The Director of nursing or designee conduct audits weekly for a month a then monthly through the quarter. Fo of audits will be presented to QA in f 2017 for review. Correction date: 1/10/2017	olan an's ng ce will , lans will ind Results	

If continuation sheet Page 10 of 47

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MINNEW	ASKA COMMUNITY F	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 10	F 2	280			
	wore black socks, a pressure reducing b pressure reducing b room. R43 remain i 2:40 when staff ass						
	the dining room hav was not wearing he	was seated in her wheelchair in ving coffee with spouse. R43 er pressure reducing boot to ore her gray half-back shoes.					
	the day room with s	s seated in her wheelchair in spouse and was not wearing ing boot to her left foot, and back shoes.					
	required extensive daily living (ADLs) a She stated she was wore, however had	5 p.m. NA-E stated R43 assistance with all activities of and could not communicate. s not sure what shoes R43 worn a protective boot at night floated when she was in bed.					
		) p.m. NA-D stated she thought n her left foot at night and not					
	(LPN)-A stated R43 whenever she was stated she just lear pillow boots during day. She stated she	5 p.m. Licensed practical nurse 3 should wear a pillow boot in bed. At 2:40 p.m. LPN-A med R43 was to wear the the night, and not during the e understood the staff's 's pressure boot schedule					

If continuation sheet Page 11 of 47

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		3) DATE SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:			COMPLETED
		245537	B. WING		12/08/2016
NAME OF F	PROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
MINNEW	ASKA COMMUNITY	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 280	Continued From pa	age 11	F 280		
	care plan correctly LPN-C entered the worn during the da	for it was not added to R43's She stated on 11/30/16, order for R43's boots to be y, and on the same day, UM-B R43 was to wear the pressure			
	(DON) confirmed F the boot during the R43's care plan ha to apply the pressu The DON stated sl	86 p.m. the director of nurses R43's physician order to wear daytime hours and verified d been changed to direct staff ire reducing boot at night only. he expected the care plan to be he accurate physicians order.			
F 282 SS=D	care plans would b dictated.	sive dated 10/22/16, identified e revised as resident condition RVICES BY QUALIFIED	F 282		1/10/17
		sive Care Plans ded or arranged by the facility, comprehensive care plan,			
	accordance with eacare.	qualified persons in ach resident's written plan of NT is not met as evidenced			
	Based on observa review, the facility repositioning assis	tion, interview and document failed to provide turning and tance as directed by the plan for 2 of 3 residents (R40,		The care plans of residents R40, R18 and R13 have been reviewed to ensu that the Care Plan continue to accura reflect the resident's current status.	re

Facility ID: 00477

If continuation sheet Page 12 of 47

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		E SURVEY PLETED
		245537	B. WING _			12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICES			95 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 282	Continued From pa	age 12	F 28	32			
	R13) who required In addition, the faci assistance for 1 of staff assistance for Findings include: R40 was not reposid directed by the care R40's care plan up was at risk for skin wound near rectum protruding colostom infection and direct repositioning every R40's hospice care indicated R40 had a buttocks due to an provide routine turn The A/B wing Turni worksheet dated 12 repositioned at 4:30 residents were to b every two hours, wh On 12/07/16, from continuous observat following: -At 5:25 p.m. R40 his left side. An air in place on R40's b left side without rep 7:35 p.m. at which (DON) was notified	assistance with repositioning. lity failed to provide grooming 1 resident (R18) who required the removal of facial hair. itioned every two hours as e plan. dated 11/16/16, indicated R40 breakdown due to chronic a, end stage metastatic cancer, ny, pain and peri-rectal ed staff to encourage two hours and as needed. e plan dated 10/25/16, an open area on the right abscess and directed staff to ning and Repositioning 2/7/16, revealed R40 was last 0 p.m. and indicated all e repositioned a minimum of hich included R40. 5:25 p.m. to 7:35 p.m., ations of R40 revealed the was observed lying in bed, on pressure mattress overlay was ed. R40 remained in bed, on positioning assistance until time the director of nursing			All residents who require assistance grooming and who are at risk for pre- ulcer development or who currently is pressure ulcers have had their care reviewed for appropriate pressure ul- interventions and for providing groom assistance, with revisions if indicated The Nursing Assistant's T&R sheets been revised and updated if indicate ensure that the necessary care interventions, including pressure ulco- interventions and assistance with grooming interventions are commun- to the nursing assistants. By January 10, 2017, nursing staff we educated regarding care plans, inclu- pressure ulcer interventions and gro assistance, the communication syste between staff, and expectations to for the care plan and care guides provid The Director of Nursing or designee conduct daily audits on all shifts for of week; then daily audits alternating sh for one week; then three times per we alternating shift through the quarter ending February 28th, 2017. Resulta audits will be presented to QA in Mat 2017 for review. Correction date: 1/10/2017	essure have plan lcer ming d. have ed to er nicated vill be uding ooming em ollow ded. will one hifts veek s of	

If continuation sheet Page 13 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/0	08/2016
NAME OF PROVIDER O	R SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEWASKA COI	MMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
and 10 m and the T indicated p.m. At t risk for s from staf DON and turn/repo- approxim grey drai brief. R4 with mois The DON repositio repositio On 12/0 required hour. On 12/7/ required and as n three hou assistant expectat hours, as R13 was directed R13's ca at risk fo encourag as neede During co 11:34 a.r R13 was	Furning and I R40 had I that time the kin breakd if with report d nursing a position R40 mately 3-4 i nage from 40's buttool sture surro N provided ned R40 of ned R40 of ned for thre 7/2016, at assistance 16 at 7:47 repositioni eeded. The urs and five ce and state ion R40 works directed. not repositioni by the care re plan data r pressure gement to performed at 2:59 performed to 2:59 per	nout repositioning assistance d Repositioning worksheet ast been repositioned at 4:30 ne DON confirmed R40 was at own and required assistance sitioning every two hours. The ssistant (NA)-I proceeded to . R40 was noted to have nches of moderate amount of the rectal abscess on the ks had deep, light pink creases unding the peri-rectal area. incontinent cares and ff of the left side. R40 was not are hours and five minutes. 5:20 p.m. NA-A stated R40 e of repositioning every one p.m. the DON verified R40 ng assistance every two hours e DON confirmed R40 went e minutes without repositioning red it was stated it was her build be repositioned every two tioned every two hours as e plan. ted 11/1/16, indicated R13 was ulcers and required reposition every two hours and p.m. (3 hours and 29 minutes) seated in a wheelchair without	F 2	282			

If continuation sheet Page 14 of 47

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· ,	IPLE CONSTRU		(X3) D	O. 0938-039 ATE SURVEY OMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDIN	NG					
		245537	B. WING _				2/08/2016		
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP	CODE			
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES			TREET,  PO BOX 40 K, MN  56381				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CC CH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 282	Continued From pa	age 14	F 28	32					
		was observed seated in her							
	wheel chair in the c	•							
		began to propel herself from A-D assisted to propel her to a							
	table in the assiste	d dining room. R13 remained							
		Ichair throughout the meal							
		n. at which time NA-C wheeled IA-C handed R13 a newspaper							
	and left the room.	IA-C handed K15 a hewspaper							
		ained seated in the wheelchair,							
		mained seated until 1:13 p.m. propelled self out of her room,							
		and into another resident's							
	room. An activity ai	d intervened and propelled							
		om. The activity aid offered to							
		er to R13, but was declined.							
		I and continued down the hall.							
		ted in the wheelchair, in her							
		a. at which time LPN-D entered fered to take R13 to activities.							
		LPN-D wheeled R13 to the							
	main dining room.								
		emained seated in the							
	remained there unt	ing room table and had il 2:33 p m							
		was in the chapel for an							
		ned seated in the wheelchair							
	without repositionin	ig assistance.							
		p.m. NA-G stated the last time							
	-	but of the wheelchair was at							
		ne was assisted to the not been repositioned since							
		nfirmed unawareness of R13's							
		and repositioned and stated							
		b be repositioned every two ed R13 had not been assisted							
	Induis. INA-O Vellin		1	1			1		

If continuation sheet Page 15 of 47

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COM	IPLETED
		245537	B. WING			12/	08/2016
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION DATE
F 282	Continued From pa	ige 15	F 28	82			
		p.m. the nurse manager					
	(NM)-A confirmed F every two hours.	R13 was to be repositioned					
	-At 2:59 p.m. NM-A	assisted R13 into the					
	-	ottom was noted to have es and the skin between her					
		thighs were a darker pink in					
		5:16 p.m. LPN-D verified the					
	reposition R13 ever	are sheet directed staff to ry two hours.					
	had expected staff	7:48 p.m. the DON stated she to follow R13's care plan and ry two hours, as directed					
	R18 was not provid directed by the care	led with facial hair removal as e plan.					
		ted 10/27/16, indicated R18					
	•	assist of two staff for grooming o report any changes in vilities.					
	seated a wheelchai	a.m. R18 was observed ir, in her room. R18 was noted					
	center of her chin a	ng, white facial hairs in the and next to the right side of her as asked if the long facial hair eplied, "yes."					
	bed and continued	p.m. R18 was observed in to have the long facial hair nately one inch in length.					

If continuation sheet Page 16 of 47

PRINTED: 01/03/2017

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	On 12/7/16, at 2:23 have long facial hai progress notes, R18 shower on Mondays On 12/7/16, at 1:56 shaving was comple basis, by the nursin hair was noticed on would remove it. On 12/7/16, at 2:01 had long, white faci her lip and verified a staff for grooming in LPN-A stated R18's the past month and purchase another of provide razors for re On 12/7/16, at 2:15 shave R18 1-2 time morning cares. How not offered nor prov R18 when she assis confirmed R18 curr razor, and pulled the drawer. NA-D confi white facial hairs or which needed remo On 12/7/16, at 2:51 reported R18 has a in her room becaus stated she just wen her face, and confir	<ul> <li>p.m. R18 was again noted to r. During review R18's</li> <li>8 was identified to have her s of each week.</li> <li>p.m. NA-C stated resident eted for all residents on a daily g assistants and if any facial bathing day, the bath aid</li> <li>p.m. LPN-A confirmed R18 al hair on her chin and next to she was totally dependent on needs which included shaving. I shaver had been missing for family was requested to one as the facility did not esidents.</li> <li>p.m. NA-D stated staff tried to es per week when providing wever, NA-D stated she had vided shaving assistance for sted her up on 12/7/16. NA-D rently did have a functioning e razor out of R18's top firmed R18 had multiple long, n the chin and next to the lip oving.</li> <li>p.m., family member (FM)-A liways had a functioning razor se she bought it for her. FM-A t into R18's room and shaved med the facial hair was long</li> </ul>	F 2	282	DEFICIENCY)		
		med the facial hair was long ld want those hairs on their					

Facility ID: 00477

If continuation sheet Page 17 of 47

					NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		245537	B. WING		12/08/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
F 282		p.m. the DON stated she ovide grooming assistance as	F 282	2	
F 312 SS=D	daily care and docu with the resident's of 483.24(a)(2) ADL C	ive revised 10/22/16 revealed imentation must be consistent care plan. CARE PROVIDED FOR	F 312	2	1/10/17
	activities of daily liv services to maintain personal and oral h This REQUIREMEN by: Based on observat review the facility fa services related to	NT is not met as evidenced tion, interview and document liled to provide grooming the removal of facial hair for 1 observed to have long facial		The Plan of Care for resident R18 was reviewed to ensure that the care Plan continues to accurately reflect the resident's current status and updated i needed. All current and future residents requirin	f
	10/21/16, indicated cognition and requi staff for completing shaving. R18's Activities of I Assessment (CAA) required total to ext	num Data Set (MDS) dated R18 had moderate impaired red extensive assist of two personal hygiene including Daily Living Care Area dated 10/28/16, indicated R18 rensive assistance of two staff / living due to left sided		assistance with grooming services have been reviewed and will be provided assistance as specified per their care plans. The nursing assistance T&R sheets have been reviewed and updat indicated to ensure that the necessary care interventions including personal needs and grooming services are communicated to the nursing assistan By January 10, 2017, nursing staff will educated regarding following resident's care plans, including providing assistan to the residents who are unable to care out activities of daily living independen	ed if ts. be s nce Ty

Facility ID: 00477

If continuation sheet Page 18 of 47

STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY PLETED
		DENTIFICATION NOWDER.	A. BUILDIN	G		
		245537	B. WING		•	08/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES		605 MAIN STREET, PO BOX 4 STARBUCK, MN 56381	D	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 312	Continued From pa	age 18	F 31	2		
		roke and a traumatic brain	The Director of Nursing or designed conduct daily audits on all shifts for week; then daily audits alternating s		all shifts for one	
	required extensive	ted 10/27/16, indicated R18 assist of two staff for grooming o report any changes in pilities.		for one week; then thre alternating shift through ending February 28th, 2 audits will be presented	e times per week the quarter 2017. Results of to QA in March,	
	her room, seated in to have several lon center of her chin a	a.m. R18 was observed in a wheelchair. R18 was noted g, white facial hairs in the and next to the right side of her as asked if the long facial hair replied, "yes."		2017 for review. Result presented to QA in Mar Correction date: 1/10/2	ch 2017 for review.	
	bed and continued	b p.m. R18 was observed in to have the long facial hair mately one inch in length.				
	have long facial ha	8 p.m. R18 was again noted to ir. During review R18's 8 was identified to have her rs of each week.				
	stated shaving was a daily basis by the to provide care to t	© p.m. nursing assistant (NA)-C completed for all residents on nursing assistants assigned he resident. NA-C stated if noticed on bath day, she				
	(LPN)-A confirmed staff for grooming, R18's shaver had b month. LPN-A stat to purchase anothe not provide razors	I p.m. licensed practical nurse R18 was totally dependent on including shaving and stated been missing for the past red R18's family was requested or one because the facility did for the residents. LPN-A I long, white facial hair on her				

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	· /	E SURVEY PLETED
		245537	B. WING			12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	qe 19	F 3	12			
	•	r lip which needed to be					
	needed extensive a shaving and stated times per week. N/ residents when they NA-D verified she h cares on 12/7/16, a provided shaving ca shave R18 through currently did have a proceeded to pull th drawer. NA-D conf white facial hairs or which needed to be On 12/7/16, at 2:51 stated R18 had alw her room because a stated she had just	p.m. family member (FM)-A ays had a functioning razor in she bought it for her. FM-A went into R18's room and					
		nd confirmed the facial hair male would want those hairs					
	(DON) verified R18 grooming needs wh	p.m. the director of nursing was depended on staff for hich included shaving and d staff to provide shaving cares.					
F 314 SS=D	requested, but not p 483.25(b)(1) TREA		F 3	14			1/10/17
	(b) Skin Integrity -						

If continuation sheet Page 20 of 47

		AND HUMAN SERVICES			PRINTED: FORM A OMB NO. (	PPROVED	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         245537		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		B. WING_		12/08/2016			
NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381			
(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 314	Continued From pa	ige 20	F 31	14			
	(1) Pressure ulcers comprehensive ass facility must ensure	sessment of a resident, the					
	professional standa pressure ulcers and ulcers unless the in	ves care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and					
	necessary treatmen professional standa healing, prevent inf from developing.	oressure ulcers receives of and services, consistent with ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced					
	by: Based on observat review, the facility f prescribed order for reducing boot and/or repositioning assist prevent a pressure worsening of a curr residents (R43, R1 risk for pressure ullo pressure ulcer and the pressure reduc	tion, interview and document ailed to follow a physician r the use of a pressure or provide turning and cance in order to heal and/or related ulcer and/or the rent pressure ulcer for 2 of 3 3, R40) reviewed who were at cers and/or the worsening of a observed not to be wearing ing boot as prescribed and/or oned timely, as directed by the		The care plans for residents R and R40 have been reviewed i of pressure ulcer treatment and prevention with revisions made indicated. Other residents who have been to be at risk for pressure ulcer development per use of Brade have had their care plans revier regarding pressure ulcer treatm prevention with changes made indicated.	n that area d e if n assessed n Scale, ewed nent and/or		
	individualized care Findings include:			The nursing assistant T&R she been reviewed and updated to necessary care interventions; i pressure ulcer treatment and p	ensure that ncluding		
	as prescribed by th			are communicated to the nursi assistants. By January 10, 20 staff will be educated regardin	ng 17, nursing g pressure		
		hange Minimum Data Set /16, indicated R43 had severe		ulcer treatment and prevention expectations to follow the care			

Facility ID: 00477

If continuation sheet Page 21 of 47

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         245537		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED		
		245527	B. WING	NG _		40/00/0040	
		245537	B. WING_	01	TREET ADDRESS, CITY, STATE, ZIP CODE	12/0	08/2016
NAME OF PROVIDER OR SUPPLIER			605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLETIO	
F 314	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 31	14	care guides (T&R Sheet). Also, the expectation that all staff will follow physician orders for use of pressur- reduction/prevention and provide tu and repositioning assistance in ord- heal or prevent the development of pressure related ulcers. The Director of Nursing or designed conduct daily audits on all shifts for week; then daily audits alternating s for one week; then three times per alternating shift through the quarter ending February 28th, 2017. Resu audits will be presented to QA in Ma 2017 for review. Results of audits of presented to QA in March 2017 for Correction date: 1/10/2017	e ulcer irning er to e will one shifts week t its of arch, will be	

Facility ID: 00477

If continuation sheet Page 22 of 47

		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		TE SURVEY
		IDENTIFICATION NUMBER:		NG	COMPLETED	
		245537	B. WING _		12	/08/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ULD BE	(X5) COMPLETIO DATE
F 314	Continued From page 22 left inner heel. Blister was bluish/purple and appeared fluid filled. The center of blister appears darker. Physicians response was to continue current cover left metatarsal. -11/21/16, 4.0 cm X 2.5 cm left heel deep blue/purple tissue from wheelchair pedal has not resolved with betadine swabbing. Physician response was to continue to pad and protect. R43's Braden Scale (assessment for pressure ulcer risk) dated 10/19/16, indicated R43 was at risk for developing pressure ulcers, had very limited ability to respond to pressure or discomfort, and was very limited in her ability to change or correct body position. The assessment also indicated R43 had a pressure reducing device in her chair, no referrals were needed and staff were to continue with current care plan. R43's Activities of Daily Living Care Area Assessment (CAA) dated 10/24/16, indicated R43 had progressive Alzheimer's disease and required extensive assistance with ADLs. The CAA further indicated R43 was at risk for developing pressure ulcers, staff were to monitor R43's skin daily and notify the physician with any significant changes, staff were to follow the facility ' s wound protocol and to continue with the current care plan. The CAA failed to address R43's blister which		F 3 <sup>-</sup>			
	developed in the fa On 2/07/16, at 11:3 her room, seated ir sheep skin which c wheelchair, a black the wheelchair, had low, half back acros wearing a pressure					

Facility ID: 00477

If continuation sheet Page 23 of 47

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		CON	IPLETED	
		245537	B. WING			12/	/08/2016	
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ION SHOULD BE COMP HE APPROPRIATE D				
F 314	Continued From pa	age 23	F 31	14				
		boot was not observed in her						
	room.							
		ing assistant (NA-D) entered formed R43 it was time for						
		ed to remove the call light from						
	-	heel her out of her room into						
	hallway. -At 12:01 n m R43	was seated in her wheelchair						
		at a table. R43 was having a						
	hard time keeping							
		F physically assisted R43 with dozed on and off during						
	feeding.							
	-At 12:40 p.m. follo	wing completion of the meal,						
		into her room and positioned R43's left foot was off the foot						
	rest, and rested on							
	-At 12:59 p.m. NA-	D and NA-E entered R43's						
		inical lift and closed the door.						
		was observed in bed on her eel on top of a flattened pillow.						
		cks and was not wearing a						
		boot on her left foot. A						
	room.	boot were not observed in her						
		t 2:02 p.m. R43 was observed						
	to remain in bed, o	n her back with her left heel						
		illow. The sock remained on ucing boot was not in place						
	nor in her room.	ucing boot was not in place						
		remained positioned in bed on						
		eft heel under a flattened						
	pillow. -At 2:40 p.m. R43 v	was observed in the dining						
	room, seated in he	r wheelchair. R43 was not						
		e reducing boot to her left foot,						
	and wore her gray -At 3:29 p.m. R43	half-back shoes. was seated in her wheelchair in						
		spouse and was not wearing						

If continuation sheet Page 24 of 47

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	· ,		(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245537	B. WING		12/08/2010		
NAME OF	PROVIDER OR SUPPLIER		<u>ا</u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
MINNEW	ASKA COMMUNITY	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 314	her pressure reduc wore her gray half- -At 3:44 p.m. R43 y Manager (UM-A) a wearing a pressure R43's left inner hee which revealed the -0.5 cm x 0.4 cm re and broken down -0.3 cm x 0.2 cm re and open -0.2 cm hard black On 12/07/16, at 2:7 required extensive could not commun not sure what shoe wore a protective b were to be floated On 12/07/16, at 2:2	back shoes. was in her room with Unit and spouse. R43 was not reducing boot to her left foot. was observed with Um-A following heel wounds: reddened area which was soft	F 314				
	stated R43 had a b silver dollar on her R43 developed the staff had not kept h was not reposition staff tried to reposi also elevate her fe thought R43 wore and not during the to wear socks whe On 12/07/16, at 2:2 (LPN)-A stated R43 had a huge blood b she thought was a	absistance with ADLS. She black, hard blister the size of a left heel. She stated she felt blister to her left heel because her feet elevated enough and ed all the time. NA-D stated tion R43 every two hours and et with a pillow or two and a boot on her left foot at night day. NA-D stated R43 was not n she had the boot on. 26 p.m. licensed practical nurse 3 required total care from staff, blister on her left heel which pressure related ulcer. She t the blister was caused from					

If continuation sheet Page 25 of 47

S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		(X3) DAT	<u>. 0938-039</u> E SURVEY
CORRECTION	IDENTIFICATION NUMBER:			CON	IPLETED
	245537	B. WING		12/	08/2016
ROVIDER OR SUPPLIER					
SKA COMMUNITY I	HEALTH SERVICES		•		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETIO DATE
not put her shoes of friction. LPN-A state protected by makin shoes on correctly, have not full backs had on the same slithe pressure ulcer stated staff were to pillow boot when slithe had an alternating repositioned and cl R43 should have h and would go chec -At 2:40 p.m. LPN-/ learned R43 was to the night, and not of understood the cor schedule because correctly on R43's of 11/30/16, LPN-C ha boots to be worn du UM-B changed the wear boots at night progress notes ass order for R43's pro was bizarre. " In ac pressure reducing applied on 10/21/16 original order for th On 12/7/16, at 3:29 stated R43 had wo	on all the way which caused ed R43's heel was to be g sure staff were putting her because R43's shoes did not on them, and confirmed R43 hoes as when she developed to her left heel. LPN-A also of loat 43's heels and apply a ne was in bed. She stated R43 air mattress and was eansed properly. LPN-A stated ad her boots on at this time k to see if she had them on. A returned and stated she had o wear the pillow boots during furing the day. She stated she fusion with R43's boot the order was not documented care plan. LPN-A stated on ad entered the order for R43's uring the day, and on 11/30/16, care plan to read R43 was to the LPN-A verified there were no sociated with the physician tective boot and stated " it ddition, LPN-A stated R43's boot was applied originally 6, but she could not find the e boot dated 10/21/16.		4		
	CORRECTION ROVIDER OR SUPPLIER ASKA COMMUNITY I SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From particular not put her shoes of friction. LPN-A state protected by making shoes on correctly, have not full backs had on the same si the pressure ulcer stated staff were to pillow boot when si had an alternating si repositioned and cl R43 should have h and would go chec -At 2:40 p.m. LPN- learned R43 was to the night, and not co understood the cor schedule because correctly on R43's of 11/30/16, LPN-C ha boots to be worn di UM-B changed the wear boots at night progress notes ass order for R43's pro was bizarre. " In ac pressure reducing applied on 10/21/10 original order for th On 12/7/16, at 3:29 stated R43 had wo day until yesterday	CORRECTION       IDENTIFICATION NUMBER:         245537         ROVIDER OR SUPPLIER         SKA COMMUNITY HEALTH SERVICES         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25 not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleansed properly. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on.         -At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the confusion with R43's boot schedule because the order was not documented correctly on R43's care plan. LPN-A stated on 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A verified there were no progress notes associated with the physician order for R43's protective boot and stated " it was bizarre." In addition, LPN-A stated R43's pressure reducing boot was applied originally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16.         On 12/7/16, at 3:29 p.m. family member (FM)-B stated R43 had worn the protective boot every day until yesterday as her understood the scab	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245537       B. WING         ROVIDER OR SUPPLIER       SKA COMMUNITY HEALTH SERVICES         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 25 not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleansed properly. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on.         -At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the confusion with R43's boot schedule because the order was not documented correctly on R43's care plan. LPN-A stated on 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A verified there were no progress notes associated with the physician order for R43's protective boot and stated " it was bizarre." In addition, LPN-A stated R43's pressure reducing boot was applied originally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16.         On 12/7/16, at 3:29 p.m. family member (FM)-B stated R43 had worn the protective boot every <td>CORRECTION       IDENTIFICATION NUMBER:       A BUILDING         245537       B. WING         ROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         SKA COMMUNITY HEALTH SERVICES       STREET, PO BOX 40         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 25       ID         not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleaneed proofy. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on.         -At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated no 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated R43's pressure reducing boot was applied or igninally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16.</td> <td>CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COW         245537       B. WING      </td>	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING         245537       B. WING         ROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         SKA COMMUNITY HEALTH SERVICES       STREET, PO BOX 40         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 25       ID         not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleaneed proofy. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on.         -At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated no 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A stated R43's pressure reducing boot was applied or igninally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16.	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COW         245537       B. WING

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	FM-B stated he tho	ught the blister was caused by	F 3	314			
	stated the current p	ds on her wheelchair. FM-B pressure ulcer interventions for adine swabs and wearing the					
	(DON) stated once they determined it v from her wheelchait they had removed t protective boot to R all day and night. T	6 p.m. the director of nurses R43's blister was identified, was caused from pressure r foot pedal bars. She stated the bars and applied a R43 's left foot which she wore The DON stated her and UM-B wearing the boot during the					
	day and both felt it y 11/30/16, UM-B had boot to night time us expected the physic followed as written care plan. She stat	was a dignity issue so on d changed the schedule of the se only. The DON stated she cian order to be accurate and and for the order to match the ted she expected the care plan <i>v</i> ised to reflect the actual					
	R43 was at risk for and verified R43 ' s progress notes rela	0 p.m. The DON confirmed developing pressure ulcers medical record lacked any ited to the use of the protective inable to find the original or the boot.					
		pressure related ulcers and mely repositioning, as directed.					
	R40 was cognitively which included mali	DS dated 10/31/16, indicated y intact and had diagnoses ignant neoplasm of colon and s and pain. The MDS					

Facility ID: 00477

If continuation sheet Page 27 of 47

STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245537	B. WING _		12	/08/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2010	
MINNEW	ASKA COMMUNITY	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 314	indicated R40 was required supervision with one staff assist transferring. The M pressure ulcer prevent (CAA) dated 11/10/ abscess near his re- which put him at rise The Minnewaska L Condition form date an open area on rig- identify any pressur- put into place. R40's Braden Scall R40 was at risk of R40's care plan da was at risk for skin wound near recturn end stage metastar colostomy, pain an care plan directed a repositioning every R40's hospice care indicated R40 had buttocks due to an had been put in plat turning and reposit The A/B wing Turnit worksheet dated 12 last repositioned at all the residents we	at risk for pressure ulcers and on, cueing and oversight along stance for bed mobility and MDS did not identify any vention interventions in place. cer Care Area Assessment /16, indicated R40 had an open ectum with wound drainage sk for skin breakdown. utheran Home Admission Skin ed 10/1/16, revealed R40 had ght buttocks. The form did not re ulcer interventions had been e dated 10/31/16, indicated skin breakdown. ted 11/16/16, indicated R40 breakdown due to chronic in that had purulent drainage, tic cancer, protruding d peri-rectal infection. R40's staff to encourage two hours and as needed. e plan dated 10/25/16, an open area on the right abscess. Various interventions ace which included routine	F 31				

If continuation sheet Page 28 of 47

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<del>.                                    </del>		OI		0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY PLETED
		245537	B. WING			12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ASKA COMMUNITY H	IFAI TH SERVICES			5 MAIN STREET, PO BOX 40		
				S	TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 28	F 3 <sup>-</sup>	14			
	bed lying on his left was observed on hi observation of R40 which R40 remaine without repositionin -At 7:35 p.m. the Du remained lying in be and 10 minutes. Th risk for skin breakd from staff to turn ar The DON and NA-I incontinent cares an incontinent brief wa wound was noted to in diameter of gray buttocks had deep, moistness surround DON and NA-I prod cares and repositio R40 had remained of 3 hours and 5 mi wing Turning and R 12/7/16, R40 was n three hours and five On 12/7/2016, at 5 required assistance hour. On 12/7/16 at 7:47 aforementioned obs required turning and every two hours, an verified according to Repositioning work repositioned at 4:30	continued until 7:35 p.m. in ed in bed on his left side g. ON was notified R40 had ed for an observed two hours he DON confirmed R40 was at own and required assistance nd reposition every two hours. proceeded to assist R40 with nd repositioning. When R40 's is removed, R40 's rectal o have approximately 3-4 inch drainage on the brief. R40's light pink creases with ding the peri-rectal area. The ceeded to complete perineal ned R40 off of his left side. in the same position for a total inutes. According to the A/B Repositioning worksheet dated not turned and repositioned for					

If continuation sheet Page 29 of 47

PRINTED: 01/03/2017

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	01/03/2017 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245537	B. WING			12/(	08/2016
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEWASKA COMMUNITY HE	EALTH SERVICES			05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>with R40's hospice reverified R40 was at hand stated R40 required would expect R40 to every two hours.</li> <li>R13 was identified at every two hour turning provided as directed R13's Physician Order identified R13's diagonalise ase, dementia and disease, dementia and disease, (a blood circor R13's quarterly MDS R13 was at risk for pressist of one staff for and utilized a wheeled reducing device.</li> <li>R13's Braden Scale at Risk, dated 10/24/16 occasionally moist, Fin bed or chair, had stated adequately, and had friction and shear. That risk for pressure states for pr</li></ul>	ed. during phone interview egistered nurse (RN)-D high risk for skin breakdown ired good perineal cares and be repositioned at least t risk for pressure ulcers and ng and repositioning was not by the care plan. er Report dated 10/19/16, noses included Parkinson's nd peripheral vascular culation disorder). 6 dated 10/25/16, indicated pressure, required extensive r bed mobility and transfers chair cushion pressure for Predicting Pressure Sore 6, indicated R13's skin was R13 spent most of each shift slightly limited mobility, ate a potential problem with he Braden indicated R13 was sores, had a pressure her chair and the current care	F3	314			

	COF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULT		E CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ` <i>´</i>				PLETED	
		245537	B. WING_	G		12/08/2016		
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MINNEW	ASKA COMMUNITY	HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 314	Continued From pa	age 30	F 3 <sup>,</sup>	14				
	• · · · · · · · · · · · · · · · · · · ·	Daily Living Care Area	10	1-1				
		2/2/16, indicated R13 was at						
	risk for skin break	down and every two hour, and						
		ioning interventions were in						
	place.							
	R13's care plan rev	vised 11/1/16, indicated R13						
	was at risk for pres	ssure ulcers and required						
		reposition every two hours and						
	as needed.							
	During observation	on 12/07/16, from 11:34 a.m.						
		irs and 29 minutes) R13 was						
		a wheelchair without having						
	been repositioned.							
	seated in her whee	was observed in the chapel,						
		3 began to propel herself in the						
	wheelchair from the	e chapel when NA-D walked						
		heelchair and propelled her to						
		e. R13 remained in the dining						
		e wheelchair until 12:37 p.m. at wheeled R13 to her room,						
		spaper and exited the room.						
		was observed seated in her						
	wheelchair, in her I							
	· ·	remained in the wheelchair,						
	asleep. -At 1·10 p.m. B13 t	turned the wheel chair towards						
	the window and sa							
	-At 1:13 p.m. R13	propelled herself out of the						
	, ,	all and into another resident's						
		id intervened and wheeled R13 The activity aid offered to read						
		R13, but was declined.						
		S stepped into the doorway of						
	R13's room, turned	and continued down the hall.						
		remained seated in the						
	wheelchair in her re	oom. Two nursing assistants						

If continuation sheet Page 31 of 47

	OF DEFICIENCIES F CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
ND PLAN U		IDENTIFICATION NUMBER:	A. BUILDIN	1G			IVIPLE I ED
		245537	B. WING			12	/08/2016
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET, PO BOX 40		
MINNEW	ASKA COMMUNITY	HEALTH SERVICES		605 I STA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 31	F 31	14			
		student nurse were in the					
	room next door wit						
	-At 1:52 p.m. R13 r wheelchair in her re	remained seated in the					
		D entered R13's room and					
		13 to activities. R13 accepted					
		d R13 to the main dining room					
		d repositioning assistance.					
		remained seated in the ing room table with four other					
		nk from a covered mug with a					
	straw and ate a de						
	-At 2:33 p.m. R13 r from the covered n	remained at the table drinking					
		as in the chapel for an activity.					
		ed in the wheelchair.					
		p.m. NA-G stated nursing					
		a book at the nurse station to ares were provided for a					
		at time. The form was titled A/B					
		Repositioning Worksheet which					
		NA-G stated the oncoming					
		e last times care was provided or each resident on to a new					
		ned night staff had written 4:00					
	a.m. for R13. Howe	ever, NA-G stated she was					
		ares night staff had provided					
		nd verified it could have been ting to visual checking on her.					
		e following was also					
	documented on the	e form by the day shift staff:					
		as assisted up from bed.					
		was assisted to the toilet.					
	At 1:00 p.m. check						
	NA-G verified R13	had not been repositioned for					
	greater than four he of R13 's turning a	ours. NA-G was also unaware					

If continuation sheet Page 32 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245537	B. WING	i		12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	stated R13 was not	to be repositioned every two	F३	314			
		ke that. p.m. shift change was 3 wing nurses station.					
	On 12/7/16, at 2:38 visually checked on have a repositioning repositioned when t not toileted R13 this Repositioning Work	p.m. NA-H stated R13 was every half hour R13 did not g schedule but would be toileted. NA-H verified she had s afternoon and the Turing and ksheet identified R13 was last m. which was four and a half					
	(NM)-A verified R13 two hours and experience reviewed the Turnin verified there was in having been reposit repositioning. At 2:5 into the bathroom at the use of a gait be the bathroom wall. I have wrinkles and of her buttocks and ini- color. NM-A indicate diligent with repositi- because of her rece able to stand indepo-	59 p.m. NM-A assisted R13 and assisted R13 to stand with It and assistive bars bolted to R13's bottom was noted to creases and the skin between ner thighs were dark pink in ed she would direct staff to be ioning R13 every two hours ent decline and was no longer					
	had a recent decline ability, was at risk for required repositioni verified the nursing	e in physical and mental or pressure ulcers and ng every two hours. LPN-D assistant care sheet directed 13 every two hours.					

Facility ID: 00477

If continuation sheet Page 33 of 47

		AND HUMAN SERVICES				FORM	: 01/03/2017 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245537	B. WING			12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	On 12/07/2016, at had expected staff hours according to assessment and ca The facility Prevent reviewed 12/3/15, in ulcers were usually remained in the sar period of time caus decrease of circular which destroyed the preventive actions f changing positions foam, gel, or air cus The facility Skin Ca indicated residents would receive the re- sores from develop The facility Turning policy reviewed 3/3, was to provide com skin irritation and bi good body alignment	7:48 p.m. the DON stated she to reposition R13 every two the tissue tolerance are plan. ion of Pressure Ulcers policy indicated pressure related formed when a resident me position for an extended ing increased pressure or a tion (blood flow) to that area, e tissues. Risk factors and for a person in a chair included every two hours and use a shion to relieve pressure. re policy dated 12/3/16, who had pressure sores ecommended treatment and e healing and prevent new ing. a Resident on his/her Side /2000, indicated the purpose fort to the resident, to prevent reakdown and to promote	F 3	:14			
F 431 SS=D	revised 10/22/16, ir documentation mus resident's care plan 483.45(b)(2)(3)(g)(h	ndicated daily care and st be consistent with the	F 4	.31			1/10/17
	The facility must pr	ovide routine and emergency					

If continuation sheet Page 34 of 47

STATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·		E CONSTRUCTION		E SURVEY IPLETED
		245537	B. WING			40	00/0040
NAME OF	PROVIDER OR SUPPLIER	240001			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2016
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		6	05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 431	drugs and biologica them under an agre §483.70(g) of this p unlicensed personn law permits, but onl supervision of a lice (a) Procedures. A f pharmaceutical ser that assure the acc dispensing, and add biologicals) to meet (b) Service Consult employ or obtain th pharmacist who (2) Establishes a sy disposition of all con- detail to enable an a (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance w the facility must sto locked compartmer	Is to its residents, or obtain eement described in art. The facility may permit iel to administer drugs if State y under the general ensed nurse. Facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed vstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and t drug records are in order and all controlled drugs is iodically reconciled. gs and Biologicals. als used in the facility must be ice with currently accepted ides, and include the ory and cautionary e expiration date when	F 4	131			

If continuation sheet Page 35 of 47

CENTEI STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB	FORM APPROVE <u>OMB NO. 0938-039</u> (X3) DATE SURVEY COMPLETED		
		245537	B. WING	i		12/08/2016		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/00/2010		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIO DATE		
F 431	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected This REQUIREMEN by: Based on observat review, the facility fit controlled substand destruction for 1 of utilized Fentanyl pa potential to affect a the facility. Findings include: On 12/8/16, at 9:43 of the A-B wing men bound narcotic (men likelihood of abuse) observed unsecure Fentanyl narcotic pa inside the front covar registered nurse (R R39's used Fentany on 12/8/16, at 6:30 R39's new Fentany placed the used pa staff member was a destruction of it. R book and Fentanyl	keys. t provide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can		431	All facility medication carts and medication rooms were immediately audited for proper medication storage, labeling, and record keeping. Storage controlled substances was reviewed at small containers that fit into the locked box on the Med Cart were provided for holding narcotic patches once removed from the resident until a licensed staff member is available to witness destruction. The facility policy on Controlled Substances Containing Transdermal Delivery System was reviewed and is current. By January 10, 2017, licensed nursing staff and TMA's will attend an in-servic which will address the use and storage controlled substances. The Director of Nursing or designee wi conduct audits weekly for one month th monthly through the quarter. Results of audits will be presented to QA in March 2017. Correction date: 1/10/2017	e e of Ill nen of		

Facility ID: 00477

If continuation sheet Page 36 of 47

PRINTED: 01/03/2017 FORM APPROVED

						). 0938-039			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION		TE SURVEY MPLETED			
		245537	B. WING		12	2/08/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE				
MINNEW	ASKA COMMUNITY	HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE			
F 431	stated the narcotic locked compartme and the facility's cu Fentanyl patches w R39's individual na indicated a new Fe (mcg) was applied On 12/8/16, at 9:48 observed to dispos into the sewer, both record. On 12/8/16, at 10:3 (DON) stated the n patch into the narco witness was availa confirmed the narco witness was availa confirmed the narco medication cart's d was placed unsecu cart which was the storage of used Fe destruction. The D medication remain patches. The facility's Contro Transdermal Delive policy dated 8/6/15 substances must b in a locked contain for any non-control locked medication container must rem when it is accessed residents. Used Fe	age 36 book did not fit into the double nt inside the medication cart irrent process of storing used vas not the perfect system. rcotic record, page 91, intanyl patch 75 micrograms on 12/8/16, at 6:30 a.m. 8 a.m. RN-A and RN-B were se of the used Fentanyl patch in nurses signed R39's narcotic 80 a.m. the director of nursing nurse tucked the used Fentanyl otic book for storage until a ble for destruction. The DON otic book did not fit into the ouble locked compartment and ured on top of the medication facility's usual practice for intanyl patches until OON acknowledged controlled ed in the used Fentanyl oiled Substances Containing ery System (i.e.: fentanyl) , indicated all controlled be stored in the medication cart er, separate from containers led medications or in the room in a locked cabinet. This nain locked at all times, except d to obtain medications for entanyl patches must be iopper in the utility room and be	F 4	31					

Facility ID: 00477

If continuation sheet Page 37 of 47

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	LE CONSTRUCTION		) <u>. 0938-039</u> TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:				MPLETED
		245537	B. WING		12	/08/2016
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	ge 37	F 431			
		in the narcotic record.				
F 441 SS=D		e)(f) INFECTION CONTROL, D, LINENS	F 441			1/10/17
	(a) Infection preven	tion and control program.				
		tablish an infection prevention n (IPCP) that must include, at owing elements:				
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	l upon the facility assessment ig to §483.70(e) and following tandards (facility assessment				
		ds, policies, and procedures hich must include, but are not				
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the				
		om possible incidents of ase or infections should be				
		ansmission-based precautions event spread of infections;				
	(iv) When and how resident; including I	isolation should be used for a				

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245537	B. WING			12/0	08/2016	
	PROVIDER OR SUPPLIER	HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	Continued From pa	ige 38	F 4	41				
	depending upon the involved, and (B) A requirement t least restrictive pos- circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact with resider contact will transmi (vi) The hand hygie by staff involved in (4) A system for req under the facility's I actions taken by the (e) Linens. Person process, and transp spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on observat review, the facility f infection control me a communally used meter. This practice 6 residents (R3, R1	ene procedures to be followed direct resident contact. cording incidents identified IPCP and the corrective e facility. nel must handle, store, cort linens so as to prevent the The facility will conduct an IPCP and update their			Licensed nursing staff and TMA's medication aides) have received education on proper disinfection of glucometer machines after use. The facility policy on "Maintaining f Glucometer/Cleaning" was review is current. By January 10, 2017 licensed nurs	f the ved and		

Facility ID: 00477

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (>	X3) DATE	0938-039 SURVEY PLETED
		IDENTIFICATION NOWBER.	A. BUILDIN	IG _		COM	
		245537	B. WING _			12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MINNEW	ASKA COMMUNITY	HEALTH SERVICES			5 MAIN STREET, PO BOX 40 FARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 441	Continued From pa	age 39	F 44	1			
	Findings include:				which will address the procedure for		
	On 12/07/2016 at	On 12/07/2016, at 5:47 p.m. licensed practical			disinfecting the glucometer in betwee use.	en	
		s observed to cleanse her			The Director of Nursing or designee	will	
		plies from the cart and donned			conduct daily audits on all shifts for o		
		curtain in a small storage area, S's finger with an alcohol wipe,			week; then daily audits alternating sh for one week; then three times per w		
	air dried the finger	and used a disposable lancet			alternating shift through the quarter		
		er. LPN-D used the glucometer			ending February 28th, 2017. Results		
		used to measure sugar levels R-16 ' s blood sugar level.			audits will be presented to QA in Mar 2017 for review. Results of audits wi		
	LPN-D returned to	the medication cart, disposed			presented to QA in March 2017 for re		
	of the disposable i glucometer on the	tems and placed the top of the cart.			Correction date: 1/10/2017		
		D placed a needle on the					
		en and turned the dial to 22 ned an alcohol wipe and					
		e curtain and administered					
		-D returned to the medication					
		sulin needle into the sharps er for used medical needles					
	and equipment), d	isposed of the alcohol wipe and					
		eaning or disinfecting the D picked it up from the top of					
		t and placed it into the top					
	drawer of the med	ication cart.					
		-D obtained the same					
		strip, alcohol wipe and R41's n. LPN-D went behind the					
	curtain in the hall v	vith R41. LPN-D used hand					
	sanitizer, donned g	gloves, placed the strip into the					
		ne and grasped R41's left hand a blood sample. At this time the					
		d. LPN-D did not proceed to					
	check R41's blood	sugar and returned to the					
	medication cart with	th the alucometer.					

Facility ID: 00477

If continuation sheet Page 40 of 47

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		E SURVEY IPLETED
NIND PLAN (	OF CORRECTION		A. BUILDING	3		IF LE I EV
		245537	B. WING		12/	08/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY	HEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 441	-At 6:08 p.m. LPN multi-use glucome without disinfecting check R16's blood had the potential to stated the usual fa- the communally us LPN-D verified all of served by this med glucometers which however, the comm the cart was used of from their rooms. On 12/08/2016, at nursing (DON) veri available in the med did not have a pers The DON stated sh glucometer machin resident use to pre bacteria and to follo practices. The DON	age 40 -D verified the intent to use the ter to check R41's blood sugar i tafter it had been used to sugar and verified this practice o spread infection. LPN-D cility practice was to disinfect ed glucometer after each use. diabetic residents currently lication cart had personal were kept in their rooms, nunally used glucometer from when the residents were away 12:21 p.m. the director of fied a glucometer was dication cart for residents who sonal glucometer in their room. he expected the multi-use hes be disinfected between vent the spread of germs and ow basic infection control N indicated all nursing staff infection control practice.	F 441	1		
F 458 SS=E	Glucometer/Cleani it was policy to adv disinfect blood gluc resident to avoid po 483.90(d)(1)(ii) BE LEAST 80 SQ FT/I (d)(1)(ii) Measure a resident in multiple least 100 square fe	tled Maintaining the ng, revised 12/5/15, indicated ise nursing staff to clean and cose meters between each ossible cross-contamination. DROOMS MEASURE AT RESIDENT at least 80 square feet per resident bedrooms, and at eet in single resident rooms; NT is not met as evidenced	F 458	3		1/10/17

Facility ID: 00477

If continuation sheet Page 41 of 47

		& MEDICAID SERVICES	0.000				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245537	B. WING	j		12/08/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 458	Based on observar review, the facility f resident rooms on a square feet of usea residents ( R8, R12 R24, R25, R27, R3 in those rooms. Findings include: During the tour of A p.m. R8, R12, R13 R25, R27, R35 and to not have at least floor space, as required On 12/5/16, at 1:58 bed. The room app -At 2:28 p.m. R8 in her room and was a needed in her room supplies. -At 2:45 p.m. R39 r small room size. -At 3:02 p.m. R13 v herself in a wheelcd observed to have d room. -At 3:17 p.m. R20 i -At 3:36 p.m. R25 r small room size. On 12/06/2016 08 a concerns with the s	A-wing on 12/5/16, at 12:00 (R 14, R17, R20, R22, R39) who currently resided (R 20, R13, R14, R17, R20, R22, R39) who currently resided (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 20, R14, R17, R20, R22, R24, R39's rooms were observed (R 30, R14, R17, R20, R22, R24, R39's rooms were observed (R 30, R14, R17, R20, R22, R24, R39's rooms were observed (R 30, R14, R17, R20, R22, R24, R39's rooms) (R 30, R14, R17, R24, R19, R14, R14, R14, R14, R14, R14, R14, R14	F 4	58	F458 Waiver requested: in rooms A-wing 25, 26, 27, 28, 29, 30, 31, 32, 33, 33 and 36 are 95.68 to 96.07 square f usable space and do not meet the minimum requirements of at least of square feet of usable space. Form complying bedrooms were reduced areas to accommodate expanded to rooms. A previous similar waiver we requested. Waiver submitted on December 28	4, 35, eet of 100 ally f in coilet vas	
	be interviewed due	to her busy schedule. R12 iewed. All rooms appeared					

	-	AND HUMAN SERVICES			FORM	: 01/03/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245537	B. WING		12/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 458	Continued From pa	ige 42	F 458	3		
	(NA)-F verified the tight when assisting when a mechanical staff were able to m though the area wa On 12/08/2016 9:17 On 12/8/16, at 12:1 (DON) indicated sh rooms not being the stated she had not regarding the small On 12/8/16, at 1:04 room was small, the with its own bathroo having the smaller if daughter was happ R14 the room felt c On 12/8/16, at 1:07 her room, had been	7 a.m. R12 refused interview. 9 p.m. the director of nursing e was aware of the A wing e required square footage and had any resident complaints room size. • p.m. R14 stated although the e benefits of a private room om and a nice view were worth living space. R14 stated her y with the room and had told				
	resident rooms on t 100 square feet of u	the administrator verified the the A-wing did have less than usable space and the facility aiver for this requirement.				
	services director (E on the A-wing were square feet of usea would be applying f	p.m. the facility environmental SD) stated the single rooms less than the required 100 able floor space, and the facility for a room wavier. The ESD to problems maintaining				

Facility ID: 00477

If continuation sheet Page 43 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245537	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER	HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 458 F 465 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 cleaning and upkeep of the rooms. 483.90(h)(5)		F 4		A whole facility environmental audit conducted on 01/03/2017 with the re- of the findings and information revier by the Environmental Service Direct Administrator, and the Director of Nu Each area will be prioritized and corr in the order prioritized. When the housekeepers are in the resident rooms, they will note repairs need to be completed on the work o located at the C-wing nurse's station By January 10, 2017, as part of the nursing in-service as well as an in-s will be provided to the housekeepers update on the procedures to follow v issues are noted within the environm filling out "Repair Request Slips".	esults wed or, the ursing. rected s that rders, n. service s to when nent,	1/10/17
	-Room A28, the off-white bathroom tile floor was dirty and stained dark behind the toilet				The Environmental Service Director designee will conduct semi-annual rounding to look for areas in need of		

Facility ID: 00477

If continuation sheet Page 44 of 47

		AND HUMAN SERVICES				FORM	01/03/2017 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY IPLETED	
		245537	B. WING	i		12/	08/2016	
	PROVIDER OR SUPPLIER	HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 465	base was dark brow behind the toilet was -Room A32, the off built-up dirt in the c -Room A34, the off dirty and stained da green lime scale but handles -Room C101, the of dirty, the bathroom damaged towards to bathroom sink had the unit and the has -Room C103, the of dirty, the bathroom damaged towards to bathroom sink had the unit and the has -Room C104, the of stained and dirty, an had green lime scal handles. -Room C106, had a off-white bathroom which measured ap inches, and the bath	ulking around the white toilet wn, and the off-white floor tile as dirty and stained dark -white bathroom tile floor had orners -white bathroom tile floor was ark, and the bathroom sink had uild up on the unit and the ff-white bathroom tile floor was door was scratched and the bottom of the door, and the green lime scale build up on ndles. ff-white bathroom tile floor was door was scratched and the bottom of the door, and the green lime scale build up on	F 4	465	environmental repairs. The results of the audit will be revi by the QA Committee in March, 20 review and further recommendatio Correction date: 1/10/2017	17 for		
	off-white bathroom	a large rust stain to the floor tile behind the toilet oproximately 4 inches x 4						

If continuation sheet Page 45 of 47

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 01/03/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245537	B. WING	i		12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	VASKA COMMUNITY H	IEALTH SERVICES			05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465	Continued From pa	age 45	F 4	465			
	inches, and the bat	hroom faucet had green lime the unit and the handles.					
		athroom sink had built up n the unit and the handles.					
	green lime scale on off-white bathroom	athroom sink had built-up n the unit and the handles, the floor tile was dirty and stained k, on the sides of toilet, and					
	bathroom wall oppo bathroom sink had the faucet and the h	significant scrapes to the osite of the toilet, and the built-up green lime scale on handles, and the off-white was dark, and in poor					
		athroom faucet had built-up n the unit and on the handles.					
		C116-2, the bathroom faucet lime scale on the unit and the					
	Services Director (E responsible for all fa housekeeping and I staff were to comple leave it at the C nur container. He stated for slips at least dai removed the repair nurses station they repairs. He stated a they signed the slip	0 a.m. Environmental ESD) stated he was acility maintenance, laundry services. He stated ete a repair request slip, and rses station in the designated d they checked the container ily. He stated when they request slips from the C prioritized and completed the after they completed a repair os, and stored them in a box on boiler room. He stated all					

If continuation sheet Page 46 of 47

		AND HUMAN SERVICES			FOR	D: 01/03/2017 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		245537	B. WING _		1	2/08/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IEALTH SERVICES		605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	staff were trained a the request slips for not aware of the res had not received ar identified concerns. couple of staff, and maintain the reside be. He stated there resident bathrooms On 12/08/16, at 12: (DON) stated she w bathrooms on A wir assumed resident b were bad too. She s dirty bathrooms to t stated she expected maintain the reside resident rooms had the facility was show maintenance. Review of the facilit 7/21/09, identified b	nnually on how to complete r repairs. He confirmed he was sident room concerns, and ny repair request slips for the . He stated he was short a they hadn't had time to nt rooms the way they should was no excuse for the to look like they did. 	F 46	65		

If continuation sheet Page 47 of 47



December 26, 2016

Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road #300 Fergus Falls, Minnesota 56537

Dear Ms. Anderson:

Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey completed by the Minnesota Department of Health and Public Safety on December 5, 2016. The waiver request is in response to the following Federal Deficiency:

1. F 458 483.70 (d)(1)(ii) Bedrooms Measure at least 100 Sq. Feet for one bed, private bedrooms.

A waiver has been previously reviewed and approved at the Minnesota Department of Health.

A Wing rooms: 24,25,26,27,28,29,30,31,32,33,34,35 and 36

Residents: R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35, R39

The facility recognizes that the square footage in the A wing for the private one bed rooms noted are between 95.68 to 96.07 square feet and will work to address the comments/concerns noted by residents in the deficiency.

A previous remodeling and expansion of the toileting rooms on the "A" wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver.

If you have any questions or concerns, please feel free to contact me.

Sincerely, Christopher Knoll,

Administrator Minnewaska Community Health Services Phone: (320) 239-7104 Email: <u>cknoll@mchs-healthcare.org</u> RECEIVED

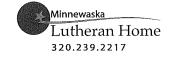
DEC 3 0 2013 MN Dept of Health Fergus Falls

605 Main St PO Box 40 | Starbuck, MN 56381 | mchs-healthcare.org

Minnewaska Therapy Services 320.239.7122



Holly Ridge Manor Assisted Living 320.239.4775



	MENT OF HEALTH			F55	37025	FORM	12/15/2016 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1 Y Y	PLE CONSTRUCTION G 01 - 01 - 1960 BUILDING AND S	(X3) DATE S COMPLE	
		245537		B. WING		12/0	7/2016
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
MINNEV	VASKA COMMUNIT'	Y HEALTH SERVIC		IN STREE UCK, MN	T. PO BOX 40 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs		K 000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Division the time of this sum Health Services Nut compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1	Survey was conduct nent of Public Safety on, on December 07 vey, Minnewaska Coursing Home was fou e requirements for p aid at 42 CFR, Subpa ety from Fire, and the Fire Protection Asso 01, Life Safety Code g Health Care Occup	, State , 2016. At mmunity ind to be in articipation art e 2012 ciation e (LSC),				
	Home is a one-stor and is fully fire sprin The original 1960 b and 1972 additions Type II(111) constru- building additions w V(111) construction was determined to The facility has a fin detection in the cor corridors which is r department notifica	nunity Health Service y building with no bankler protected throu- building along with the were determined to uction. The 1988 and vere determined to b the 2000 building be of Type II(111) con- re alarm system with rridors and spaces of nonitored for automa- ation. The facility has and had a census of	asement, lighout. e 1968 be of d 1996 be of Type addition onstruction. o smoke pen to the atic fire a				
	The requirement at MET.	t 42 CFR, Subpart 4	83.70(a) is				
LABORATC	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	BNATURE	TITLE		(X6) DATE

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



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 21, 2016

Mr. Christopher Knoll, Administrator Minnewaska Community Health Services 605 Main Street, PO Box 40 Starbuck, Minnesota 56381

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5537028

Dear Mr. Knoll:

The above facility was surveyed on December 5, 2016 through December 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

Minnewaska Community Health Services December 21, 2016 Page 2

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104, or email: lyla.burkman@state.mn.us.

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

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

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

Sincerely,

## Mark meath

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

Minnesc	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	ъ. I ́ ́		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00477	B. W	'ING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADDRESS	S, CITY, S	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY F	IEALTH SERVICE	95 MAIN STRI FARBUCK, M	-			
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2 000	Initial Comments		2 0	00			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER	t l				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has be	ued , it is ed lation nce e of een ow. to ered oon e will e item				
	that may result fron orders provided tha the Department wit	hearing on any assessr n non-compliance with t t a written request is ma hin 15 days of receipt of nt for non-compliance.	nese ade to				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The Stat delineated on the a	participate in the electr nsure orders consistent artment of Health in 14-01, available at tate.mn.us/divs/fpc/profi e licensing orders are	with				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTAT	IVE'S SIGNATUR	RE	TITLE		(X6) DATE 12/28/16

Electronically Signed

STATE FORM

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If continuation sheet 1 of 44

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00477		B. WING		12/	08/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	•	ige 1 Ith orders being submitted to	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	Department's staff the following correct Please indicate in y correction that you	h 12/8/16, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of co "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	umber appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/08/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I		NSTREET, F CK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/10/17
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observative review, the facility for repositioning assist individualized care R13) who required In addition, the facial assistance for 1 of	ent is not met as evidenced ion, interview and document ailed to provide turning and cance as directed by the plan for 2 of 3 residents (R40, assistance with repositioning. lity failed to provide grooming 1 resident (R18) who required the removal of facial hair.		Corrected		
	Findings include: R40 was not reposidirected by the care	itioned every two hours as e plan.				
	R40's care plan up was at risk for skin	dated 11/16/16, indicated R40 breakdown due to chronic , end stage metastatic cancer,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00477		B. WING		12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		605 MAIN	I STREET, PC			
MINNEW	ASKA COMMUNITY H		CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	ige 3	2 565			
	infection and direct repositioning every R40's hospice care indicated R40 had buttocks due to an provide routine turn The A/B wing Turni worksheet dated 12 repositioned at 4:30 residents were to b every two hours, wh On 12/07/16, from	ny, pain and peri-rectal ed staff to encourage two hours and as needed. plan dated 10/25/16, an open area on the right abscess and directed staff to ning and repositioning 2/7/16, revealed R40 was last 0 p.m. and indicated all e repositioned a minimum of hich included R40. 5:25 p.m. to 7:35 p.m., ations of R40 revealed the				
	his left side. An air in place on R40's b left side without rep 7:35 p.m. at which (DON) was notified -At 7:35 p.m., the D remained lying in b and 10 minutes with and the Turning and indicated R40 had p.m. At that time the risk for skin breakd from staff with repo DON and nursing a turn/reposition R40 approximately 3-4 i grey drainage from brief. R40's buttool	was observed lying in bed, on pressure mattress overlay was ed. R40 remained in bed, on positioning assistance until time the director of nursing DON was notified R40 had ed for an observed two hours hout repositioning assistance d Repositioning worksheet last been repositioned at 4:30 ne DON confirmed R40 was at own and required assistance ositioning every two hours. The assistant (NA)-I proceeded to . R40 was noted to have nches of moderate amount of the rectal abscess on the ks had deep, light pink creases unding the peri-rectal area.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00477		B. WING		12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICE	N STREET, PC ICK, MN 5638'			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	repositioned for thr	ee hours and five minutes.				
		5:20 p.m. NA-A stated R40 e of repositioning every one				
	required reposition and as needed. Th three hours and five assistance and sta	p.m. the DON verified R40 ing assistance every two hours e DON confirmed R40 went e minutes without repositioning ted it was stated it was her ould be repositioned every two	9			
	R13 was not repos directed by the care	itioned every two hours as e plan.				
	at risk for pressure	ted 11/1/16, indicated R13 was ulcers and required reposition every two hours and				
	11:34 a.m. to 2:59 R13 was observed repositioning assist -At 11:34 a.m. R13 wheel chair in the c -At 11:42 a.m. R13 the chapel when N table in the assiste seated in the whee time until 12:37 p.n	was observed seated in her chapel. 3 began to propel herself from A-D assisted to propel her to a d dining room. R13 remained Ichair throughout the meal n. at which time NA-C wheeled	t I			
	and left the room. -At 12:53 p.m. rem in her room and ren at which time R13 p across the hall way	IA-C handed R13 a newspape ained seated in the wheelchair mained seated until 1:13 p.m. propelled self out of her room, and into another resident's d intervened and propelled				

STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/08/201	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
INNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
	read the newspape -At 1:40 p.m. NA-G R13's room, turned R13 remained seat room until 2:13 p.m R13's room and off R13 accepted and main dining room. At 2:19 p.m. R13 re wheelchair at a dini remained there unt -At 2:46 p.m. R13 v	was in the chapel for an ned seated in the wheelchair				
	R13 was assisted of 10:00 a.m. when sh bathroom and had that time. NA-G con need to be turned a R13 did not need to hours. NA-G verifie	p.m. NA-G stated the last time but of the wheelchair was at ne was assisted to the not been repositioned since nfirmed unawareness of R13's and repositioned and stated be repositioned every two ed R13 had not been assisted in for greater than four hours.				
	(NM)-A confirmed F every two hours. -At 2:59 p.m. NM-A bathroom. R13's bo wrinkles and crease	p.m. the nurse manager R13 was to be repositioned assisted R13 into the ottom was noted to have es and the skin between her thighs were a darker pink in				
		5:16 p.m. LPN-D verified the are sheet directed staff to ry two hours.				
	On 12/07/2016, at	7:48 p.m. the DON stated she				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00477	B. WING		12/	08/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 6	2 565			
	had expected staff to follow R13's care plan and reposition R13 every two hours, as directed					
	R18 was not provided with facial hair removal as directed by the care plan.					
	required extensive	ted 10/27/16, indicated R18 assist of two staff for grooming o report any changes in ilities.	]			
	seated a wheelchai to have several lor center of her chin a	a.m. R18 was observed ir, in her room. R18 was noted ng, white facial hairs in the and next to the right side of her as asked if the long facial hair eplied, "yes."				
	bed and continued	p.m. R18 was observed in to have the long facial hair nately one inch in length.				
	have long facial hai	p.m. R18 was again noted to ir. During review R18's 8 was identified to have her s of each week.				
	shaving was compl basis, by the nursir	p.m. NA-C stated resident eted for all residents on a daily g assistants and if any facial bathing day, the bath aid	/			
	had long, white fac her lip and verified staff for grooming r	p.m. LPN-A confirmed R18 ial hair on her chin and next to she was totally dependent on needs which included shaving. s shaver had been missing for				

STATE FORM

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If continuation sheet 7 of 44

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING	B. WING		08/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
NINNEW	ASKA COMMUNITY H		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 7	2 565			
		l family was requested to one as the facility did not esidents.				
	shave R18 1-2 time morning cares. Ho not offered nor prov R18 when she assi confirmed R18 curr razor, and pulled th drawer. NA-D confi	p.m. NA-D stated staff tried to se per week when providing wever, NA-D stated she had vided shaving assistance for sted her up on 12/7/16. NA-D rently did have a functioning re razor out of R18's top firmed R18 had multiple long, the chin and next to the lip poving.				
	reported R18 has a in her room becaus stated she just wen her face, and confi	p.m., family member (FM)-A lways had a functioning razor se she bought it for her. FM-A it into R18's room and shaved med the facial hair was long Id want those hairs on their				
		p.m. the DON stated she ovide grooming assistance as e plan.				
		vive revised 10/22/16 revealed imentation must be consistent				
	The director of nurs implement policies ensuring staff imple	THOD FOR CORRECTION: sing (DON) or designee could and procedures related to ement resident care plans. The and assurance committee				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - 12/08/2016	
				·		
		00477	B. WING			
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IINNEW	ASKA COMMUNITY I		N STREET, F CK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	could perform rand compliance.	lom audits to ensure				
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21	)			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			1/10/17
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of e resident assessment required subpart 3, item B.				
	by: Based on observat review, the facility f care plan to include reducing boot for 1 for pressure ulcers	ent is not met as evidenced ion, interview and document failed to accurately revise the e the use of a pressure of 3 residents (R43) reviewed and had a physician order uled use of a pressure a device.		Corrected		
	Findings include:					
	R43's computerize					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00477	B. WING		12/08/2016		
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	ASKA COMMUNITY	HEALTH SERVICE 605 MAI	N STREET, PC	BOX 40			
		STARBU	CK, MN 56381				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE <sup>-</sup> DATE	
2 570	Continued From pa	age 9	2 570				
		11/30/16, indicated R43 was to wear a pressure reducing boot to the left foot during daytime hours.					
	R43 had severe co required extensive care plan also indic developing pressur developed a bluish 2.5 cm fluid filled b care plan directed needs and to follow care plan further id ordered a pressure the boot was to be Treatment record f on 11/24/16, a press worn during night ti	dated on 11/30/16, indicated ognitive impairment and assistance with ADLs. The cated R43 was at risk for re ulcers and on 10/21/16, had /purple, 4.5 centimeters (cm) x lister on her left inner heel. The staff to anticipate all of R43's v facility wound protocol. The entified R43's physician e reducing boot and indicated worn at night only. R43's or December 2016, indicated ssure reducing boot was to be ime hours. However, R43's ected the use during the day					
	seated in her whee her TV. R43 had s left arm of her whe cushion under her wheelchair. R43 we low, half back acro was off the back of wearing a pressure	88 a.m. R43 was observed elchair, in her room, in front of sheep skin which covered the elchair and a black foam bottom in the seat of her ore gray, no-tie shoes with a ss her left heel. R43's left hee the footrest and she was not e reducing boot on her left foot. g boot was not observed in her					
	nursing assistant (I room in front of TV	wing lunch in the dining room, NA)-F wheeled R43 into her . R43's left foot was off the foo the floor. No boot was in	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00.477	B. WING		400	10/00/2040	
		00477			12/	08/2016	
	PROVIDER OR SUPPLIER	605 MAI	DDRESS, CITY, ST N STREET, PO				
MINNEW	ASKA COMMUNITY I		CK, MN 56381				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From page 10		2 570				
	place.						
	wore black socks, a pressure reducing pressure reducing	was assisted into bed. R43 and was not wearing a boot on her left foot, and boots were not observed in he in bed without the boot on unti sisted her up.					
	the dining room ha	was seated in her wheelchair in ving coffee with spouse. R43 er pressure reducing boot to ore her gray half-back shoes.	ו				
	the day room with s	s seated in her wheelchair in spouse and was not wearing sing boot to her left foot, and back shoes.					
	required extensive daily living (ADLs) a She stated she was wore, however had	S p.m. NA-E stated R43 assistance with all activities of and could not communicate. s not sure what shoes R43 I worn a protective boot at nigh floated when she was in bed.	t				
		) p.m. NA-D stated she though n her left foot at night and not	t				
	(LPN)-A stated R43 whenever she was stated she just lear pillow boots during day. She stated she	5 p.m. Licensed practical nurse 3 should wear a pillow boot in bed. At 2:40 p.m. LPN-A rned R43 was to wear the the night, and not during the e understood the staff's by pressure boot schedule					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/	08/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IINNEW	ASKA COMMUNITY		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 11	2 570			
	because the order for it was not added to R43's care plan correctly. She stated on 11/30/16, LPN-C entered the order for R43's boots to be worn during the day, and on the same day, UM-B changed it to read R43 was to wear the pressure boot at night.					
	(DON) confirmed F the boot during the R43's care plan ha to apply the pressu The DON stated sh	36 p.m. the director of nurses R43's physician order to wear daytime hours and verified d been changed to direct staff are reducing boot at night only. he expected the care plan to be he accurate physicians order.				
	•	ty policy, Care sive dated 10/22/16, identified e revised as resident condition	L.			
	resident's care plan necessary with any overall provision of the appropriate car provide to maximiz improvement. Care revised, at a minim member of the care care plans at the tin	THOD OF CORRECTION: A in should be revised as of changes which affect the f care to a resident to ensure re, services and treatments are the a resident's potential for the plans should be reviewed and hum on a quarterly basis. A the planning team could review me of the care conference to re completed timely.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/08/2016	
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
INNEW	ASKA COMMUNITY H		NSTREET, F CK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 900	Continued From pa	ige 12	2 900			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/10/17
	comprehensive res of nursing services development of a n provides that:	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	tho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observative review, the facility for prescribed order for reducing boot and/or repositioning assist prevent a pressure worsening of a curr residents (R43, R13 risk for pressure und pressure und the pressure reduct	ent is not met as evidenced ion, interview and document ailed to follow a physician r the use of a pressure or provide turning and cance in order to heal and/or related ulcer and/or the rent pressure ulcer for 2 of 3 3, R40) reviewed who were at cers and/or the worsening of a observed not to be wearing ing boot as prescribed and/or oned timely, as directed by the plan.		Corrected		
	Findings include:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00477	B. WING		12/	12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
INNEW	ASKA COMMUNITY I		N STREET, PO JCK, MN 5638 <sup>-</sup>				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 13	2 900				
	R43's pressure reducing boot was not provided as prescribed by the physician.						
	cognitive impairme assistance with all and had diagnoses diabetes, and apha further identified R4 ulcers, had no curr no pressure ulcer p place.	716, indicated R43 had severe nt, required extensive activities of daily living (ADLs) which included dementia, usia (non-verbal). The MDS 43 was at risk for pressure ent pressure ulcers and had prevention interventions in					
	11/30/16, indicated	d physician order dated R43 was to wear a pressure e left foot during daytime					
	had severe cognitive extensive assistance indicated R43 was ulcers and on 10/2 bluish/purple, 4.5 c filled blister on her directed staff to and to follow the facility indicated R43's phy reducing boot whic	ted 11/30/16, indicated R43 ve impairment and required ce with ADLs. The care plan at risk for developing pressure 1/16, had developed a entimeters (cm) x 2.5 cm fluid left inner heel. The care plan ticipate all of R43's needs and wound protocol. The care pla ysician had ordered a pressure h was to be worn at night only hysician had ordered the boot laytime hours.	n Ə				
	indicated on 11/24/ was to be worn dur	ecord for December 2016, 16, a pressure reducing boot ing night time hours. However der directed the use during the					
	Review of R43 's F						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/08/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
INNEW	ASKA COMMUNITY I		I STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 14	2 900			
	forms revealed the wounds:	following pressure related				
	left inner heel. Blist appeared fluid filled darker. Physicians current cover left m -11/21/16, 4.0 cm X blue/purple tissue f resolved with betac response was to co R43's Braden Scale ulcer risk) dated 10 risk for developing limited ability to res discomfort, and wa change or correct b also indicated R43 device in her chair,	<ul> <li>I a 4.5 cm x 2.5 cm blister on er was bluish/purple and</li> <li>d. The center of blister appears response was to continue netatarsal.</li> <li>( 2.5 cm left heel deep rom wheelchair pedal has not line swabbing. Physician portinue to pad and protect.</li> <li>e (assessment for pressure 0/19/16, indicated R43 was at pressure ulcers, had very pond to pressure or s very limited in her ability to pody position. The assessment had a pressure reducing no referrals were needed and ue with current care plan.</li> </ul>				
	Assessment (CAA) had progressive Ala extensive assistant indicated R43 was ulcers, staff were to notify the physician staff were to follow and to continue with	Daily Living Care Area dated 10/24/16, indicated R43 zheimer's disease and required ce with ADLs. The CAA further at risk for developing pressure o monitor R43's skin daily and with any significant changes, the facility 's wound protocol h the current care plan. The ess R43's blister which cility on 10/21/16.				
	her room, seated ir sheep skin which c wheelchair, a black	8 a.m. R43 was observed in the wheelchair. R43 had overed the left arm of her foam cushion on the seat of gray, no-tie shoes on with a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/	08/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNEW	ASKA COMMUNITY H		N STREET,PC CK, MN 56381			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 15	2 900			
	wearing a pressure R43's left heel was pressure reducing I room. -At 11:59 a.m. nurs R43's room and infi lunch and proceede R43's hands and w hallway. -At 12:01 p.m. R43 in the dining room a hard time keeping I -At 12:07 p.m. NA-I her with meal. R43 feeding. -At 12:40 p.m. follor NA-F wheeled R43 her in front of TV. I rest, and rested on -At 12:59 p.m. NA-I room with a mecha -At 1:08 p.m. R43 w back with her left he R43 wore black soo pressure reducing I pressure reducing I pressure reducing I proom. -At 1:36 p.m. and a to remain in bed, or under a flattened pi and a pressure red nor in her room. -At 2:26 p.m. R43 r her back with the left pillow. -At 2:40 p.m. R43 v	F physically assisted R43 with dozed on and off during wing completion of the meal, into her room and positioned R43's left foot was off the foot the floor. D and NA-E entered R43's inical lift and closed the door. was observed in bed on her eel on top of a flattened pillow. cks and was not wearing a boot on her left foot. A boot were not observed in her at 2:02 p.m. R43 was observed in her back with her left heel illow. The sock remained on ucing boot was not in place remained positioned in bed on off heel under a flattened was observed in the dining				
		r wheelchair. R43 was not reducing boot to her left foot, half-back shoes.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/08/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
IINNEW	ASKA COMMUNITY H		I STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	-At 3:29 p.m. R43 w the day room with s her pressure reduc wore her gray half- -At 3:44 p.m. R43 w Manager (UM-A) ar wearing a pressure R43's left inner hee which revealed the -0.5 cm x 0.4 cm re and broken down -0.3 cm x 0.2 cm re and open -0.2 cm hard blacke On 12/07/16, at 2:1 required extensive could not communi not sure what shoe wore a protective b were to be floated w On 12/07/16, at 2:2 required extensive stated R43 had a b silver dollar on her R43 developed the staff had not kept h was not repositione staff tried to repositi also elevate her fee thought R43 wore a and not during the	vas seated in her wheelchair in spouse and was not wearing ing boot to her left foot, and back shoes. vas in her room with Unit areducing boot to her left foot. el was observed with Um-A following heel wounds: eddened area which was soft				
	(LPN)-A stated R43 had a huge blood b she thought was a	6 p.m. licensed practical nurse required total care from staff, lister on her left heel which pressure related ulcer. She the blister was caused from				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00477	B. WING	B. WING		08/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 5638 <sup>,</sup>			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 900	Continued From pa	age 17	2 900			
	not put her shoes of friction. LPN-A state protected by makin shoes on correctly, have not full backs had on the same sit the pressure ulcer stated staff were to pillow boot when sit had an alternating a repositioned and cl R43 should have he and would go chec -At 2:40 p.m. LPN-/ learned R43 was to the night, and not of understood the cor schedule because correctly on R43's of 11/30/16, LPN-C ha boots to be worn du UM-B changed the wear boots at night progress notes ass order for R43's pro was bizarre. " In ac pressure reducing applied on 10/21/16 original order for th On 12/7/16, at 3:29 stated R43 had wo day until yesterday	pedals and/or someone had on all the way which caused ed R43's heel was to be g sure staff were putting her because R43's shoes did not on them, and confirmed R43 hoes as when she developed to her left heel. LPN-A also float 43's heels and apply a ne was in bed. She stated R43 air mattress and was eansed properly. LPN-A stated ad her boots on at this time k to see if she had them on. A returned and stated she had b wear the pillow boots during luring the day. She stated she fusion with R43's boot the order was not documented care plan. LPN-A stated on ad entered the order for R43's uring the day, and on 11/30/16, care plan to read R43 was to . LPN-A verified there were no bociated with the physician tective boot and stated " it ddition, LPN-A stated R43's boot was applied originally 6, but she could not find the e boot dated 10/21/16.	I			
	anymore. RM-B sta blister the size of a and R43 had worn	R43 did not need the boot ated R43 had a dead blood quarter before Thanksgiving the same shoes which had her developing the blister.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00477	B. WING		12/	12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
IINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
2 900	Continued From pa	age 18	2 900				
	FM-B stated he thought the blister was caused by the foot pedal guards on her wheelchair. FM-B stated the current pressure ulcer interventions for the blister were betadine swabs and wearing the boot.						
	(DON) stated once they determined it y from her wheelchai they had removed protective boot to F all day and night. T had discussed R43 day and both felt it 11/30/16, UM-B ha boot to night time u expected the physi followed as written care plan. She sta	36 p.m. the director of nurses R43's blister was identified, was caused from pressure in foot pedal bars. She stated the bars and applied a R43 's left foot which she wore The DON stated her and UM-B & wearing the boot during the was a dignity issue so on d changed the schedule of the ise only. The DON stated she cian order to be accurate and and for the order to match the ted she expected the care plan vised to reflect the actual					
	R43 was at risk for and verified R43 's progress notes rela	50 p.m. The DON confirmed developing pressure ulcers medical record lacked any ated to the use of the protective unable to find the original or the boot.					
		pressure related ulcers and mely repositioning, as directed					
	R40 was cognitivel which included mail liver, rectal abscess	DS dated 10/31/16, indicated y intact and had diagnoses lignant neoplasm of colon and s and pain. The MDS at risk for pressure ulcers and					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00477	B. WING	B. WING		08/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MINNEW	IASKA COMMUNITY I	HEALTH SERVICE	N STREET, PO CK, MN 5638 <sup>,</sup>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 900	Continued From pa	age 19	2 900			
	transferring. The N	tance for bed mobility and IDS did not identify any vention interventions in place.				
	R40's Pressure Ulcer Care Area Assessment (CAA) dated 11/10/16, indicated R40 had an open abscess near his rectum with wound drainage which put him at risk for skin breakdown.		1			
	Condition form date an open area on rig	utheran Home Admission Skin ed 10/1/16, revealed R40 had ght buttocks. The form did not re ulcer interventions had beer				
	R40's Braden Scale R40 was at risk of s	e dated 10/31/16, indicated skin breakdown.				
	was at risk for skin wound near rectum end stage metastat colostomy, pain an care plan directed s	ted 11/16/16, indicated R40 breakdown due to chronic in that had purulent drainage, tic cancer, protruding d peri-rectal infection. R40's staff to encourage two hours and as needed.				
	indicated R40 had buttocks due to an	e plan dated 10/25/16, an open area on the right abscess. Various interventions ice which included routine ioning.	3			
	worksheet dated 12 last repositioned at all the residents we	ng and Repositioning 2/7/16, revealed R40 had been 4:30 p.m. The form revealed ere to be repositioned a two hours, which included R40				
		5 p.m. R40 was observed in t side. An air mattress overlay				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00477			12/	08/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
INNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
	which R40 remained without repositionin -At 7:35 p.m. the D remained lying in b and 10 minutes. T risk for skin breakd from staff to turn an The DON and NA-I incontinent cares a incontinent brief wa wound was noted to in diameter of gray buttocks had deep, moistness surround DON and NA-I prod cares and reposition R40 had remained of 3 hours and 5 m wing Turning and F 12/7/16, R40 was n three hours and five On 12/7/2016, at 5 required assistance hour. On 12/7/16 at 7:47 aforementioned ob required turning an every two hours, ar verified according t Repositioning work repositioned at 4:30 expectation was for two hours, as direct	<ul> <li>continued until 7:35 p.m. in ed in bed on his left side ng.</li> <li>ON was notified R40 had ed for an observed two hours he DON confirmed R40 was at lown and required assistance and reposition every two hours. I proceeded to assist R40 with and repositioning. When R40 's as removed, R40 's rectal o have approximately 3-4 inch drainage on the brief. R40's, light pink creases with ding the peri-rectal area. The ceeded to complete perineal oned R40 off of his left side. In the same position for a total inutes. According to the A/B Repositioning worksheet dated not turned and repositioned for e minutes.</li> <li>5:20 p.m. NA-A stated R40 ewith repositioning every one</li> <li>p.m. the DON confirmed the servations and verified R40 if repositioning assistance and as needed. The DON to the A/B wing Turning and tsheet, R40 was last 0 p.m. and stated her r staff to reposition R40 every ited.</li> </ul>	5			
		a.m. during phone interview registered nurse (RN)-D				

	NT OF DEFICIENCIES OF CORRECTION	CALL CALL CALL CALL CALL CALL CALL CALL		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/	08/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
INNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 21	2 900			
	and stated R40 req	t high risk for skin breakdown uired good perineal cares and to be repositioned at least				
		at risk for pressure ulcers and ing and repositioning was not d by the care plan.				
	identified R13's dia disease, dementia	der Report dated 10/19/16, gnoses included Parkinson's and peripheral vascular irculation disorder).				
	R13 was at risk for assist of one staff f	S dated 10/25/16, indicated pressure, required extensive or bed mobility and transfers lchair cushion pressure				
	Risk, dated 10/24/1 occasionally moist, in bed or chair, hac adequately, and ha friction and shear. at risk for pressure	e for Predicting Pressure Sore 16, indicated R13's skin was R13 spent most of each shift I slightly limited mobility, ate d a potential problem with The Braden indicated R13 was sores, had a pressure ther chair and the current care was to continue.	5			
	indicted R13 could	ance Test dated 10/20/16, tolerate two hours seated or on without change to skin				
	Assessment dated risk for skin break o	Daily Living Care Area 2/2/16, indicated R13 was at down and every two hour, and oning interventions were in				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00477	B. WING		12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNEW	ASKA COMMUNITY		N STREET,PC CK, MN 56381			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	)MPLE <sup>-</sup> DATE
2 900	Continued From pa	age 22	2 900			
	was at risk for pres	vised 11/1/16, indicated R13 soure ulcers and required reposition every two hours and				
	to 2:59 p.m. (3 hou observed seated in been repositioned. -At 11:34 a.m. R13 seated in her whee -At 11:42 a.m. R13 wheelchair from the up behind R13's wi a dining room table room, seated in the which time, NA-C whanded R13 a new -At 12:53 p.m. R13 wheelchair, in her -At 1:08 p.m. R13 t	B began to propel herself in the e chapel when NA-D walked heelchair and propelled her to e. R13 remained in the dining wheelchair until 12:37 p.m. at wheeled R13 to her room, rspaper and exited the room.				
	the window and sa -At 1:13 p.m. R13 p room, across the h room. An activity a back to her room. the newspaper to F -At 1:40 p.m. NA-G	propelled herself out of the all and into another resident's id intervened and wheeled R13 The activity aid offered to read R13, but was declined. S stepped into the doorway of				
	-At 1:45 p.m. R13 r wheelchair in her r and the LPN and a room next door wit -At 1:52 p.m. R13 r wheelchair in her r	remained seated in the oom. D entered R13's room and				

D0477         B. WING	TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
Bit De PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       665 MAIN STREET, PO BOX.40         STARBUCK, MN 56381       SUMMARY STATEMENT OF DEFICIENCES       ID       ID       PROVIDER'S PLAN OF CORRECTION       CROSS-REFERENCED TO THE ADDRESOLUD BE       COME         VIETX       SUMMARY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION       CROSS-REFERENCED TO THE ADDRESOLUD BE       CROSS-REFERENCED TO THE ADDRESOLUD BE       CROSS-REFERENCED TO THE ADDRESOLUD BE         VIETX       REGULATORY OR LSC IDENTIFYING INFORMATION       PRETX       RECOULTORY OR LSC IDENTIFYING INFORMATION       PRETX       CROSS-REFERENCED TO THE ADDRESOLUD BE       CROS			00477			12/08/2016	
NINE-WASKA COMMUNITY HEALT IN SERVICE         STARBUCK, MN 56381           WILD TAG         SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)         IP REFIX TAG         PROVIDERSC IN ACTION SHOULD BE DEFICIENCY)         Over LSC OF ORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         IP REFIX TAG         PROVIDERSC IN ACTION SHOULD BE DEFICIENCY)         Over LSC         Ove	AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
STARBUCK, MM 5331           DENOMPRY STREEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECUT OR USC IDENTIFYING INFORMATION)         IPAGE CONRECTUR ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECUT OR USC IDENTIFYING INFORMATION)         DEFICIENCY           2 900         Continued From page 23 and LPN-D wheeled R13 to the main dining room. R13 was not offered repositioning assistance. -A12:19 p.m. R13 remained seated in the wheelchair at a dining room table with four other residents. R13 drank from a covered mug with a straw and ate a dessert. -A12:33 p.m. R13 remained seated in the table drinking from the covered mug. A12:46 p.m. R13 was in the chapel for an activity. She remained seated in the wheelchair.         No	IINNEW						
Image: Proceeding of the second se			STARBU	CK, MN 5638	1		
<ul> <li>and LPN-D wheeled R13 to the main dining room.</li> <li>R13 was not offered repositioning assistance.</li> <li>-At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table with four other residents. R13 drank from a covered mug with a straw and ate a dessent.</li> <li>-At 2:33 p.m. R13 remained at the table drinking from the covered mug.</li> <li>At 2:46 p.m. R13 was in the chapel for an activity. She remained seated in the wheelchair.</li> <li>On 12/7/16 at 2:04 p.m. NA-G stated nursing assistant staff used a book at the nurse station to write down what cares were provided for a resident and at what time. The form was titled A/B wing Turning and Repositioning Worksheet which was dated 12/7/16. NA-G stated the oncoming staff transferred the last times care was provided and documented for each resident on to a new form. NA-G confirmed night staff had provided R13 at 4:00 a.m. and verified it could have been anything from tolleting to visual checking on her. NA-G confirmed the following was also documented on the form by the day shift staff: At 8:10 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the toilet. At 10:00 a.m. R13 was assisted to the collet. At 10:00 a.m. R13 was not beer repositioned for greater than four hours. NA-G was also unaware of R13's turing and repositioning schedule and stated R13 was not to be repositioned every two hours or anything like that.</li> <li>On 12/7/16, at 2:30 p.m. shift change was occurring at the A/B wing nurses station.</li> <li>On 12/7/16, at 2:30 p.m. NA-H stated R13 was</li> </ul>	(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLET
R13 was not offered repositioning assistance. -At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table with four other residents. R13 drank from a covered mug with a straw and ate a dessert. -At 2:33 p.m. R13 remained at the table drinking from the covered mug. At 2:46 p.m. R13 was in the chapel for an activity. She remained seated in the wheelchair. On 12/7/16 at 2:04 p.m. NA-G stated nursing assistant staff used a book at the nurse station to write down what cares were provided for a resident and at what time. The form was titled A/B wing Turning and Repositioning Worksheet which was dated 12/7/16. NA-G stated the oncoming staff transferred the last times care was provided and documented for each resident on to a new form. NA-G confirmed night staff had written 4:00 a.m. for R13. However, NA-G stated she was unaware of what cares night staff had provided R13 at 4:00 a.m. and verified it could have been anything from tolieting to visual checking on her. NA-G confirmed the following was also documented on the form by the day shift staff: At 10:00 a.m. R13 was assisted to the toliet. At 10:00 a.m. R13 was assisted to the toliet. At 10:00 a.m. R13 had not been repositioned for greater than four hours. NA-G was also unaware of R13 's turning and repositioning schedule and stated R13 was not to be repositioned for greater than four hours. NA-G was also unaware of R13 's turning and repositioned for greater than four hours. NA-G was also unaware of R13 was not to be repositioned for greater than four hours. NA-G was also unaware of R13 's turning and repositioned for greater than four hours. NA-G was also unaware of R13 's turning and repositioned for greater than four hours. NA-G was also unaware of R13 's turning and repositioned every two hours or anything like that. On 12/7/16, at 2:38 p.m. NA-H stated R13 was	2 900	Continued From pa	ge 23	2 900			
·		and LPN-D wheele R13 was not offere -At 2:19 p.m. R13 r wheelchair at a dini residents. R13 drar straw and ate a des -At 2:33 p.m. R13 r from the covered m At 2:46 p.m. R13 w She remained seat On 12/7/16 at 2:04 assistant staff used write down what ca resident and at what wing Turning and R was dated 12/7/16. staff transferred the and documented for form. NA-G confirm a.m. for R13. Howe unaware of what ca R13 at 4:00 a.m. ar anything from toilet NA-G confirmed the documented on the At 8:10 a.m. R13 w At 10:00 a.m. R13 w At 10:00 p.m. checke NA-G verified R13 greater than four ho of R13 's turning an stated R13 was not hours or anything li On 12/7/16, at 2:30	d R13 to the main dining room d repositioning assistance. emained seated in the ng room table with four other ak from a covered mug with a ssert. emained at the table drinking nug. as in the chapel for an activity. ed in the wheelchair. p.m. NA-G stated nursing a book at the nurse station to res were provided for a at time. The form was titled A/B epositioning Worksheet which NA-G stated the oncoming e last times care was provided or each resident on to a new hed night staff had written 4:00 ever, NA-G stated she was ares night staff had provided nd verified it could have been ing to visual checking on her. e following was also form by the day shift staff: as assisted up from bed. was assisted to the toilet. observed at church. ed. had not been repositioned for ours. NA-G was also unaware nd repositioning schedule and to be repositioned every two ke that. p.m. shift change was a wing nurses station.				
esota Lepariment of Health	nesota De	On 12/7/16, at 2:38 epartment of Health	p.m. NA-H stated R13 was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00477	B. WING		12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNFW	ASKA COMMUNITY I		N STREET, PC			
		STARBU	CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE <sup>-</sup> DATE
2 900	Continued From pa	age 24	2 900			
	have a repositionin repositioned when not toileted R13 thi Repositioning Worl	n every half hour R13 did not g schedule but would be toileted. NA-H verified she had s afternoon and the Turing and ksheet identified R13 was last m. which was four and a half				
	(NM)-A verified R13 two hours and experience reviewed the Turnin verified there was r having been reposit repositioning. At 2: into the bathroom a the use of a gait be the bathroom wall. have wrinkles and her buttocks and in color. NM-A indicat diligent with reposit	59 p.m. NM-A assisted R13 and assisted R13 to stand with alt and assistive bars bolted to R13's bottom was noted to creases and the skin between oner thighs were dark pink in ted she would direct staff to be tioning R13 every two hours ent decline and was no longer				
	had a recent declin ability, was at risk f required reposition verified the nursing	5:16 p.m. LPN-D stated R13 ie in physical and mental for pressure ulcers and ing every two hours. LPN-D assistant care sheet directed R13 every two hours.				
	had expected staff	7:48 p.m. the DON stated she to reposition R13 every two the tissue tolerance are plan.				
	reviewed 12/3/15, i	tion of Pressure Ulcers policy ndicated pressure related / formed when a resident				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00477			12/	08/2016
		605 MAI	DDRESS, CITY, ST N STREET, PC			
IINNEW	ASKA COMMUNITY		CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 25	2 900			
	period of time cause decrease of circular which destroyed th preventive actions changing positions foam, gel, or air cu The facility Skin Ca indicated residents would receive the r	me position for an extended sing increased pressure or a tition (blood flow) to that area, e tissues. Risk factors and for a person in a chair included every two hours and use a shion to relieve pressure. are policy dated 12/3/16, who had pressure sores recommended treatment and e healing and prevent new	Ŀ			
	policy reviewed 3/3 was to provide com skin irritation and b good body alignme					
	revised 10/22/16, in	lans-Comprehensive policy ndicated daily care and st be consistent with the n.				
	assure policies and implemented, and staff impliment phy	rsing, and/or designee could d procedures were current, monitored to assure nursing rsician orders, and assessed essure ulcer treatment and				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				

STATEMENT OF DEFICIENCIES       (X) PROVIDERSUPPLIENCIA       (X) PROVIDERSUPPLIENCIA<	Minnesc	ta Department of He	alth				
NAME OF PROVIDER OR SUPPLIE         STREET ADDRESS, CITY, STATE, ZP CODE           MINNEWASKA COMMUNITY HEALTH SERVICE         605 MAIN STREET, PO BOX 40 STABULK, MN 56381           (X4) ID PREFIX         SUMMARY STATEMENT OF DEFICIENCIES (BOX 10 DEFICIENCY MOST BUE TREPROCEMED BY FULL TAG         PROVIDERS PLAN OF CORRECTION (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL TAG         PROVIDERS PLAN OF CORRECTION (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL TAG         PROVIDERS PLAN OF CORRECTION (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL (BCX11 CORRECTION MOST BUE TREPROCEMED BY FULL TAG         PROVIDERS PLAN OF CORRECTION (BCX11 CORRECTION TAG         CONTENT STATE, ZP CODE           2 920         MIN Rule 4658.0525 Subp. 6 B Rehab - ADLs         2 920         1/10/17           Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services related to the removal of facial hair for 1 of 1 resident (R16) observed to have long facial hair which was not removed by staff.         Corrected           Findings include:         R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving.         R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for activities of daily living due to left sided paralysis from a stroke and a traumatic brain injury (TB)).         R18's care plan							
MINNEW-SKA COMMUNITY HEALTH SERVICE         665 MAIN STREET, PD BOX 0 STARBUCK, MN 66331           (PA) ID FREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)         IP         PREVIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)         IP         PREVIX TAG         PREVIX CROSS-REFERENCED ID TO TE APROPRIATE         COMPETI- DEFICIENCY           2 920         MN Rule 4658.0525 Subp. 6 B Rehab - ADLs         2 920         2 920         1/10/17           Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living roceives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.         Corrected           This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal p facial hair which was not removed by staff.         Corrected           Findings include:         R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving.         R18's Activities of Daily Living Care Area Assessment (CAA) dated 10/221/6, indicated R18 required total to testinsive assist of two staff for carepleting personal hygiene including and directed staff to report any changes in injury (TB)).         R18's care plan dated 10/27/16, indicated R18 required total to teste			00477	B. WING		12/0	8/2016
Display         STARBUCK, MN 56381           Provide Provide Residuation of the second seco	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE       CORSE-THE DEFICIENCY         2 920       MN Rule 4658.0525 Subp. 6 B Rehab - ADLs       2 920       1/10/17         Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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.       2 920       1/10/17         This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming arrives related to the removal of facial hair for 1 of 1 resident (R18) observed to have long facial hair which was not removed by staff.       Corrected         Findings include:       R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving.       R18's Activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assistance of two staff for activities of daily living due to left sided paralysis from a stroke and a traumatic brain injury (TB).       R18's care plan dated 10/27/16, indicated R18 required textensive assist of two staff for activities of assist of two staff for activities of assist of two staff for activities of the port any changes in maind for extensive assist of two staff for activities of the port any changes in maind incetted staff to report any changes in maind incetted staff to report any changes in maint to report any changes in maint	MINNEW	ASKA COMMUNITY F					
Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal of facial hair for 1 of 1 resident (R18) observed to have long facial hair which was not removed by staff. Findings include: R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving. R18's Activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assist of two staff for activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assistance of two staff for activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assist of two staff for activities of Daily Living Care Area Assessment (CAA) dated 10/27/16, indicated R18 required extensive assist of two staff for activities of daily living due to left sided paralysis from a stroke and a traumatic brain injury (TBI). R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for grooming and directed staff to report any changes in	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
grooming needs/abilities.		Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and o This MN Requireme by: Based on observati review the facility fa services related to of 1 resident (R18) hair which was not Findings include: R18's annual Minim 10/21/16, indicated cognition and requi staff for completing shaving. R18's Activities of I Assessment (CAA) required total to ext for activities of daily paralysis from a str injury (TBI). R18's care plan dat required extensive	of daily living. Based on the ident assessment, a nursing that: is unable to carry out ing receives the necessary n good nutrition, grooming, ral hygiene. ent is not met as evidenced ion, interview and document ailed to provide grooming the removal of facial hair for 1 observed to have long facial removed by staff. num Data Set (MDS) dated R18 had moderate impaired red extensive assist of two personal hygiene including Daily Living Care Area dated 10/28/16, indicated R18 tensive assistance of two staff / living due to left sided oke and a traumatic brain				1/10/17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00477	B. WING		12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 27	2 920			
	her room, seated in to have several lon center of her chin a lips. When R18 w bothered her, she r On 12/6/16, at 2:36 bed and continued which was approxin On 12/7/16, at 2:23 have long facial ha progress notes, R1 shower on Monday On 12/7/16, at 1:56 stated shaving was a daily basis by the to provide care to t	5 p.m. R18 was observed in to have the long facial hair mately one inch in length. 8 p.m. R18 was again noted to ir. During review R18's 8 was identified to have her				
	(LPN)-A confirmed staff for grooming, R18's shaver had b month. LPN-A stat to purchase anothe not provide razors confirmed R18 had	I p.m. licensed practical nurse R18 was totally dependent on including shaving and stated been missing for the past red R18's family was requested or one because the facility did for the residents. LPN-A I long, white facial hair on her er lip which needed to be				
	needed extensive a shaving and stated times per week. N	5 p.m. NA-D confirmed R18 assistance from staff for staff tried to shave R18 1-2 A-D stated staff shaved the y provided morning cares.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00477	7 B. WING		12/	2/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
IINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE	
2 920	Continued From pa	age 28	2 920				
	cares on 12/7/16, a provided shaving c shave R18 through currently did have a proceeded to pull the drawer. NA-D cont white facial hairs of which needed to be On 12/7/16, at 2:51 stated R18 had alw her room because stated she had just shaved her face, an was long and no fe on their face. On 12/7/16, at 5:49 (DON) verified R18 grooming needs wh	had assisted R18 with morning and had not offered nor ares and had not attempted to bout the day. NA-D stated R18 a functioning razor and he razor out of R18's top firmed R18 had multiple long, in the chin and next to the lip e removed. I p.m. family member (FM)-A vays had a functioning razor in she bought it for her. FM-A t went into R18's room and ind confirmed the facial hair emale would want those hairs O p.m. the director of nursing a was depended on staff for hich included shaving and ad staff to provide shaving					
	A facility policy rela requested, but not	ted to grooming was					
	The facility could re for providing shavin by the assessed ne education to nursin directed by the card	THOD OF CORRECTION: eview policies and procedures ng/grooming needs as directed eeds of residents and provide ng staff to follow cares as e plan. The facility could ment an auditing system to ompliance.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00477	B. WING		12/08/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
INNEW	ASKA COMMUNITY H		STREET, F CK, MN 563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
2 920	Continued From pa	ge 29	2 920		
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one			
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375		1/10/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on observati review, the facility f infection control me a communally used meter. This practice 6 residents (R3, R1	ent is not met as evidenced ion, interview and document ailed to ensure appropriate easures were implemented for I glucometer/blood glucose e had the potential to effect all 6, R20, R25, R35, R41) who ose monitoring on the A/B		Corrected	
	Findings include:				
	nurse (LPN)-D was hands, gather supp gloves. Behind a c LPN-D wiped R-16' air dried the finger to prick R16's finge (a medical device u in blood) to check F LPN-D returned to	5:47 p.m. licensed practical observed to cleanse her lies from the cart and donned urtain in a small storage area, s finger with an alcohol wipe, and used a disposable lancet r. LPN-D used the glucometer used to measure sugar levels R-16 ' s blood sugar level. the medication cart, disposed ems and placed the top of the cart.			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477			12/08/2016	
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			00/2010
		605 MAI	N STREET, PC			
INNEW	ASKA COMMUNITY I		CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21375	Continued From pa	age 30	21375			
	Humalog insulin per units. LPN-D obtain returned behind the R16's insulin. LPN- cart, placed the ins container (container and equipment), di gloves. Without cle glucometer, LPN-D the medication card drawer of the medi -At 6:05 p.m. LPN- glucometer, meter Levemir insulin per curtain in the hall w sanitizer, donned g glucometer machin in order to obtain a surveyor intervener check R41's blood medication cart wit -At 6:08 p.m. LPN- multi-use glucometer	-D obtained the same strip, alcohol wipe and R41's h. LPN-D went behind the <i>i</i> th R41. LPN-D used hand loves, placed the strip into the le and grasped R41's left hand blood sample. At this time the d. LPN-D did not proceed to sugar and returned to the				
	check R16's blood had the potential to stated the usual fac the communally us	sugar and verified this practice spread infection. LPN-D cility practice was to disinfect ed glucometer after each use. diabetic residents currently				
	glucometers which however, the comm	ication cart had personal were kept in their rooms, nunally used glucometer from when the residents were away				
nesota De		12:21 p.m. the director of fied a glucometer was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			
		00477	B. WING		12/08/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNEW	ASKA COMMUNITY I		N STREET, PC ICK, MN 56381			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 31	21375			
	did not have a pers The DON stated sh glucometer machin resident use to pre bacteria and to follo practices. The DON were aware of the in The facility policy ti Glucometer/Cleani it was policy to adv disinfect blood gluc resident to avoid po SUGGESTED MET The director of nurs review and revise p to disinfecting the o to prevent the spre designee could dev	dication cart for residents who sonal glucometer in their room. he expected the multi-use hes be disinfected between vent the spread of germs and ow basic infection control N indicated all nursing staff infection control practice. tled Maintaining the ng, revised 12/5/15, indicated ise nursing staff to clean and cose meters between each ossible cross-contamination. THOD OF CORRECTION: sing (DON) or designee could policies and procedures related communal glucometer in order ad of infection. The DON or velop and implement an ensure on-going compliance.	4			
21426	(21) Days	R CORRECTION: Twenty-one A.04 Subd. 3 Tuberculosis ntrol	21426			1/10/17
	(a) A nursing home maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's				

KT3D11

If continuation sheet 32 of 44

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
				·		
		00477	B. WING		12/08/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
INNEW	ASKA COMMUNITY		N STREET, F CK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 32	21426		<u>·</u>	
	This program must infection control pla unpaid employees, residents, and volu Health shall provid regarding impleme (b) Written compli be maintained by the This MN Requirem	ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and , contractors, students, inteers. The Department of e technical assistance intation of the guidelines. ance with this subdivision must he nursing home.	t			
	facility failed to ens (TST) had been co residents (R43), ar	v and document review, the sure the Tuberculin Skin Test ompleted, as required for 1 of \$ nd for 2 of 5 employees (E4 for the tuberculosis (TB)	5	Corrected		
	Findings include:					
	Review of the R43 revealed the TST s 3/24/2015. Howeve documentation of t	to the facility on 3/24/15. Is immunization record screen was completed er, the record lacked he date and interpretation of irst and second TST.				
	of E4's employee r	e facility on 9/21/2016. Review ecord revealed the TST screer 1/16, the first step TST was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING	B. WING		08/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY		N STREET,PC ICK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 33	21426			
	9/23/16. However t	he date and interpretation of				
	of E4's employee r was completed 9/2 administered on 9/ 9/29/16. However t	he date and interpretation of	ר ו ו			
	director of nursing step TST was not of stated she expecte procedures, and st facility also failed to	n 12/8/16, at 12:36 p.m. the (DON) confirmed the second complotted for E4 and E5. She ed staff to follow their ated they had forgot. The p provide documentation of the tion of the results for R43's ep TST.				
	Assessment policy staff and residents receive an initial tw had a history of a p	culosis Control Plan/Risk dated 1/7/14, identified all of the nursing home would vo-step Mantoux unless they positive Mantoux, which -ray to determine Tuberculosis				
	The infection contr review the TB polic required informatio could be educated	THOD OF CORRECTION: ol nurse or designee could cies and procedures to ensure in is included. Appropriate stat regarding requirements. uld be conducted and the	ff			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
INNEW	ASKA COMMUNITY H		N STREET, PC CK, MN 5638′			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ge 34	21426			
	results reviewed at meetings.	the quality committee				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21630	MN Rule 4658.1350 Medications; Destru	0 Subp. 2 A.B. Disposition of uction	21630			1/10/17
	remaining in the nu discharge of a resid prescribed, or any of discontinued perma manner recommen or the consultant pl pharmacist must fur instructions and for kept on file in the n B. Unused port drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpart destruction listing th medication, prescri person destroying to	tions of controlled substances rsing home after death or dent for whom they were controlled substance anently must be destroyed in a ded by the Board of Pharmacy narmacist. The board or the rnish the necessary ms, a copy of which must be ursing home for two years. tions of other prescription the nursing home after the of the resident for whom they				
	This MN Requirem by: Based on observati	ent is not met as evidenced		Corrected		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/	08/2016
IAME OF F	PROVIDER OR SUPPLIER		NDRESS, CITY, S			
INNEW	ASKA COMMUNITY		JCK, MN 5638'			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21630	Continued From pa	age 35	21630			
	controlled substand destruction for 1 of utilized Fentanyl pa potential to affect a the facility.	failed to properly secure ces while waiting for f 1 resident (R39) who currentl atches. This practice had the all 40 residents who resided in	у			
	Findings include: On 12/8/16, at 9:43 a.m. during a random review of the A-B wing medication storage cart, a black bound narcotic (medications that have a high likelihood of abuse) medication log book was observed unsecured, on top of the cart. A used Fentanyl narcotic patch was observed tucked inside the front cover of the. At this time, registered nurse (RN)-A stated she had placed R39's used Fentanyl patch in the narcotic book on 12/8/16, at 6:30 a.m. after she had applied R39's new Fentanyl patch. RN-A stated she had placed the used patch in the narcotic book until a staff member was available to witness the destruction of it. RN-A confirmed the narcotic book and Fentanyl patch had been unsecured on top of the medication cart since that time. RN-A stated the narcotic book did not fit into the double locked compartment inside the medication cart and the facility's current process of storing used Fentanyl patches was not the perfect system.	1				
	indicated a new Fe (mcg) was applied On 12/8/16, at 9:48 observed to dispos	arcotic record, page 91, entanyl patch 75 micrograms on 12/8/16, at 6:30 a.m. B a.m. RN-A and RN-B were se of the used Fentanyl patch h nurses signed R39's narcotic				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00477			12/	08/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST N STREET, PC			
INNEW	ASKA COMMUNITY I		CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21630	Continued From pa	age 36	21630			
	patch into the narco witness was availal confirmed the narc medication cart's d was placed unsecu cart which was the storage of used Fe destruction. The D	urse tucked the used Fentanyl otic book for storage until a ble for destruction. The DON otic book did not fit into the ouble locked compartment and ired on top of the medication facility's usual practice for ntanyl patches until ON acknowledged controlled ed in the used Fentanyl				
	Transdermal Delive policy dated 8/6/15 substances must b in a locked contain for any non-control locked medication container must rem when it is accessed residents. Used Fe flushed down the h witnessed by anoth	olled Substances Containing ery System (i.e.: fentanyl) , indicated all controlled e stored in the medication cart er, separate from containers led medications or in the room in a locked cabinet. This nain locked at all times, except d to obtain medications for entanyl patches must be opper in the utility room and be her nurse. Both nurses are in the narcotic record.				
	The director of nurs implement policies disposition of narco fentanyl/duragesic destruction. The q	uality assessment and tee could perform random				
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21)	)			

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00477	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H		I STREET, F CK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Subp. 4. Housekeep provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requireme by: Based on observati review, the facility to in a clean and sanit resident bathrooms A28, A30, A32, A34 C108, C109, C110, to be in need of clear Findings include: During resident roo the following was id	eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and , including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on, interview and document o maintain resident bathrooms ary manner for 15 of 30 on the A and C wings (A26, I, C101, C103, C104, C106, C111, C113, C116) observed aning and repair.	21695	Corrected		1/10/17
	dirty and stained da					
	dirty and stained da					
	base was dark brov	ulking around the white toilet vn, and the off-white floor tile s dirty and stained dark				
	built-up dirt in the c	white bathroom tile floor had orners				
Vinnesota D STATE FORI	epartment of Health M		6899	KT3D11	If continuatio	n sheet 38 of 44

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21695	Continued From pa	age 38	21695			
	dirty and stained da	-white bathroom tile floor was ark, and the bathroom sink hac uild up on the unit and the	1			
	dirty, the bathroom damaged towards t	ff-white bathroom tile floor was door was scratched and the bottom of the door, and the green lime scale build up on ndles.				
	dirty, the bathroom damaged towards t	ff-white bathroom tile floor was door was scratched and the bottom of the door, and the green lime scale build up on ndles				
	stained and dirty, a	ff-white bathroom tile floor was nd the bathroom sink faucet le build up on the unit and the	5			
	off-white bathroom which measured ar inches, and the bat	a large rust stain on the floor tile behind the toilet oproximately 4 inches x 4 hroom faucet had green lime he unit and the handles.				
	off-white bathroom which measured ar inches, and the bat	a large rust stain to the floor tile behind the toilet oproximately 4 inches x 4 hroom faucet had green lime he unit and the handles.				
		athroom sink had built up n the unit and the handles.				
		athroom sink had built-up n the unit and the handles, the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/	08/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MINNEW	IASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	age 39	21695			
		floor tile was dirty and stained k, on the sides of toilet, and				
	bathroom wall opport bathroom sink had the faucet and the	significant scrapes to the osite of the toilet, and the built-up green lime scale on handles, and the off-white was dark, and in poor				
		athroom faucet had built-up n the unit and on the handles.				
		C116-2, the bathroom faucet lime scale on the unit and the				
	Services Director ( responsible for all f housekeeping and staff were to compl leave it at the C nu container. He state for slips at least da removed the repair nurses station they repairs. He stated a they signed the slip the tool shelf in the staff were trained a the request slips fo not aware of the re had not received an identified concerns couple of staff, and maintain the reside	0 a.m. Environmental ESD) stated he was facility maintenance, laundry services. He stated ete a repair request slip, and rses station in the designated d they checked the container ily. He stated when they request slips from the C prioritized and completed the after they completed a repair os, and stored them in a box or boiler room. He stated all annually on how to complete r repairs. He confirmed he was sident room concerns, and ny repair request slips for the . He stated he was short a they hadn't had time to ent rooms the way they should a was no excuse for the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00477	B. WING		12/08/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	12/	2/00/2010	
		HEALTH SERVICE 605 MAI	N STREET, PO	BOX 40		
		STARBU	CK, MN 56381		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21695	Continued From pa	age 40	21695			
	(DON) stated she were bathrooms on A wind assumed resident were bad too. She dirty bathrooms to stated she expected maintain the resider resident rooms had the facility was show maintenance. Review of the facility 7/21/09, identified bathrooms had the facility of the facility for the facility f	:36 p.m. director of Nursing was aware of the dirty resident ng, and stated she just bathrooms on the other wings stated she had mentioned the the ESD in the past, and ed the ESD to clean and ent rooms. She stated she felt d not been maintained because ort staffed in housekeeping and ity policy, "Bathrooms" dated bathrooms would be an and sanitary manner and n a daily basis.	3			
	The director of main reporting system we repairs were made ensure staff are cle	THOD OF CORRECTION: intenance could ensure a vas in place and necessary A Audits could be conducted to eaning and making timely s could be brought to the for review.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
22155	MN Rule 4658.410 New Construction	5 Subp. 2 Bedroom Design;	22155			1/10/17
	area and the arran	oor area. The usable floor gement and shape of the vide space for furnishings, for				

6899

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00477	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H		STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
22155	Continued From pa	ge 41	22155			
	the free movement handicaps, and for floor area" does no toilet rooms, vestibu wardrobes, lockers usable floor area pe square feet per res at least 120 square This MN Requireme by: Based on observati review, the facility for resident rooms on t square feet of usea residents ( R8, R12	of residents with physical nursing procedures. "Usable t include spaces occupied by ules, permanently installed , closets, or heating units. The er bed must be at least 100 ident in double bedrooms, and feet in single bedrooms. ent is not met as evidenced ion, interview and document ailed to ensure the 13 single the A-wing had at least 100 able floor space for 12 of 12 2, R13, R14, R17, R20, R22, 5, R39) who currently resided		Corrected		
	Findings include:					
	p.m. R8, R12, R13, R25, R27, R35 and	-wing on 12/5/16, at 12:00 R14, R17, R20, R22, R24, R39's rooms were observed 100 square feet of useable uired.				
Minnesota D	bed. The room app -At 2:28 p.m. R8 ind her room and was a needed in her room supplies. -At 2:45 p.m. R39 r small room size. -At 3:02 p.m. R13 v herself in a wheelch	p.m. R17 was observed in eared neat and orderly. dicated she was pleased with able to have all the things she n, including her knitting eported no concerns with the was observed propelling nair in her room. R13 was not ifficulty moving about the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00477	B. WING		12/	08/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IINNEW	ASKA COMMUNITY I		N STREET, PC ICK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22155	Continued From pa	age 42	22155			
		ndicated he liked his room. reported no concerns with the				
	On 12/06/2016 08 a concerns with the s	a.m. R24 reported no mall room size.				
	be interviewed due	survey R22 was unavailable to to her busy schedule. R12 weed. All rooms appeared home like.				
	(NA)-F verified the tight when assisting when a mechanical	9:10 a.m. nursing assistant rooms on A-wing were a little g residents and even more so l lift was needed. NA-F stated nanage all resident needs ever is small.	1			
	On 12/08/2016 9:1	7 a.m. R12 refused interview.				
	(DON) indicated sh rooms not being the	9 p.m. the director of nursing was aware of the A wing required square footage and had any resident complaints l room size.				
	room was small, th with its own bathroo having the smaller	p.m. R14 stated although the e benefits of a private room om and a nice view were worth living space. R14 stated her by with the room and had told cozy.				
	her room, had beer	p.m. R27 reported she liked n offered to move to a larger d declined and stated "it is				
	On 12/8/16, at 2:29	the administrator verified the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		12/	08/2016
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IINNEW	ASKA COMMUNITY I		N STREET, PC CK, MN 56381			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
22155	Continued From pa	age 43	22155			
	100 square feet of	the A-wing did have less than usable space and the facility vaiver for this requirement.				
	services director (E on the A-wing were square feet of usea would be applying f	b p.m. the facility environmenta SD) stated the single rooms less than the required 100 able floor space, and the facility for a room wavier. The ESD to problems maintaining				
	The administrator of waiver and monitor ongoing basis for s The quality assess	THOD FOR CORRECTION: could apply for the federal identified rooms on an afety and resident satisfaction, ment and assurance erform random audits to				
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21)	)			

KT3D11

If continuation sheet 44 of 44