*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
August 10, 2023

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN  56726

RE: CCN: 245616
Cycle Start Date: April 13, 2023

Dear Administrator:

On June 21, 2023 and July 6, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered
April 26, 2023

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN  56726

RE: CCN: 245616
Cycle Start Date: April 13, 2023

Dear Administrator:

On April 13, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

## 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 July 13, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by October 13, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

**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.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245616 | A. BUILDING _____ B. WING _____ | C 04/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFECARE GREENBUSH MANOR | 19120 200TH STREET GREENBUSH, MN 56726 |

| (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 |
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| E 000 | Initial Comments<br><br>On 4/10/23 through 4/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 4/10/23 through 4/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with no deficiency(s) issued.<br>H56161028C (MN92064)<br>H56161063C (MN91401)<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/03/2023 |

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

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| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to comprehensively assess for the use of a mechanical lift chair 1 of 1 resident (R3) observed to use a mechanical lift chair.<br><br>Findings include:<br><br>R3's quarterly Minimum Data Set dated 3/15/23, identified R3 had severe cognitive impairment, required assistance with transfers and had functional impairment of range of motion in both lower extremities. R3 had two or more since admission without injury.<br><br>R3's care plan dated 12/5/22, directed staff to place the mechanical lift chair remote control out of reach, and unplug recliner when occupied.<br><br>On 4/11/23 at 4:28 p.m., R3's was observed in her mechanical lift chair. The chair was in the reclined position with the foot rest extended straight out. R3 was seated in an upright position with her legs extended straight out in front of her and was attempting to get out of the chair without staff assistance. The call light was not on. R3 stated she was trying to get into her wheelchair. | F 689 | 1.R3□s lift chair has been screened by occupational therapy on 4-19-2023. OT recommends to remove the lift recliner and replace with regular recliner. Resident□s POA felt strongly about keeping the lift chair and provided rational for keeping it. Education provided to POA: risks of ongoing use of recliner and POA signed a risk review.<br>2.Care coordinators will assess all current residents□ who have lift reciners prior to plan of correction date.<br>3.The Safety Risk Data Collection Assessment tool is completed on admission, quarterly, annually, and PRN. Questions added to the assessment Is there a history of fall(s) from a lift recliner? Can the user operate appropriately by return demonstration? This tool identifies residents that use lift recliners, and appropriateness of lift recliner use is discussed at IDT. In the future, if IDT determines a resident is not safe (i.e. resident is found to be using the remote inappropriately, BIMS score indicates moderate or severe cognitive impairment, and/or there are other safety concerns | 5/31/23 |

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| F 689 | Continued From page 2<br>Surveyor alerted staff that R3 was attempting to get out of the mechanical lift chair. Nursing assistant (NA)-D entered R3's room and offered to assist R3 into her wheelchair. NA-D stated R3 made frequent attempts to self transfer out of the recliner, so staff needed to elevate the foot rest, put the remote out of reach in the pocket of the recliner, and unplug the lift chair from the wall.<br><br>R3's medical record lacked a safety assessment for use of a mechanical lift chair.<br><br>During interview on 4/12/23 at 2:18 p.m., registered nurse (RN)-C stated R3 had a history of falls. On 1/24/23, R3 was found on the floor with the mechanical lift chair in the standing position. R3 previously was seated in the mechanical lift chair with the TABS alarm (an alarm where a string attaches to the clothing of the resident on one end, and an affixed box at the other, when the resident moves, the string pulls out of the box and an alarm sounds) clipped to her shirt. Staff heard the alarm sounding and found R3 sitting on the floor with her feet out in front of her. R3 didn't use the call light for staff assistance. The facility implemented and intervention to keep the mechanical lift chair remote out of reach of R3; however, an assessment for the safe use of the mechanical lift chair was not completed, to ensure resident safety with self transferring from a chair in reclined position.<br><br>During interview on 4/12/23 at 8:17 a.m., NA-D stated R3 would raise the mechanical lift chair to the upright position and attempt to self transfer out of the chair. At times, staff had to take R3's chair remote away or unplug the chair to ensure the resident's safety. | F 689 | noted) then a screen will be sent to Occupational Therapy for further insight/recommendations. If therapy determines that there is safety concerns noted with lift recliner use, will discuss and provide education to resident and/or family.<br>4.DON or designee will complete audits weekly X 12 weeks for appropriateness of lift chair use. Findings will continue to be reviewed by the Quality Assurance and Performance Improvement Committee on a quarterly basis.<br>5.Staff education will be completed in May 2023 regarding lift chair safety and appropriateness. | |

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| F 689 | Continued From page 3<br><br>During observation on 4/12/23 at 8:24 a.m., R3 was seated in the chair in her room. The chair was in the reclined position and the TABS alarm was clipped to the back of R3's shirt. The remote was in the pocket of the chair and out of reach of the resident.<br><br>During interview on 4/12/23 at 4:19 p.m., the director of nursing (DON) stated resident assessments should be completed upon admission, quarterly, annually and with any significant changes. Assessments for mechanical lift chair would be completed based on when the resident received the chair, their cognition and if the resident appeared safe with the chair.<br><br>A policy for safe mechanical lift chair use was requested; however the facility did not have a policy. | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to to act on continued complaints of pain for 1 of 1 residents (R82) reviewed for pain.<br><br>Findings include: | F 697 | 1. R82 was seen on 4-17-23 for a special visit and pain medications were adjusted. Pain improved. 5-1 was seen on Dr. rounds and had medications adjusted more. R 82 has been enjoying going for drives out of the facility with her | 5/31/23 |

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| F 697 | Continued From page 4<br><br>R82's admission Minimum Data Set (MDS) dated 4/9/23, identified R6 had moderate cognitive impairment. R6 reported frequent and moderate pain. R6 received non-pharmacological pain interventions as well as scheduled and as needed (PRN) pain medications. Diagnoses included a wedge compression fracture (a break in the vertebrae, the bones that make up your spine, caused by force) of the lower spine and low back pain.<br><br>R82's physician orders dated 3/27/23, included the following:<br>- Duragesic-50 transdermal patch (used for persistent moderate to severe pain) 72 hour 50 mcg/hours (hr) Apply 50 mcg patch transdermally one time a day every 3 day(s) related to wedge compression fracture of second lumbar vertebra.<br>- Lidocaine external patch 5 % (used to help reduce itching and pain from certain skin conditions and may also be used to help relieve nerve pain). Apply to lower back topically every 24 hours for on for 12 hours - off for 12 hours related to low back pain<br>- Morphine sulfate (concentrate) oral solution (used to treat severe pain) 100 milligram (mg)/5 milliliter (ml) give 0.25 ml by mouth every 4 hours PRN pain/discomfort related to wedge compression fracture of second lumbar vertebra.<br>- Tramadol hcl (used to help relieve moderate to moderately severe pain) 50 mg oral tablet give 50 mg by mouth every 8 hours as needed for pain/discomfort related to wedge compression fracture of second lumbar vertebra.<br>- Tylenol extra strength (used to treat mild to moderate pain) 500 mg tablets give 2 tablets by mouth three times a day related to wedge compression fracture of second lumbar vertebra. | F 697 | husband.1.Pain assessments are completed on admission, quarterly, annually, and PRN weekly with vitals and prn.<br>2. If PRN pain medication administration is deemed ineffective, explore both non-pharmacological and pharmacological interventions. After all of these interventions are exhausted, if still ineffective, a provider will be contacted for further instruction regarding pain management.<br>3.Will complete shift to shift audits of prn pain medications administered and their effectiveness. If a problem is identified, the oncoming nurse will explore non-pharmacological and pharmacological interventions that can be utilized for further management of pain. If all interventions listed above are ineffective or the resident fails to have adequate pain control, the licensed nurse will contact a provider.<br>4. Audits will be completed 3x/week X 12 weeks and findings will be reported to QAPI committee.<br>5.Staff education will be completed in May 2023 regarding importance follow-up on PRN medication administration and documentation of non-pharmalogical interventions. Provide staff ideas of non pharmalogical interventions. | |

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| F 697 | Continued From page 5<br>- Xanax (an antianxiety medication) give 0.125 mg by mouth every 4 hours as needed for anxiousness for 14 days dated 4/3/23<br><br>R82's care plan dated 4/2/23, directed staff to encourage weight bearing exercise as tolerated to help maintain bone mass, give pain medications as ordered by the physician and monitor/document for side effects and effectiveness, and provide pillows, etc. to help maintain comfortable position. The care plan also identified R82 had an alteration in musculoskeletal status related to aging condition of her body and chronic conditions and directed staff R82 needed to change position (every 1-2 hours) along with alternated periods of rest with activity out of bed in order to prevent respiratory complications, dependent edema, flexion deformity and skin pressure areas.<br><br>R82's pain Care Area Assessment (CAA) dated 4/9/23, identified R82 was having severe back pain when first admitted to the facility. R82's pain improved, and R82 used as needed morphine and Tramadol less. R82 was being managed by Tylenol 1,000 mg three times a day, Lidocaine patch 5%, and Duragesic patch 50 microgram (mcg). Vertebroplasty (a procedure in which a special cement is injected into a fractured vertebra - with the goal of relieving spinal pain and restoring mobility) was done to help with pain. Plan to maintain or improve R6's pain to maintain quality of life. The CAA did not address R82's non-pharmacological pain interventions.<br><br>On 4/10/23 at 2:18 p.m., R82 was observed sitting in her wheelchair with her elbows resting on the tops of her thighs, back hunched, and rocked her wheelchair back in forth with her feet. | F 697 | | |

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| F 697 | Continued From page 6<br>R82 stated she recently was admitted to the facility due to a fall at home. R82 was having back pain that had worsened after having a dressing changed to her lower back and stated she told nursing staff. R82 was given Tylenol but it was not helping. "It was pretty good until that dressing change." R82 never had pain like that before and "uff, I just can't stand it." R82 rated her pain at a 7 on a 0-10 scale (a score of 0 means no pain, and 10 means the worst pain you have ever known).<br><br>R82's April 2023 Electronic Medication Administration Record (EMAR) identified on 4/10/23 at 4:37 p.m., R82 was given morphine sulfate (concentrate) oral solution 100 mg/5 ml give 0.25 ml by mouth for pain; however, the administration was documented as ineffective and there was no evidence R82's pain was followed up on.<br><br>During observation on 4/10/23 at 6:12 p.m., R82 was sitting at the supper table in her wheelchair with her meal in front of her. R82 continued to grimace with movement and was rocking her wheelchair back and forth with her foot. R82 ate approximately 25% of her meal and stated it tasted good, but "I just can't."<br><br>During a telephone interview on 4/11/23 at 4:06 p.m., registered nurse (RN)-A stated on 4:30 p.m. on 4/10/23, she did give R82 a dose of morphine sulfate due to complaints of increased pain. Approximately two hours later, R82 reported her pain was unchanged. RN-A stated she did not offer any non-pharmacological interventions or other PRN pain medications. as R82 routinely complained of pain when going to the bathroom or standing up. Further, R82 routinely reported | F 697 | | |

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| F 697 | Continued From page 7<br>her pain at a 6-7 and, because of this, RN-A stated additional pain medication was not warranted.<br><br>During an interview on 4/12/23, at 2:17 p.m. the director of nursing stated she expected staff to offer something more such as another PRN pain medication to relieve R82's pain and/or to try something non-pharmacological such as an ice pack or hot pack.<br><br>The facility policy Pain Assessment/Monitoring Procedure revised 2/14, identified if a resident stated they had pain, take his/her word for it. Pain was a subjective experience. The policy identified indicators of pain included frowning, abnormal body posture, grimacing, and decrease in usual activities. If the resident continued to experience pain, the pain medication needed to be re-assessed. Non-pharmacological interventions included: altering the environment for comfort, ice pack, mild heat, repositioning, and diversions. | F 697 | | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively assess and implement interventions for specific identified behavior triggers for 1 of 3 residents (R17) reviewed for dementia care. | F 744 | 1.R17 Care plan was updated to identify triggers and provide interventions. Staff educated on changes.<br>2. Will review all current resident behavior care plans for appropriate behavior triggers and interventions by completion | 5/31/23 |

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| LIFECARE GREENBUSH MANOR | 19120 200TH STREET GREENBUSH, MN 56726 |

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| F 744 | Continued From page 8<br>Findings include:<br><br>R17's quarterly Minimum Data Set (MDS) dated 2/2/23, identified R17 had a severe cognitive impairment and R17 did not exhibit behaviors during the look back period. A diagnosis of dementia without behavioral disturbance was included.<br><br>R17's cognitive loss/dementia Care Area Assessment (CAA) dated 5/5/22, identified R17 had a severe cognitive impairment. R17's risk factors were identified as verbal or physical abuse by staff or others, avoidance by staff or others, social isolation, neglect of cares, unmet needs, increased signs/symptoms of depression. R17 was very hard of hearing and directed staff to utilize a pocket talker and/or visual aids to communicate with R17. The CAA did not address interventions for his risk factors.<br><br>R17's care plan revised 3/21/23, directed staff to do the following:<br>- Reminisce with the R17 using photos of family and friends.<br>- When conflict arose, remove R17 to a calm safe environment and allow to vent/share feelings.<br>- R17 would refuse staff assistance to change incontinent product or toileting at times due to his progressive dementia. Staff were to reapproach at a later time, different staff members, encouragement, or distraction if agitated, combative or declining cares.<br><br>R17's Behavior Tracking Log dated March 2023, identified the following:<br>- On 3/4/23 at 7:00 p.m., care was attempted and R17 appeared calm in R17's bathroom. R17 refused cares and wanted to go take care of the | F 744 | date.<br>3. For residents that exhibit worsening behaviors, or behaviors that place themselves or others at risk for harm, IDT will review and revise the resident□s care plan with resident-focused goals and interventions. Changes made to the resident□s plan of care will be relayed to the resident's caregivers via a printed copy of the resident□s behavior care plan, at stand-up, and via nurse-to-nurse report. Ongoing resident-specific dementia cares and approaches will be monitored through review of nurses' notes. IDT will identify behavior incidents and will interview the staff assisting while the adverse behavior occurred to see how staff responded and if the response was appropriate.<br>4.Audits will be completed by DON or designee 3x/week and prn X 12 weeks. Findings will be report to QAPI committee.<br>3. RN will assess behaviors on all residents specifically to the particular behaviors identified on admission, quarterly, annual and prn. These interventions will be included in future CAA.<br>5. Staff education will be completed in May 2023 to address resident specific behaviors and addressing interventions specific to the behavior. Educate staff on interventions to try specific to resident plan of care. Education on providing care to a resident with dementia diagnosis. | |

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| F 744 | Continued From page 9<br>cows and/or farm. Staff attempted distraction and change of staff, but the behavior remained the same.<br><br>- On 3/7/23 at 6:00 p.m., care was attempted in the "dining room." R17 had dumped a whole pepper shaker in his lap. Staff redirected and provided distraction and the behavior stopped.<br><br>- On 3/20/23 at 6:30 a.m., care was attempted in R17's bathroom. R17 was combative, hitting, and yelling out. 1-2 staff did calm him down then R17 started back up again.<br><br>During an interview on 4/11/23 at 3:13 p.m., nursing assistant (NA)-E stated staff were told R17 had Alzheimer's disease and R17's mood/behaviors could go from 0-10 quickly. R17 preferred female caregivers, but NA-E personally didn't have any problems when taking care of R17. If R17 became angry and/or combative, NA-E would attempt to calm him using a soft voice, distraction, but ultimately because R17 preferred females he would request assistance from a co-worker.<br><br>During a telephone interview on 4/11/23, at 4:16 p.m. registered nurse (RN)-A stated R17 exhibited behaviors of anger, combativeness or refusal of care. Usually, R17 just said no. RN-A would instruct the nursing assistants to just walk away and reapproach in 20 minutes. Either R17 would or he wouldn't allow the care.<br><br>During a telephone interview on 4/11/23, at 4:26 p.m. NA-A stated R17 was hard to take care of most of the time. R17 had increased behaviors on the evening of 3/19/23, but finally went to bed. NA-A let R17 sleep all night but did check on him | F 744 | | |

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| F 744 | Continued From page 10<br>to make sure he was safe. When R17 woke the morning of 3/20/23, NA-A believed R17 needed to have cares completed because he had been sleeping for 12 hours, wasn't toileted and was incontinent of bowel and bladder. R17 was refusing to get out of bed or to stand. Because of this, NA-A obtained a standing lift and used the lift to assist R17 to the bathroom, but R17 continued to be resistive with cares and refused. NA-A asked NA-B to assist him with R17's cares and they were able to get him dressed the best they could. R17 did say no and refused cares, and when cares didn't stop, R17 began yelling, swearing, and striking out. NA-A stated he had considered stopping cares, but believed cares needed to be finished because R17 had a history of skin breakdown. R17 continued to refuse cares, yell, hit and swear at NA-A and NA-B. "I don't know what his deal was."<br><br>During interview on 4/12/23 at 11:12 a.m., NA-B stated R17 did well with her usually. NA-B would ask R17 if he wanted to get up and if not, if R17 was safe, NA-B would go back and try again later. R17 did refuse cares and staff were to try to get him to use the bathroom. R17 had dementia and it was important on how staff approached R17. R17 could be happy one minute, then unhappy the next. R17 did better with female caregivers than male caregivers. There were male caregivers that did fine with R17, but NA-A was loud and abrasive. On the morning of 3/20/23, NA-B assisted NA-A with R17's cares. NA-B asked R17 if he wanted to get up, but R17 did not begin moving. NA-B did not want to push him, but NA-A entered the room and began telling R17 loudly "we were going to get you up." R17 did not want to, but NA-A stated "nope, we're going to get you up" and dressed. R17 wasn't having anything | F 744 | | |

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| F 744 | Continued From page 11<br>to do with it.<br><br>- R17 was refusing to stand and NA-A obtained a bedside commode, but R17 continued to refuse. NA-A then obtained the standing lift because they couldn't get R17 into his wheelchair. NA-B stated she knew R17 wasn't care planned to use a standing lift, but wanted to ensure R17 was safe and did not fall. R17 began hitting, kicking, striking out while NA-A and NA-B transferred him using the standing lift to his wheelchair. R17 was yelling "get out", "don't touch me." Once R17 was on the toilet, NA-A left the room. NA-B calmly asked R17 if she could finish his cares and R17 agreed as long as NA-A did not return. R17 completed cares without further resistance. NA-B stated she did not speak up during the incident to tell NA-A to stop nor did she request help from other staff. After NA-B assisted R17 to breakfast, she reported the incident to the licensed practical nurse (LPN)-A.<br><br>During a telephone interview on 4/12/23 at 11:46 a.m., LPN-A stated NA-B reported NA-A and NA-B continued to provide morning cares to R17 even though he refused on 3/20/23. LPN-A then reported the incident to the director of nursing (DON) when she arrived to the facility approximately at 8:00 a.m. that morning. LPN-A stated R17 did have behaviors. If you try to help, he will push you away. R17 will kick, hit, and yell. For example, if he fell asleep at the dining table, if you try to assist him to his room he will become angry. Staff were directed to make sure R17 was safe, then reapproach later. You just make it worse if you keep fighting the bear. R17 did have triggers for his behaviors. Sometimes, he just did not want to be touched. R17 was very hard of hearing and had a communication board in his | F 744 | | |

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| F 744 | Continued From page 12<br>room. R17 did not have any preferences for male or female caregivers, but it was how you approached him; with a calm clear voice.<br><br>During an interview on 4/12/23 at 11:57 a.m., NA-C stated you just never knew because R17 was one of those people that just refused a lot. When it came to refusing, sometimes he would say no, get out, or he would just ignore you. Plus, R17 was one where if you kept asking, it would make it worse. NA-C stated R17 was usually cooperative for her. NA-C would ask if he needed to go to the bathroom. If R17 said no, NA-C would ask in a different way to make sure he heard her, but if R17 continued to ignore her or say no, she would leave and go back later. If R17 still refused, she would tell the nurse or another staff member to try.<br><br>During an interview on 4/12/23, at 12:28 p.m. LPN-B stated R17 refused cares a lot and it was how staff approached him. However, R17 had no specific trigger for his behaviors. R17 was a farmer and habitually rose early in the morning. Sometimes, R17 believed he was busy with farm work and if staff tried to toilet him or do cares, R17 just didn't have time for it. Staff were to reapproach when he refused.<br><br>During an interview on 4/12/23, at 2:39 p.m. the DON stated she had not reviewed R17's care plan herself but the staff had talked about his behaviors during the interdisciplinary team (IDT) meeting. R17's behaviors had worsened in the past few months and he had become more resistive, possibly due to pain. The DON was unaware of what R17's behavior triggers were, but she was told he worries about the farm, the cows, and how his son will be able to take care of | F 744 | | |

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| F 744 | Continued From page 13<br>it. The DON had never been told R17 preferred female caregivers, preferred a calm, quiet voice, and/or would become angry with repeated questions, but all of that should have been in R17's assessment and care plan. The DON believed the incident happened not because of how R17 reacted to the situation, but how NA-A reacted to R17. Because of this, R17's care plan did not need new interventions. Staff not familiar with a residents care would need to review the care plan, but did expect staff to reapproach any resident who refused cares.<br><br>The undated Care Planning policy, identified a care plan would be developed and maintained on each resident according to the RAI guidelines. The comprehensive care plan had been designed to:<br>A. incorporate identified problem areas.<br>B. Incorporate risk factors associated with identified problems.<br>C. Build on the resident's strengths.<br>D. Reflect treatment goals and objectives in measurable outcomes.<br>E. Identify the professional services that are responsible for each element of care.<br>F. Maintain and prevent declines in the resident's functional status and/or functional levels.<br><br>A dementia care policy was requested but not received. | F 744 | | |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/11/2023. At the time of this survey, Lifecare Greenbush Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

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

Electronically Signed | 05/03/2023

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

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| K 000 | Continued From page 1 | K 000 | | |

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building.

The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system

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| K 000 | Continued From page 2<br>installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection.. The fire alarm system is monitored for automatic fire department notification.<br><br>The facility has a capacity of 40 beds and had a census of 30 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 351 SS=E | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, | K 351 | | 4/12/23 |

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| K 351 | Continued From page 3<br>19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/12/2023, between 11:30am and 2:30pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads.<br><br>These obstructions were found in:<br>1) Central Supply Office/room - E116<br>2) Storage room - E125<br>3) Activities Office<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 351 | K 351<br>Obstructions were removed on 4-12-2023. Brett Dallager the Maintenance Supervisor will place laminated signage in storage rooms that read no storage of items 18 under and around sprinkler heads. Maintenance Supervisor will audit storage rooms on quarterly safety rounds. | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and | K 712 | | 5/3/23 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 712 | Continued From page 4<br>unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/11/2023, between 11:30am and 2:30pm, it was revealed by a review of available documentation that fire drills were not completed: second shift - missing first quarter (January - March) and missing second quarter (April - June) drills completely.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 712 | Brett Dallager the Maintenance Supervisor will use a spread sheet to monitor fire drills. A spread sheet will help assure our goal of fire drills on appropriate shifts quarterly. The spread sheet will be in the binder with the fire drills to view monthly for proper completion. Fire drills will be reported to the Environmental Safety Committee. The spread sheet will be implemented on 5-3-2023. | |