DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 18, 2019

Mr. Blake Dehnke,
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

Subject: Evergreen Terrace - IDR
CMS Certification Number (CCN) 245495
Project # S5495028

Dear Mr. Dehnke:

This is in response to your letter of September 7, 2018, concerning your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F678 issued pursuant to the complaint survey event LD6V11, completed on August 10, 2018.

The information presented with your letter, the CMS 2567 dated August 10, 2018 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

F678 Scope and severity (S/S) – J – 42 CFR §483.24 (a)(3) – Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Intent: "To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs, and the resident's advance directives."

Guidance at **§483.24** (a)(3) indicates – *"Additionally, facilities should have procedures in place to document a resident's choices regarding issues like CPR. Physician orders to support these choices should be obtained as soon as possible after admission, or a change in resident preference or condition, to facilitate staff in honoring resident choices. Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises.* Resident wishes express through a resident representative, as defined at **§483.5**, must also be honored, although, again physician orders should be obtained as soon as possible.

Appendix Q of the SOM provides guidance for surveyors in determining whether or not residents are in an Immediate Jeopardy situation:

- **Only ONE INDIVIDUAL needs to be at risk.** Identification of IJ for one individual will prevent risk to other individuals in similar situations.
- **Serious harm, injury, impairment, or death does NOT have to occur before considering IJ.** The high potential for these outcomes to occur in the very near future also constitutes IJ.

If the team identifies an IJ situation, the following points are to be considered:

- **The entity either created or allowed a situation to continue which resulted in serious harm or a potential for serious harm**, injury, impairment or death to individuals.
- The entity had an **opportunity to implement corrective or preventive measures**.

Summary of the facility's reason for the IDR of these tags: The facility asserts their primary failure with respect to the findings at F678 for R46 and R58 was to ensure a current copy of the resident's advanced directive wishes was in the resident's medical record. The facility indicated that while a Physician's Orders for Life Sustaining Treatment form (POLST) is one document used to communicate advanced directives for a resident, it is not the sole document that should be considered when determining the course of action in the event of an arrest. Further, the facility stated that R46's instance did not meet criteria for immediate jeopardy, as no instance of cardiopulmonary arrest actually occurred.

Summary of facts: R46 was a severely cognitively impaired resident who was admitted to the facility on 6/2/18, with diagnoses including epilepsy, major depression and cognitive impairment. R46's physician's order summary printed on 8/7/18 indicated a full code status (perform CPR following cardiopulmonary arrest). R46's POLST form which was on file in the active medical record reflected a resuscitation status of DNR (do not resuscitate), which conflicted with the physician's orders as well as the R46's care plan, which indicated R46 was full code.

A change in R46's preferences for CPR was expressed at a care conference held on 6/13/18 and a new POLST form was initiated indicating she wished CPR be administered in the event of cardiac arrest. The POLST form remained unsigned and was located during the course of the survey on 8/08/18, nearly two months after R46's care conference. In addition, R46 was noted to have had a recent medical emergency on 8/2/18, related to a seizure lasting approximately 10 minutes, which required transfer to the local emergency room. Interviews with facility nursing staff and the director of nursing indicated the POLST was the document nursing staff were to reference in the event a resident experienced cardiopulmonary arrest.

R58 was a cognitively intact resident that admitted to the facility on 4/18. R58's current physician orders indicated a code status of DNR/DNI, however, the POLST form R58 and the nurse practitioner had signed, as well as R8's care plan indicated CPR should be performed in the event of an arrest. R58's code status was clarified on 8/7/18 during the course of the survey to be a full code.

Summary of findings: R46's instance met the required components of noncompliance at F678 at immediate jeopardy. The facility had been aware of R46's wish to change their code status for nearly two months, failed to ensure documentation was forwarded to the physician for signature, and failed

to ensure the POLST in R46's chart reflected their current desired code status. R46 had recent hospital visits due to underlying medical conditions, making it especially important for staff to be aware of R46's wishes. R58 was cited as a secondary example of noncompliance as the current physician's orders indicated a code status of DNR/DNI, however, the POLST indicated a full code. The discrepancy between the physician's orders and POLST was not clarified until nearly four months later, when called to the facility's attention by survey staff. F678 is a valid deficiency and is properly cited at the scope and severity of "J', immediate jeopardy.

This concludes the Minnesota Department of Health informal dispute resolution process.
Please note, it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Holly Kranz, RN, PHN, Mankato Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: (507) 344-2742 Fax: (507) 344-2723

Cc: Office of Ombudsman for Long-Term Care
Pamela Kerssen, Assistant Program Manager
Kathleen Lucas, St. Cloud B Unit Supervisor
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LD6V

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/04/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

An immediate jeopardy began on 6/13/18 on F0678 Cardio-Pulmonary Resucitation (CPR). The administrator and clinical vice president were notified of the immediate jeopardy on 8/8/18, at 12:17 p.m. and the immediate jeopardy was removed on 8/9/18, at 12:05 p.m., but non-compliance remained at a lower scope and severity level of no more than minimal harm at an isolated pattern, level D.

17. SURVEYOR SIGNATURE — Date:
Kathleen Lucas, Unit Supervisor — 10/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 10/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/26/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 8, 2018

CMS Certification Number (CCN): 245495

Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

Dear Administrator:

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 October 4, 2018 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

October 8, 2018

Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495028

Dear Administrator:

On August 29, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 2, 2018. (42 CFR 488.422)

- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 10, 2018 that included an investigation of complaint number H5495058. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On October 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 4, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2018, as of September 21, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 21, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated August 29, 2018:

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 10, 2019 be rescinded as of September 21, 2018. (42 CFR 488.417 (b))

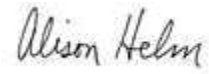
The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File [

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: LD6V

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/10/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

An immediate jeopardy began on 6/13/18 on F0678 Cardio-Pulmonary Resucitation (CPR). The administrator and clinical vice president were notified of the immediate jeopardy on 8/8/18, at 12:17 p.m. and the immediate jeopardy was removed on 8/9/18, at 12:05 p.m., but non-compliance remained at a lower scope and severity level of no more than minimal harm at an isolated pattern, level D.

17. SURVEYOR SIGNATURE Date:
Lisa Ciesinski, HFE NE II 09/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 09/25/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

REVISED LETTER

August 30, 2018

Evergreen Terrace
Attn: Administrator
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495028 and H5495058

This revised letter will replace the letter dated August 29, 2018. We have made the following corrections in the letter; the IJ removal date is August 9, 2018. All remedies dates will be based of the letter from August 29, 2018.

Dear Administrator:

On August 10, 2018, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 which was found to be unsubstaniated.

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

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

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

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 9, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343

Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

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

this Department is imposing the following remedy:

- State Monitoring effective September 2, 2018. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Evergreen Terrace is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 9, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800)

397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

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

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 10, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
August 29, 2018

Mr. Lee Harwarth, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495028 and H5495058

Dear Mr. Harwarth:

On August 10, 2018, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 which was found to be unsubstaniated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 that was found to be unsubstantiated.

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate

jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 10, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be

imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 2, 2018. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Evergreen Terrace is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 10, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

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

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 10, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections

Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 6th-10th during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness policies and procedures addressed	E 024	Immediate corrective action: *The use of volunteers in an emergency or other emergency staffing strategies,	9/21/18

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

Electronically Signed | 09/07/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 1 the use of volunteers in an emergency, or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This had the potential to affect all 72 residents residing in the facility. Findings include: The facility emergency preparedness plan dated 6/18, lacked direction for the use of volunteers during an emergency. During an interview on 8/10/18, at 10:50 a.m. the environmental services manager (ESM) stated there was no policy on the use of volunteers or staffing strategies addressed in the emergency preparedness plan.	E 024	including the process and role for integration of State and Federally designated healthcare professionals to address surge needs during an emergency was developed and added to the facility's Emergency Preparedness Plan. Action as it applies to others: *the Policy and Procedure for "Disaster/Emergency use of Volunteers" was developed. *Education for all staff on the policy was held on 8/28/18. Date of completion: 9/21/18 Recurrence will be prevented by: *The facility will engage in community Disaster Drill annually, will conduct internal drills, and will conduct "Table Top" discussion to include a scenario of alternative care site and challenge questions and use of volunteers and other professionals to test the revised Emergency Preparedness Plan. The correction will be monitored by: Maintenance Director/Administrator	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 026		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 2 this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings include: The facility emergency preparedness plan dated 6/18, lacked identification of the facility's role in providing care and treatment to clients at an alternate site, under the 1135 waiver as part of the facility's Emergency Preparedness Program Plan. During an interview o 8/10/18, at 10:55 a.m. the	E 026	Immediate Corrective action: *The need for care at an alternative care site during an emergency was developed and added to the facility's Emergency Preparedness Plan. Action as it applies to others: *The Policy and Procedure for "Resident Caress at Alternate Facility" was developed. *Education for all staff on the policy was held on 8/28/18 to review the updates to the Emergency Preparedness Plan. Date of completion: 9/21/18 Recurrence will be prevented by: *the facility will engage in community disaster Drill annually, will conduct internal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 3 environmental service manager (ESM) stated the ESM had not addressed the 1135 waiver as part of the emergency preparedness plan.	E 026	drills, and will conduct "Table Top" discussion to include a scenario and challenge questions to include care at an alternative care site to test the revised Emergency Preparedness Plan. The correction will be monitored by: Maintenance Director/Administrator	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 4 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure they conducted exercises to test their emergency plan at least annually, including participation in a full scale and table top exercises. This had the potential to affect all 72 residents currently residing in the facility, as well as staff and visitors. The findings include:	E 039	Immediate Corrective action: *Exercised to include participation in community disaster plan drill in April, 2018 (the specific date has not been set yet) as well as "Table Top" on 9/21/18, discussion with scenario to prepare for an emergency was developed and added to the facility's Emergency Preparedness Plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 5 A review of the facility's emergency preparedness plan dated 6/18, failed to indicate the facility had conducted exercises to test their emergency plan. During interview on 8/10/18, at 11:35 a.m. with environmental service manager (ESM) stated the facility had not yet conducted any exercises.	E 039	Action as it applies to others: *The Policy and Procedure for "Participation in Community Based Emergency Plan Testing" was developed. *Education for all staff on the policy was held on 8/28/18 to review the updates to the Emergency Preparedness Plan. Date of correction: 9/21/18 Recurrence will be prevented by: *The facility will engage in community Disaster Drill annually, will conduct internal drills, and will conduct "Table Top" discussion to include a scenario of alternative care site and challenge questions and use of volunteers and other professionals to test the revised Emergency Preparedness Plan. The correction will be monitored by: Maintenance Director/Administrator	
F 000	INITIAL COMMENTS A recertification survey was conducted August 6th-10th and complaint a investigation was also completed at the time of the extended survey. An investigation of complaint H5495058 was completed and was not substantiated. An extended survey was completed on August 10, 2018, due to an immediate jeopardy cited at F678. Life Sustaining Treatment (POLST) in R46's record that was signed and updated on 6/13/18, as full code status. The POLST that was reviewed in R46's record on 8/6/18, and had been in R46's record since her admission on 6/2/18, indicated DO NOT RESUSCITATE (DNR). Upon	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 6 interview, several of the nurses identified that if a resident was found to be in need of resuscitation, they would look first to the POLST for direction on code status and would follow the directive of the POLST. In the case of R46, this would have been DNR. This failure to file a correct POLST in the resident record that indicated the residents wished to be resuscitated, resulted in an immediate jeopardy situation for R46. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified environment for 1 of 1 residents (R114) who had a poor fitting high rise commode resulting in urinating on self and on the floor. Findings include: R114's Minimum Data Set (MDS) had not been	F 550	Immediate Corrective Action: Resident #114 was discharged on 8/27/18. Action as it applies to others: *The Policy and Procedure for Resident dignity was reviewed and remains current. *The residents who could be affected who's bathrooms have high rise	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8 completed as R114 was recently admitted to facility for a short term stay following a right knee revision. She required rehabilitation and strengthening of left knee. R114's Care Plan indicated R114 was cognitively intact, makes own decisions, communicate needs, independent with activities of daily living, assist of one but transfers self with walker, and continent of bowel and bladder. During an interview and observation on 8/9/18, at 11:03 a.m. housekeeper (HK)-A stated the facility has a problem with the high rise commodes not fitting properly over the existing toilets. HK-A stated the seat does not go back far enough because of the lid. HK-A stated one person in the room may need the high rise toilet and the other may not, and when it gets moved around (she demonstrated the gap) urine and feces get on the floor. HK-A stated they have problems with other residents voiding all over the bathroom floors related to commodes not fitting properly. HK-A stated the high rise commodes do not fit properly and are not steady. Two high rise commodes were currently in use, one in the bathroom of R114 which was shared with her room mate and a resident from another room. The other high rise commode was in a bathroom shared by 2 residents in 204-1 and 204-2. Both bathroom commodes were observed to be fitting/positioned poorly with the front portion of the commode seat sticking out 4-5 inches from the front of the toilet, leaving a large gap. During an interview on 8/9/18, at 1:56 p.m. HK-B stated there are different size high rise commodes and they do not fit correctly over the toilet so they have problems with urine getting on	F 550	commodes, will have them removed and if needed replaced with a better option. *All nursing staff were trained on resident dignity on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented by: *Audits of 5 random residents will be interviewed weekly x 90 days to assure their resident rights regarding dignity are being met and the results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: *Social Services/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

the floor. HK-B stated the seats do not go back far enough and this has been a problem for months.

During an interview on 8/9/18, at 2:07 p.m. R114 stated she has been voiding on her self, legs, on the floor and on her clothes due to the high rise commode over the existing toilet in the bathroom. R114 stated she shares the toilet with two other women, her room mate and a women in the next room. R114 stated the high rise commode also hurts her surgical leg when she sits on it, she has a healing incision with staples and a dressing following a left total knee revision from the week prior. R114 stated she does not need the high rise commode herself, it is for her room mate. However, since it is over the existing toilet she has to use it. R114 stated at night it is the worse because she does not have the strength to remove the high rise commode off the toilet and she has urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and self. R114 stated she has wiped up the urine on the floor with her own clothes because she is embarrassed when she voids on herself. R114 stated she did not want to tell anybody that she voided all over the floor and self, which was why she cleaned it up herself using her own clothes. R114 stated she feels like a child afraid of getting in trouble and that she was ashamed of herself. R114 stated she does not believe the commode is safe for her as she could slip on the urine that is on the floor. R114 stated she had reported this to a couple of nursing assistants and trained medication administration assistants about the high-rise commodes not fitting properly and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10 urinating on self and floor, however, she does not recall who she talked to. R114 stated they looked at it, but nothing was done, so she gave up. The facility Resident Rights and Dignity for all Nursing Procedures policy dated March 2013, indicates residents are to be treated with dignity and respect.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure access to a call light was provided for 1 of 1 residents (R6) reviewed for reasonable accommodations of needs. Findings include: R6's quarterly Minimum Data Sets (MDS) indicated moderately impaired cognition, total assistance with activities of daily living, mechanically altered diet and feeding tube, and a tracheostomy with regular scheduled nebulizer treatments to help keep airway open. The quarterly MDS indicated R6 had diagnoses of cerebral vascular accident (stroke) was unable to walk or transfer herself, had a history of seizures,	F 558	Immediate corrective action: *The call light for resident #6 was placed within reach as soon as the discrepancy was identified. Action as it applies to others: *The Policy and Procedure for Answering Call Lights which includes placement of call lights was reviewed and remains current. *A facility wide audit was completed to assure all residents had call lights within reach. *Education for all nursing staff on proper placement of call lights within reach was held o n 8/21/18. Date of completion: 9/21/18	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 11 muscle weakness and difficulty communicating. R6's Care Plan dated 7/11/18, indicated R6 had a history of seizures and falls and had a difficult time communicating her needs. Interventions to follow include: anticipating her needs and having her call light within her reach. During observation on 8/8/18, at 2:19 p.m. R6 was in her bed with her eyes closed and her call light was at the end of her bed and out of reach. At 2:43 p.m. R6's call light remained at the end of her bed. At 3:51 p.m. her call light was within her reach on her abdomen. During observation on 8/10/18, at 10:47 a.m. R6 was in her recliner chair with the legs elevated and her call light was on the end of the foot rest of the recliner (call light was by her feet) it did not appear as though she could reach it. During interview on 8/10/18, at 10:51 a.m. nursing assistant (NA)-D stated R6 might be able to bend forward to reach the call light but not very well. NA-D further stated the light could be closer to her. During interview on 8/10/18, at 10:54 a.m. licensed practical nurse (LPN)-B stated R6 could not reach the call light by her feet. LPN-B moved the call light and placed call light on R6's lap. LPN-A stated she would call maintenance and get a clip for the call light. At 10:58 a.m. LPN-B stated she found a clip and placed it on the call light for R6 so it would not slip out of place. The facility's Answering the Call Light policy was reviewed and indicated the purpose of this procedure is to respond to the residents requests	F 558	Recurrence will be prevented by: *Visual audits of call light placement will b e conducted for 5 random residents weekly x 90 days and results shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12 and needs. One of the general guidelines is to be sure the call light is within easy reach of the resident.	F 558		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 13 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative nursing services to maintain ability to ambulate for 1 of 1 resident (R54) reviewed for restorative nursing programs and have ability to ambulate. R54's quarterly Minimum Data Set (MDS) dated 5/17/18, indicated R54's cognition was intact. R54 needed extensive assistance of one staff for transfers, moving from seated surface to standing position, and walking. R54 had lower extremity impairment on both sides. R54's care plan dated 6/5/18, indicated a restorative nursing program (RNP) for R54 was to ambulate 40 feet in the parallel bars with assist of one staff with stand by assist (SBA), use a transfer belt and wheelchair three times a week for four weeks. R54's Diagnosis Report provided 8/10/18, indicated R54's diagnoses included diabetes, right humerus fracture, and left leg below the knee amputation. During an observation and interview on 8/10/18, at 11:42 a.m. R54 was sitting in the wheelchair in R54's room. R54 stated once in a while nursing assistant (NA)-A comes in to help with her restorative program. R54's task information on the computer dated 8/10/18, at 11:57 a.m. indicated R54's nursing	F 676	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide on 8/22/18. *Resident #54 was evaluated by OT on 8/19/18 and it was determined the resident was able to perform her Functional Maintenance exercised independently and no longer needed the existing FNP. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative program, which program, how often and a plan to assure these programs are provided by Restorative Aide or Nursing staff. All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents receiving a Restorative Program will be conducted weekly x 90 days to assure the Program is occurring and is documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 14 rehab program was walking 10 to 20 feet in the parallel bars three times a week. A review of Unit 4 Restorative Treatment Schedule form dated 7/23/18 through 7/29/18, indicated R54 received RNP one day. The week of 7/30/18 through 8/5/18, indicated R54 received RNP one day. The week of 8/6/18 through 8/12/18, indicated R54 received RNP one day. During an interview on 8/10/18, at 1:02 p.m. NA-A stated, "When I was on vacation RNP probably did not get completed." NA-A added, "I will get pulled to work on the floor a couple of times a week for short staffing or ill calls." NA-A stated a walking program was attempted for the residents but it did not work because there were not enough staff or enough time to complete it. NA-A stated the most important thing for residents was a walking program for them to keep their independence. During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed. The Restorative Nursing Program policy revised 1/18, indicated restorative nursing staff will document the program performed on the point of care computer. Documentation of the resident's restorative progress will be assessed and documented quarterly by the RN manager in the progress notes. Restorative nursing job summary indicated responsible to work with	F 676	The results of the audits will be shared with the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 15 resident needing restorative nursing measure to gain or maintain highest functional level. Responsible for providing consistency between therapist's work and carry over on a daily basis.	F 676		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accurate CPR directives for 2 of 25 residents (R46, R58) reviewed for health care directives that were consistent with the resident's wishes for resuscitation. This had the potential to result in serious harm, or death to R46 when R46's Provider Order for Life Sustaining Treatment (POLST) that was located in R46's record, indicated Do Not Resuscitate and her wishes were Full Code. The immediate jeopardy began on 6/13/18, when the facility failed to file a POLST in R46's record that was signed and updated on 6/13/18, as full code status (allows for all interventions needed to restore breathing or heart functioning, including chest compressions, a defibrillator and a breathing tube). The POLST that was reviewed in R46's record on 8/6/18, and had been in R46's record since her admission on 6/2/18, indicated DO NOT RESUSCITATE (DNR). Upon interview, several of the nurses identified that if a resident	F 678	Immediate corrective action: *Resident #46 completed an updated POLST on 6/13/18 but a copy was not placed in her chart per protocol while awaiting MD signature. Once discrepancy was identified, a copy of the POLST was placed in the resident's chart The MD signed original POLST is now in the resident's chart. The Care Plan, Face sheet, EMAR and MD order was updated. Immediate education was started with all licensed nurses on what to do if POLST and MD order are conflicting. *Resident #58 completed a new POLST on 8/7/18 indicating her wishes of CPR. Action as it applies to others: *The Policy and Procedure for POLST was reviewed and revised to include assuring MD order and POLST match and to obtain a telephone order at the time a new or revised POLST is written. It has always been the policy to place a copy in	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 16 was found to be in need of resuscitation, they would look first to the POLST for direction on code status and would follow the directive of the POLST. In the case of R46, this would have been DNR. The administrator and clinical vice president were notified of the immediate jeopardy on 8/8/18, at 12:17 p.m. and the immediate jeopardy was removed on 8/9/18, at 12:05 p.m., but non-compliance remained at a lower scope and severity level of no more than minimal harm at an isolated pattern, level D. Findings include: R46's Admission Record, printed 8/7/18, indicated R46 was admitted to the facility on 6/2/18, with diagnoses including encephalopathy, mild cognitive impairment, epilepsy, anxiety and major depressive disorder. R46's admission Minimal Data Summary (MDS) dated 6/9/18, indicated a brief interview of mental status (BIMS) score of 3 which is consistent with severe cognitive impairment. R46's Order Summary Report printed 8/7/18, indicated full code (directions to perform cardiopulmonary resuscitation following respiratory/cardiac arrest) with order date of 6/13/18. R46's POLST form dated 6/2/18, located in the front of R46's paper chart, indicated do not attempt resuscitation (DNR). This POLST order was signed by R46, admission intake staff and physician. R46's electronic medical record was reviewed on	F 678	the medical record while awaiting signature on an original POLST. *All resident charts were reviewed to assure most current POLST was in medical record and that MD orders matched POLST. *Education was provided to all licensed nurses during the Survey after the Policy was revised. Date of completion: 9/21/18 Recurrence will be prevented by: *Reviewing all POLST was added to the daily Quality Conference Tool to assure all new revised POLST are reviewed and matching documentation is confirmed. This will be an ongoing audit shared with the facility's QAPI committee. An additional audit of 5 random residents per week will be completed x 90 days and the results shared with QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/Desingee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 17	F 678		

8/7/18, at 10:16 a.m. the profile indicated code status was full code.

R46's care plan dated 6/20/18, indicated a focus of "Advanced Directives: I have a Full Code status." Further indicated, "Staff will intervene appropriately if I should need cardiac resuscitation."

During an interview on 8/7/18, at 1:42 p.m. when asked if a resident was found unconscious and without a pulse, licensed practical nurse (LPN)-B stated she would look at the electronic Medication Administration Record (EMAR) for resident's code status, "it is usually what I have open and available to me."

During an interview on 8/7/18, at 2:06 p.m. when asked if a resident was found unconscious and without a pulse, registered nurse (RN)-B stated she would look at the front of the paper chart at the POLST, or she might look at the EMAR, it depends on what is open at the time.

During an interview on 8/7/18, at 2:23 p.m. LPN-A unit manager indicated the EMAR and the POLST for R46 did not match. LPN-A identified this as a problem. LPN-A confirmed the original POLST in the front of R46's paper chart was DNR and dated 6/2/18. LPN-A went on to say, copies of the original POLST are placed in a plastic sheet holder behind the original, and the copies are sent with if the resident needs to be transferred to the hospital. LPN-A confirmed the POLST copies in the plastic sheet holder indicated DNR and was dated 6/2/18. LPN-A further stated if a resident was found unconscious and without a pulse, that she would expect her staff to go to the chart, and follow the POLST.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 18	F 678		

R46's progress note dated 8/2/18, indicated R46 had a seizure around 5:00 p.m. which lasted about 10 minutes, R46 was slow to respond, was unable to move left arm and could only answer one word answers. The note further indicated on call MD was notified, orders to send to emergency room (ER). A subsequent progress note dated 8/7/18, at 9:45 p.m. indicated R46's foot got caught behind a foot pedal and attempted to stand and fell forward. When R46 fell her glasses lacerated her right eyebrow. R46 was sent to ER for an evaluation. During interview on 8/7/18, at 2:23 p.m. LPN-A stated a copy of the POLST is sent with the residents when transferred to the hospital, the POLST on 8/2/18, and on 8/7/18, that would have been in the resident record, indicated DNR and was dated 6/2/18. During this interview, the interim director of nursing (IDON) provided an electronic form, Nursing Home to Hospital Transfer Form dated 8/2/18. This form indicating full code. IDON was unable to state if POLST dated 6/2/18, indicating DNR was sent with to the hospital for these recent hospital admissions.

During an interview on 8/7/18, at 4:31 p.m. IDON stated upon admission, residents are to be asked advanced directive wishes. IDON indicated they also talk to family when a resident is cognitively impaired. She further stated POLST are then filled out to represent their wishes, the resident and/or family signs the POLST, staff sign as a witness and that the POLST form should be dated. IDON stated when the POLST is signed by the resident or family, a copy is made and placed in front of the resident's chart and the original is kept for the nurse practitioner (NP) to sign when she does rounds. Once the POLST is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 19	F 678		

signed by NP the copy is removed from the chart and replaced with the signed original. IDON went on to say, staff are directed to look at the POLST to determine code status. The POLST, once signed by the NP is the order. Staff refer to the POLST when entering the order into the computer.

During an interview on 8/8/18, at 7:04 a.m. when asked if a resident was found unconscious and without a pulse, RN-A stated first she would look at the resident's POLST in the paper chart. That is the first place she would go if told there was a code. "I would expect the rest of my staff to look at the POLST if there was a code." RN-A stated if a POLST indicated DNR and the electronic chart indicated full code, she would go with patient wishes on the POLST. If POLST indicated a full code and electronic chart indicated DNR, she would go with the POLST that is the resident's wishes.

During an interview on 8/8/18, at 7:11 a.m. when asked if a resident was found unconscious and without a pulse, RN-C stated she would check the resident's POLST first, it is in the front of the chart. RN-C went on to say she was told staff should go by the POLST because that is the resident's wishes.

During an interview on 8/08/18, at 7:14 a.m. when asked if a resident was found unconscious and without a pulse, RN-D stated the first thing is to look at the paper chart at their POLST to see what the code status is. RN-D stated she would go with the POLST. If there was a discrepancy with the electronic orders and the POLST she would go with the POLST as it is the most

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 20	F 678		

updated sheet, and the medical doctor (MD) signs the POLST.

During an interview on 8/8/18, at 7:17 a.m. IDON referred to the facility's policy which directed, "although a physician's notification and order for the advance directive should be obtained, the advance directive should be honored and followed immediately after the individual advanced directive is determined, which may be prior to the physicians order." IDON stated whatever the POLST states is what staff go by. R46's paper chart and electronic chart were reviewed with the IDON. The front of the paper chart contained a POLST signed by R46 indicating DNR, director of admissions (DOA)-E prepared the POLST and signed and dated it 6/2/18. Nurse practitioner (NP)-D signed POLST, undated. Electronic chart orders dated 8/7/18, indicated full code. Initial order in electronic chart was 6/5/18, for DNR. Order in the electronic record was changed to full code on 6/13/18. The IDON stated R46's daughter, RN-A, and social services (SS)-A spoke at a care conference on 6/13/18, in regards to code status and full code was decided at that time. On 6/13/18, computer order was entered by RN-A/Unit Manager as full code. When asked about the electronic order and the POLST not matching, the IDON left her office and returned with a POLST form for R46. The POLST form was signed by R46 and SS-A on 6/13/18, as full code. POLST lacked NP-E signature. When asked where the form was found, the IDON stated it was found in the social worker's office. When asked why the form lacked NP-E's signature, IDON-A stated it just must have not gotten to her. IDON went on to say the process should be to make a copy of the new 6/13/18, full code POLST and place it into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 21	F 678		

paper chart while awaiting NP-E's signature. IDON stated this was not done. After reviewing paper chart, IDON-A stated the POLST in the paper chart at this time is the DNR POLST dated 6/2/18. IDON-A stated if R46 would have coded, staff would have looked at the POLST and seen it indicated DNR and not initiate resuscitation. IDON stated, "This is of concern." IDON called LPN-A into the office. LPN-A stated a message was left for the family of R46 to confirm code status, however, had not received a response as of yet.

During an interview on 8/8/18, at 8:53 a.m. SS-A stated R46 wanted to be DNR upon admission after transferring from another facility. At R46's care plan meeting in June, family and resident decided on a full code and signed a new POLST, the updated POLST should have been sent to health unit coordinator (HUC) and a copy of the updated POLST should have been put in her chart. SS-A stated, "It was probably my error, it should have been put in [R46's] chart, not in my office." SS-A also indicated that IDON found R46's updated POLST from 6/13/18, in her office that morning.

R46's family member (FM)-A was called on 8/8/18, at 9:47 a.m. R46's FM-A stated on 6/13/18, R46's code status was changed to full code. FM-A stated she wanted it changed and added, "I was looking through [R46's] paperwork and noticed she was a DNR, I know she did not understand what she was signing, I don't think she is capable of making her own decisions, I am currently pursuing guardianship."

R46's 14 day MDS dated 6/19/18, indicated a brief interview of mental status (BIMS) score of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 22	F 678		

(indicating severe cognitive impairment).

During a subsequent interview on 8/9/18, at 8:15 a.m. when asked if a resident was found unconscious and without a pulse, RN-A stated she would look at the POLST in front of the chart, if POLST said DNR and electronic chart order was full code she would go with resident's wishes on the POLST. If POLST was full code and electronic chart order stated DNR she would go with the POLST and follow resident's wishes.

During an interview on 8/9/18, at 8:51 a.m. when asked if a resident was found unconscious and without a pulse, RN-C stated if the POLST read DNR she would go by the POLST. When asked if the POLST and the orders did not match, RN-C stated she would get clarification from the MD of their status. She went on to state, "I don't know, I will have to check, I have gotten different directions, I have to get clarification on what should be done. I'm not real sure what to follow."

During interview on 8/9/18, at 10:00 a.m. when asked if a resident was found unconscious and without a pulse, IDON stated licensed staff were trained since immediate jeopardy was called to look at the orders in the electronic medical records and the POLST to determine code status. If discrepancy, staff are to look into it further. When asked what that means, IDON stated staff need to call the MD or look in the progress notes. When asked how long staff are to be looking into the discrepancy before initiating CPR, IDON stated, "No longer than a minute." IDON further indicated that prior to the retraining staff were only to check the POLST in the paper chart.

During interview on 8/9/18, at 10:23 a.m. IDON,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 23	F 678		

and VP were notified that at least 2 staff were stating they would look at the POLST, which was not matching what IDON-A stated they were trained to do. IDON stated she would provide more education to her licensed staff in regards to the revised Advance Directives policy.

During interview on 8/9/18, at 11:51 a.m. IDON stated, "I educated all licensed staff on the floor, I will continue to make calls to licensed staff, I have not reached evening staff yet, they cannot work until they are educated, I will stay until they can be trained as soon as they come in for their shift."

The immediate jeopardy that began on 6/13/18, was removed on 8/9/18, at 12:05 p.m. after the facility updated their Advanced Directives policy, provided training and retraining to the licensed staff that would be responsible for following resident code status wishes. Surveyors interviewed all licensed staff that were on duty. Their responses and understanding was consistent with the Advanced Directives policy.
R58's diagnosis report printed 8/10/18, indicated R58's diagnoses included cellulitis of the left lower limb, lymphedema (swelling in an arm or leg caused by a lymphatic system blockage), and peripheral venous insufficiency.

R58's quarterly MDS dated 7/19/18, indicated R58 was cognitively intact.

R58's admission confidence sheet undated, indicated R58 was a full code.

Review on an interagency transfer orders dated 4/13/18, indicated R58 was a full code.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 24	F 678		

R58's POLST undated, and signed by the nurse practitioner and R58, indicated R58 wanted CPR to be attempted in the event of a cardiac/respiratory arrest.

R58's order summary report printed 8/7/18, from the computer, indicated R58's code status was DNR/DNI (do not intubate). The order started 4/13/18, on the day of admission and continued to be active on 8/7/18.

Review of a multidisciplinary care conference summary dated 7/20/18, indicated R58 did not attend and was marked a DNR on the care level review area.

Review of R58's care plan dated 8/3/18, indicated R58's code status at a full code.

During an interview on 8/7/18, at 2:04 p.m. when asked about the process for recording code status in the resident record, LPN-A stated the HUC puts the resident's code status in the computer and the nurse should verify the order is correct in the computer.

During an interview on 8/7/18, at 2:45 p.m. R58 stated, "I have not made up my mind yet as to what I am going to put as my code status."

During an interview on 8/7/18, at 4:31 p.m. LPN-E stated if a resident needed to be resuscitated, she would look for the code status on computer first, if the computer was logged in to. LPN-E stated if there was no code status on the computer, would assume the resident a full code and proceed to do CPR.

During an interview on 8/8/18, at 8:57 a.m. RN-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 25 stated she wrote DNR/DNI in the computer and she would look for the code status designation for residents from the POLST. RN-A stated she wrote full code on the admissions confidence sheet and that information was from the transferring facility. RN-A stated she was unaware of how R58's code status became DNR/DNI on the computer order. On 8/7/18, LPN-A verified with R58 on what the code status the resident wanted. R58 signed and dated the new POLST along with LPN-A. R58 wanted to be a full code. LPN-A changed the order on the computer to read full code for R58. The Advance Directives/POLST policy revised 8/18, indicated a physician order should be obtained to support the POLST, but if order has not been obtained and resident is discovered to be unconscious and without a pulse, the POLST document will be followed. If there is ever any discrepancy between a POLST and MD orders, the MD and resident representative will be contacted. CPR is always performed in the case of not knowing a person's code status.	F 678		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 26 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative nursing services to maintain mobility and range of motion for 3 of 3 residents (R46, R35, R8) reviewed for restorative nursing programs. Findings include: R46's 14 day prospective payment system (PPS) MDS on 7/11/18, indicated a brief interview for mental status (BIMS) score of 7 (severe cognitive impairment). R46's Diagnosis Report printed on 8/7/18, indicated the following diagnoses: encephalopathy unspecified (any disease or disorder of the brain), epilepsy, hemiplegia and hemiparesis following cerebral infarction (stroke). R46's 14 day MDS dated 7/11/18, indicated R46 required extensive assistance with bed mobility, locomotion on unit, locomotion off unit, dressing, toilet use and personal hygiene. During observation on 8/10/18, at 9:32 a.m. R46 was having difficulty propelling her wheelchair forward towards dining room. She required assistance of one staff to propel to her spot at the table for breakfast. After meal set up, R46 was	F 688	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide(s) on 8/22/18. Education included updated documentation to be performed in POC from paper tool used for Restorative. *Resident #8, #35, and #46 were evaluated by OT on 8/19/18 and the results were to continue resident #8 & #46 Programs and Discontinue Resident #35 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative Program, which program, how often and a plan to assure these programs are provided by Restorative Aide or Nursing staff. *Those residents needing Restorative Programs will have updated information added to their Care Plan and POC Tasks. *All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 27 able to complete her breakfast with minimal assistance. R46's Physical Therapy Plan of Care indicated start of care 6/25/18 with end of care 7/20/18, referred due to a decline in strength due to encephalopathy, UTI and epilepsy. R46's physical therapy progress note (PT PN) dated 7/15/18, analysis of functional outcome/clinical impression, indicated that R46 worked well with therapy. R46 will remain at long term care and will begin restorative nursing program (RNP). R46's PT PN dated 7/20/18, discharge plans and instructions indicated, R46 will remain in this skilled nursing facility on RNP. R46's Occupation Therapy Plan of Care indicated a start of care on 6/25/18 with end of care 7/20/18, referred due to a decline of self-cares and function mobility due to seizures, and encephalopathy. R46's occupational therapy progress note (OT PN) dated 7/17/18, update to treatment approach, indicated plan to address discharge plan and continue to educate restorative nursing on program prior to end of week discharge. R46's OT PN dated 7/20/18, discharged from OT services with home exercise program with RNP. R46's electronic task tracking printed on 8/10/18, indicated restorative nursing section, starting 7/20/18 to 8/8/18. R46 was to use the Omni cycle for 15 minutes, 3 times per week, and arm bike for 15 minutes, 3 times per week. There	F 688	scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents receiving a Restorative Program will be conducted weekly x 90 days to assure the Program is occurring and is documented. The results of the audits will be shared with the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 28	F 688		

was a total of 13 opportunities as indicated on the Restorative Treatment Schedule printed on 8/10/18, 3 of 13 opportunities were documented refused by R46, 1 of 16 opportunities was documented unable to participate, 9 of 13 opportunities were documented not applicable (NA). R46's Restorative Treatment Schedule printed on 8/10/18, revealed she received 0 out of 13 opportunities since starting RNP on 7/20/18.

During interview on 8/10/18, at 10:00 a.m. restorative nursing assistant/ NA-A stated that NA is documented when the restorative program is not completed for whatever reason, there is not any place to chart why it did not occur other than the resident refusal box or unable to participate box. NA-A stated, "To be honest, I get pulled to the floor a lot and I just can't get to it all." NA-A went on to say, she gets pulled for appointments then she will sit at the clinic for two or more hours, when she gets back it is time to help feed residents not leaving much time after lunch and then it is time for her to leave. NA-A went on to say, that it is her job to do the restorative programs and when she is pulled to the floor, or on vacation, there is no one to take her place. NA-A stated registered nurse (RN)-A is aware she gets pulled to the floor, making it difficult to get restorative nursing completed.

R46's PT plan of care dated 8/7/18, indicated an order for evaluation only after being hospitalized 8/2/18-8/4/18. Initial assessment revealed there was no functional decline noted and current restorative nursing program remain appropriate.

R46's OT plan of care dated 8/8/18 indicated an order for evaluation only after being hospitalized 8/2/18-8/4/18. Evaluation indicates R46 does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 29	F 688		

demonstrate functional decline at this time. R46 has a restorative nursing program and will continue with this program.

R35's quarterly MDS dated 6/28/18, indicated moderate cognitive impairment. R35 required extensive staff assistance with transfers. The MDS indicated R35 was not steady and only able to stabilize with staff assistance when moving from a seated to standing position and from the bed to a chair. The MDS further identified limitations to R35's range of motion (ROM) of upper and lower extremity on one side.

R35's electronic Diagnosis Report dated 8/10/18, revealed diagnoses of hemiplegia, hemiparesis, and generalized weakness.

R35's care plan dated 6/29/18, indicated R35 was on a RNP. The care plan directed active range of motion (AROM) to bilateral lower extremities (BLE) hip flexion, extension and abduction. Knee and ankle flexion and extension 10 repetition/joint 5 times weekly. Left knee extension stretching for contracture of -20 degree extension. The care plan updated on 7/24/18, decreasing the frequency of the RNP program to 2 times weekly. The care plan directed one staff assisted R35 with transfers using a PAL (mechanical device to assist with transfers) and required extensive assistance of 1 staff with bed mobility.

Review of Unit 2's Restorative Treatment Schedule from 7/9/18 to 7/29/18, directed the following:
AROM BLE hip flexion, extension and abduction 10 reps/joint. Left knee extension stretch of -20 degrees 5 times weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 30	F 688		

-7/9/18 to 7/15/18: no documented RNP was offered/completed on the 5 scheduled dates
-7/16/18 to 7/22/18: no documented RNP was offered/completed on the 5 scheduled dates
-7/23/18 to 7/29/18: R35 was offered and refused one time. No documentation RNP was offered/completed the remaining 4 scheduled dates.
After 7/29/18, RNP schedule changed from 5 times weekly to twice weekly.
-7/30/18 to 8/5/18: R35 documented ROM was completed or refused 2 of the 2 scheduled days.
-8/6/18 to 8/12/18: R35 was scheduled for RNP on Tuesday and Thursday and was not offered/completed.

R35's electronic Point of Care (POC) Response History task of restorative rehabilitation directed: AROM to right and left lower extremities hip flexion, extension and abduction, knee and ankle flexion and extension 10 reps per joint 2 times weekly. Left knee extension stretching for contracture of -20 degrees extension. From 7/12/18 to 8/9/18, (29 days) "not applicable" documented 20 times. The POC lacked documentation of completion or refusals of the ROM.

During interview on 8/10/18 at 9:24 a.m. restorative nursing assistant/ NA-A reviewed the restorative nursing schedule from 7/9/18 to 8/9/18.
-NA-A stated for the week of July 9th, ROM was not offered 5 out of the 5 scheduled times.
-NA-A stated for the week of July 16th, ROM was not offered 5 out of 5 scheduled times, as she was on vacation.
-NA-A stated for the week of July 23rd, R35 was offered and refused one time. R35 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 31	F 688		

offered ROM the remainder of the 4 scheduled times.
-NA-A stated for the week of July 30th, R35 was scheduled 2 times and was refused or completed the scheduled 2 times.
-NA-A stated during the week of August 6th. ROM was not offered 2 of the 2 scheduled days.

During an interview on 8/10/18, at 9:07 a.m. when asked about ROM with moving legs, knee and ankle R35 laughed and stated, "I'm pretty much on my own." When asked the last time ROM therapy was offered R35 stated, "it has not been done for awhile."

R8's quarterly MDS dated 5/10/18, indicated short and long term memory impairment. R8 required extensive assistance with transfers. The MDS indicated R8 was not steady and only able to stabilize with staff assistance when moving from a seated to standing position and from the bed to a chair. The MDS further identified limitations to R8's ROM of lower extremity on one side.

R8's electronic Diagnosis Report dated 8/10/18, revealed diagnoses of Alzheimer's disease and generalized muscle weakness.

R8's physical therapy evaluation only form, dated 3/22/18, indicated current RNP of standing frame x 10 minutes remains appropriate as R8 and restorative aide able to complete safely.

R8's care plan dated 6/5/18, indicated R8 was on a RNP. The care plan directed to use a standing frame 3 times a week. If unable to use the standing frame, to complete 15 minutes on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 32	F 688		

omnicycle to maintain ROM. The care plan directed one staff assisted R8 with transfers using a PAL lift.

Review of Unit 2's Restorative Treatment Schedule directed "standing frame 10 to 15 minutes 3 times a week or omnicylcle for 15 minutes 3 times a week." Documentation revealed the following:
-7/9/18 to 7/15/18: no documented RNP was offered or completed.
-7/16/18 to 7/22/18: no documented RNP was offered or completed.
-7/23/18 to 7/29/18: no documented RNP was offered or completed.
-7/30/18 to 8/5/18: documented ROM completed 2 of the 3 scheduled days.
-8/6/18 to 8/12/18: no documented RNP was offered or completed.

R8's electronic POC Response History task of nursing rehab from 7/13/18 to 8/9/18 (28 days) directed "standing frame 10 -15 minutes 2 times week. If [R8] will not stand have [R8}] complete 15 minutes on the onmicycle." Staff documented "Not Applicable" 17 times. RNP was completed one time during the 28 day time frame on 8/2/18. All dates were blank under resident refused.

During an interview on 8/8/18, at 3:48 p.m. family member (FM)-J stated she visits almost every afternoon. FM-J stated at times staff have R8 riding the bicycle, but wished they would do it more often. FM-J stated, "I think they have given up." FM-J stated she had not seen the stand platform in use.

During an interview on 8/9/18, at 9:26 a.m. nursing assistant (NA)-D stated the nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33	F 688		

assistants working on the floor do not complete ROM for residents in the restorative program. NA-D stated the restorative aide completes the ROM program. NA-A stated if ROM is completed by the aide working on the unit, the completion is documented in POC. NA-D stated not applicable (NA) is documented when the ROM is not offered to the resident.

During an interview on 8/9/18, at 1:29 p.m. restorative aide/ NA-A stated when working as the restorative aide, she gets pulled to work on the unit, sometimes up to 3 times a week. NA-A stated the restorative program does not get completed when she is pulled. NA-A stated it takes about 5 hours to complete the RNP for all 22 residents on the RNP list. NA-A stated the aides document under the electronic POC if the ROM is completed on the floor. NA-A reviewed the Restorative Treatment Schedule from 7/9/18 to 8/9/18.
-NA-A stated for the week of July 9th, ROM was not completed. NA-A stated, "I must have been pulled."
-NA-A stated for the week of July 16th, ROM was not offered/completed as she was on vacation.
-NA-A stated for the week of July 23rd, ROM was not offered/completed. NA-A stated she must have been pulled to work on the unit and was on vacation on Friday. NA-A stated the ROM does not get completed when she gets pulled to work on the unit or is on vacation.
-NA-A stated for the week of July 30th. ROM was offered and completed on July 30th. NA-A stated ROM was completed 2 of the 3 scheduled days. NA-A stated R8's ROM was not offered/completed on August 3rd, as she was pulled to work on the unit.
-NA-A stated for the week of August 6th, R8 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34	F 688		

scheduled for ROM on the 6th and 8th. NA-A stated ROM was not offered to R8 as she "just got so busy helping on the wing." NA-A stated she plans on completing the ROM as scheduled the next day, 8/10/18.

During an interview on 8/10/18 at 9:56 a.m. physical therapist (PT)-K was asked to complete a screening to identify if a decline had occurred since PT discontinued on R8 and R35. PT-K stated the restorative aide gets pulled out of the rehab department. When asked how often the aide is pulled, PT-K stated, "you would have to ask her, but it seems quite frequently." At 10:03 a.m. PT-K stated she screened R8 and R35 and neither resident had a decline.

During an interview on 8/10/18, at 11:13 a.m. RN-A stated the restorative program is being changed from 7 days to 5 days. RN-A stated "sometimes" the restorative aide gets pulled to work on the floor or sent out to appointments with residents. RN-A stated the floor nursing assistants are to complete the restorative program and document the completion of the ROM in POC. RN-A stated the RNP was not consistently being completed. RN-A stated this is "partly staffing and busy." RN-A stated the facility was switching the restorative program from 7 days to 5 days and hired another restorative aide to help solve the issue.

During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 The Restorative Nursing Program policy revised 1/18, indicated restorative nursing staff will document the program performed on the point of care computer. Documentation of the resident's restorative progress will be assessed and documented quarterly by the RN manager in the progress notes. Restorative nursing job summary indicated responsible to work with resident needing restorative nursing measure to gain or maintain highest functional level. Responsible for providing consistency between therapist's work and carry over on a daily basis.	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to track fluid intake for 1 of 1 resident (R9) on fluid restrictions reviewed for dialysis. Findings include: R9's provider progress note dated 5/18/18, indicated R9's diagnosis included chronic kidney disease, stage V and hemodialysis. The annual Minimum Data Set (MDS) dated 5/10/18, indicated R9 was severely cognitively impaired. R9's Order Summary Report with a start date of	F 698	Immediate corrective action: *A new calculation of fluids within the restriction was developed for resident #9 to include resident's desire for coffee between meals. Action as it applies to others: *All residents on a fluid restriction were reviewed to assure calculation includes water/coffee/other liquids offered at activities or in-between medication and meal times. Fluids allotted for each department will be documented each day in the medical record.	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 36 11/9/15, indicated R9 was on a fluid restriction of 1500 cc's (cubic centimeter) per day, every shift, related to dependence on renal dialysis. The Order Summary Report directed staff to give 120 cc's per shift with the medication pass. R9's care plan updated 6/5/18, indicated R9 went to dialysis three times a week and was on a 1500 cc fluid restriction as follows: 120 cc's at med pass, Nepro (nutritional supplement that is specifically designed to replace protein and nutrients that have been lost during dialysis) 240 cc's, 8 ounces (oz) coffee and 4 oz beverage of choice for a total of 360 cc's at breakfast, 8 oz coffee and 4 oz beverage of choice for a total of 360 cc's at lunch, and 8 oz coffee and 4 oz beverage of choice for a total of 360 cc's at supper. A review of the registered dietician (RD) Nutrition Follow up dated 6/21/18, indicated R9's weight had increased 18 pounds from 5/22/18 to 6/12/18. The RD documentation indicated they did not anticipate weight gain. The form indicated R9's potassium was 4.9 (3.5 to 5.0 normal). During an interview on 8/7/18, at 8:36 a.m. R9 stated (R9) did not have any fluid restrictions and was able to drink as much as they like. R9 stated, "I get coffee whenever I want it." A review of nursing assistant charting, Follow Up Question Report, from the computer dated 2/10/18 through 8/7/18, indicated staff documented R9's fluid intake one to two times a day. The Follow Up Question Report indicated that staff did not document R9's fluid intake on all days for all meals. Staff failed to document R9's fluid intake between 7/31/18 to 8/7/18.	F 698	*The Policy and Procedure for Fluid Restriction/Promotion was reviewed an remains current *Dietary, Activities and nursing staff were trained on how to divide fluids for residents on a fluid restriction to allot for personal choice when able. Date of completion: 9/21/18 Recurrence will be prevented by: *An audit of 5 random residents on a fluid restriction will be conducted weekly x 90 days to assure the fluids are divided according to resident choice when able, and all fluids are documented. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease o r discontinue the audits. A Risk/Benefit will b e administered, Care Planned and MD notified if any resident chooses not to abide by their fluid restriction. The correction will be monitored by: *DON/Dietary Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 37	F 698		

A review of R9's Medication Administration Record (MAR) dated 7/1/18-7/31/18, indicated the nursing staff document the total intake of fluid given during the medication administration times, however, did not include the additional fluid intake for the day outside of medication administration time.

During an observation 8/08/18, at 7:14 a.m. R9 was sitting in dining room in a wheelchair dressed for the day and drinking coffee with others at the table.

During an interview on 8/8/18, at 11:43 a.m. trained medication assistant (TMA)-A stated R9 went to dialysis Monday, Wednesday, and Friday. R9 was observed to get a cup of coffee prior to going to dialysis. TMA-A stated everyone knows he is non-compliant with the fluid restriction of 1500 cc's. TMA-A stated R9 or family would get R9 a cup of coffee, and they do not document that fluid intake.

During an interview on 8/8/18, at 2:14 at p.m. certified dietary manager (CDM) stated R9 was on a 1500 cc fluid restriction. The CDM stated R9 and family member will access a cup of coffee for R9 and they do not report how much coffee was taken at that time to nursing. The CDM stated the nursing assistants are trained on how to record residents fluid intake and how many cc's a beverage container holds. The CDM stated R9's fluids were looked at when a quarterly assessment was due.

During an interview on 8/9/18, at 1:22 p.m. the registered dietician (RD) stated R9 had the same 1500 cc fluid restriction for the last three years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 38	F 698		

The RD stated staff should document the intake of fluids for R9 at all three meals and if they get R9 coffee outside of meal times. The RD stated, "I am not sure where staff are to chart the fluid intake." The RD stated the family was informed of R9's potassium being high due to the increased coffee consumption as coffee has a lot of potassium in it. The RD further stated staff had not been documenting the fluid intake correctly. The RD stated there was no risk verses benefits, related to R9's fluid intake, gone over with R9 and the family members in R9's chart. Even though staff were aware of R9's non-compliance, the record lacked education or risk verses benefits for R9 or family regarding they were aware of the importance of the fluid restriction.

During an interview on 8/10/18, at 8:42 a.m. LPN-A stated the staff should document the amount of fluid at all three meals taken in. LPN-A indicated there should be more fluid intake documented by staff in the computer for R9. LPN-A stated staff give R9 coffee and should alert the nurse prior to giving R9 coffee and let the nurse determine if R9 could have coffee at that time. LPN-A stated, "I do not look at [R9's] fluid intake, the CDM does." (However, in a previous interview, the CDM indicated fluid intake is looked at on a quarterly basis). LPN-A further stated she did not have any documentation that dialysis is aware that R9 is noncompliant with fluid intake.

During an interview on 8/10/18, at 12:53 p.m. LPN-E stated if a resident is on a fluid restriction the nurses need to know the amount of the resident's intake of fluids. LPN-E stated they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 39 document the total fluid intake in the MAR. During an interview on 8/10/18, at 1:16 p.m. TMA-B stated family should tell the nursing staff how much they have given R9 while they are at facility. TMA-B stated that R9 should have an input and output (I&O) tab on the computer. However, R9 did not have one. The facility policy Encouraging and Restricting Fluids, dated 3/14, indicated staff should record the amount of fluid consumed on the intake side of the intake and output record. The policy also indicated to document the amount of fluids consumed by the resident during the shift.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 40 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement restorative nursing programs related to ambulation, range of motion and strengthening exercises for 4 of 4 residents (R46, R54, R35, R8). This had the potential to affect all 22 residents who received restorative nursing services. Findings include: See F688: The facility failed to routinely provide restorative exercises for 4 of 4 residents (R46, R54, R35, R8) reviewed with a restorative nursing program. R46's physical therapy progress note (PT PN) dated 7/15/18, analysis of functional outcome/clinical impression, indicated that R46 worked well with therapy. R46 will remain at long term care and will begin restorative nursing program (RNP). R46's electronic task tracking printed on 8/10/18, indicated restorative nursing section, starting 7/20/18 to 8/8/18. R46 was to use the Omni cycle for 15 minutes, 3 times per week, and arm bike for 15 minutes, 3 times per week. There was a total of 13 opportunities as indicated on the	F 725	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide(s) on 8/22/18. Education included updated documentation to be performed in POC from paper tool used for Restorative. *Residents #8, #35 and #46 were evaluated by OT on 8/19/18 and the results were to continue Resident #8 and #46 Programs ad Discontinue Resident #35 and #54 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative Program, which program, how often and a plan to assure these programs are provided by Restorative Aide or Nursing staff. *Those residents needing Restorative Programs will have updated information added to their Care Plan and POC Tasks Those assessed as being able to complete programs independently, non longer warranted, or not in need of a program as often will be updated and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 41 Restorative Treatment Schedule printed on 8/10/18, 3 of 13 opportunities were documented refused by R46, 1 of 16 opportunities was documented unable to participate, 9 of 13 opportunities were documented not applicable (NA). R46's Restorative Treatment Schedule printed on 8/10/18 revealed she received 0 out of 13 opportunities since starting RNP on 7/20/18. During interview on 8/10/18, at 10:00 a.m. restorative nursing assistant/ NA-A stated, "To be honest, I get pulled to the floor a lot and I just can't get to it all." NA-A went on to say, she gets pulled for appointments then she will sit at the clinic for two or more hours. NA-A went on to say, that it is her job to do the restorative programs and when she is pulled to the floor, or on vacation, there is no one to take her place. Review of the weekly restorative worksheet for R46's unit, indicated the frequency of the restorative aide having been reassigned from providing the services as indicated below: -week of 7/16/18: NA-A on vacation this week. -week of 7/23/18: NA-A reassigned to floor two days, and on vacation two days. -week of 7/30/18: NA-A reassigned to floor one day. -week of 8/6/18: NA-A reassigned to floor two days, sent on appointment off campus one day. R54's task information on the computer dated 8/10/18, at 11:57 a.m. indicated R54 nursing rehab program was walking 10 to 20 feet in the parallel bars three times a week. A review of Unit 4 Restorative Treatment	F 725	focus will be on ability to provide the programs to those in need. *All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. *In the case of the Restorative Aide being needed to work as a caregiver on the floor, the Restorative Coordinator will assure the Programs missed that day will be completed a different day that week. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents receiving a Restorative Program will be conducted weekly x 90 days to assure the Program is occurring and is documented. The results of the audits will be shared with the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 42	F 725		

Schedule form dated 7/23/18 through 7/29/18, indicated R54 received RNP one day. The week of 7/30/18 through 8/5/18, indicated R54 received RNP one day. The week of 8/6/18 through 8/12/18, indicated R54 received RNP one day.

During an interview on 8/10/18, at 1:02 p.m. NA-A stated when she was on vacation the RNP probably did not get completed. NA-A stated she would get pulled to work on the floor a couple of times a week for short staffing or ill calls. NA-A stated a walking program was attempted for the residents but it did not work because there were not enough staff or enough time to complete it. NA-A stated the most important thing for residents was a walking program for them to keep their independence.

R35's Restorative Treatment Schedule from 7/9/18 to 7/29/18 directed the following for R35. AROM BLE hip flexion, extension and abduction 10 reps/joint. Left knee extension stretch of -20 degrees 5 times weekly.
-7/9/18 to 7/15/18: no documented RNP was offered/completed on the 5 scheduled dates
-7/16/18 to 7/22/18: no documented RNP was offered/completed on the 5 scheduled dates
-7/23/18 to 7/29/18: R35 was offered and refused one time. No documentation RNP was offered/completed the remaining 4 scheduled dates.
After 7/29/18, RNP schedule changed from 5 times weekly to twice weekly.
-7/30/18 to 8/5/18: R35 documented ROM was completed or refused 2 of the 2 scheduled days.
-8/6/18 to 8/12/18: R35 was scheduled for RNP on Tuesday and Thursday and was not offered/completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43	F 725		

R35's electronic Point of Care (POC) Response History task of restorative rehabilitation directed: AROM to right and left lower extremities hip flexion, extension and abduction, knee and ankle flexion and extension 10 reps per joint 2 times weekly. Left knee extension stretching for contracture of -20 degrees extension. From 7/12/18 to 8/9/18 (29 days) "not applicable" documented 20 times. The POC lacked documentation of completion or refusals of the ROM.

During an interview on 8/10/18, at 9:07 a.m., when asked about ROM with moving legs, knee and ankle R35 laughed and stated, "I'm pretty much on my own." When asked the last time ROM therapy was offered R35 stated, "it has not been done for awhile."

During interview on 8/10/18 at 9:24 a.m. NA-A reviewed the restorative nursing schedule from 7/9/18 to 8/9/18.
-NA-A stated for the week of July 9th, ROM was not offered 5 out of the 5 scheduled times.
-NA-A stated for the week of July 16th, ROM was not offered 5 out of 5 scheduled times, as she was on vacation.
-NA-A stated for the week of July 23rd, R35 was offered and refused one time. R35 was not offered ROM the remainder of the 4 scheduled times.
-NA-A stated for the week of July 30th, R35 was scheduled 2 times and was refused or completed the scheduled 2 times.
-NA-A stated during the week of August 6th. ROM was not offered 2 of the 2 scheduled days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 44	F 725		

R8's physical therapy evaluation only form, dated 3/22/18, indicated current restorative nursing program (RNP) of standing frame x 10 minutes remains appropriate as R8 and restorative aide able to complete safely.

Review of Unit 2's Restorative Treatment Schedule directed, "standing frame 10 to 15 minutes 3 times a week or omnicylcle for 15 minutes 3 times a week." Documentation revealed the following:
-7/9/18 to 7/15/18: no documented RNP was offered or completed.
-7/16/18 to 7/22/18: no documented RNP was offered or completed.
-7/23/18 to 7/29/18: no documented RNP was offered or completed.
-7/30/18 to 8/5/18: documented ROM completed 2 of the 3 scheduled days.
-8/6/18 to 8/12/18: no documented RNP was offered or completed.

R8's electronic Point of Care (POC) Response History task of nursing rehab from 7/13/18 to 8/9/18 (28 days) directed, "standing frame 10 -15 minutes 2 times week. If [R8] will not stand have [R8}] complete 15 minutes on the onmicycle." Staff documented "Not Applicable" 17 times. RNP was completed one time during the 28 day time frame on 8/2/18. All dates were blank under resident refused.

During an interview on 8/8/18, at 3:48 p.m. family member (FM)-J stated she visits almost every afternoon. FM-J stated at times staff have R8 riding the bicycle, but wished they would do it more often. FM-J stated "I think they have given up." FM-J stated she had not seen the stand platform in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 45	F 725		

During an interview on 8/9/18, at 1:29 p.m. NA-A stated when working as the restorative aide, she gets pulled to work on the unit, sometimes up to 3 times a week. NA-A stated the restorative program does not get completed when she is pulled. NA-A stated it takes about 5 hours to complete the RNP for all 22 residents on the RNP list. NA-A stated the aides document under the electronic POC if the ROM is completed on the floor. NA-A reviewed the Restorative Treatment Schedule from 7/9/18 to 8/9/18.
-NA-A stated for the week of July 9th, ROM was not completed. NA-A stated, "I must have been pulled."
-NA-A stated for the week of July 16th, ROM was not offered/completed as she was on vacation.
-NA-A stated for the week of July 23rd, ROM was not offered/completed. NA-A stated she must have been pulled to work on the unit and was on vacation on Friday. NA-A stated the ROM does not get completed when she gets pulled to work on the unit or is on vacation.
-NA-A stated for the week of July 30th. ROM was offered and completed on July 30th. NA-A stated ROM was completed 2 of the 3 scheduled days. NA-A stated R8's ROM was not offered/completed on August 3rd, as she was pulled to work on the unit.
-NA-A stated for the week of August 6th, R8 was scheduled for ROM on the 6th and 8th. NA-A stated ROM was not offered to R8 as she "just got so busy helping on the wing." NA-A stated she plans on completing the ROM as scheduled the next day, 8/10/18.

During an interview on 8/10/18, at 11:13 a.m. registered nurse (RN)-A stated the restorative program is being changed from 7 days to 5 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46 RN-A stated "sometimes" the restorative aide gets pulled to work on the floor or sent out to appointments with residents. RN-A stated the floor nursing assistants are to complete the restorative program and document the completion of the ROM in POC. RN-A stated the RNP was not consistently being completed. RN-A stated this is "partly staffing and busy." RN-A stated the facility was switching the restorative program from 7 days to 5 days and hired another restorative aide to help solve the issue. During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed.	F 725		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary bathrooms related to improperly fitted commodes for 4 of 4 residents (R28, R54, R5, R114) reviewed for safe and sanitary environment. In addition, failed to ensure proper working order of a bathroom door (room 409). Findings include:	F 921	Immediate corrective action: *The door for bathroom #409 was repaired on 9/5/18. *The high rise commodes including those in bathrooms for residents #5, #28, #54 & #114 will be removed and replaced with a better option based on the resident need. Action as it applies to others: *The Procedure for Preventive	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 47 R28's admission Minimum Data Sets (MDS) dated 6/3/18, indicated moderate cognitive impairment and had diagnoses of anemia, malnutrition, bipolar disease and a urinary track infection. During interview and observation on 8/9/18, at 10:52 a.m. R28 stated her toilet was flooded and she could not use it. R28 further stated it had been flooding for the last month, so she had to use a public bathroom. R28's bathroom had water on the floor. The housekeeper (HK)-A over heard R28 talking, came into her room and bathroom to check out the water on the floor. HK-A stated it was not water on the floor it was urine. HK-A cleaned up the bathroom. During an interview and observation on 8/9/18, at 11:03 a.m. HK-A stated the facility had a problem with the high rise commodes in the facility not fitting properly over the existing toilets. HK-A stated the seat can not go back far enough because of the toilet lid. HK-A stated one person in the room may need the high rise toilet and the other may not, and when it gets moved around, it does not fit properly (she demonstrated the gap) and urine and feces gets on the floor. HK-A stated they have problems with other residents voiding all over the bathroom floors as well. The highrise commode was noted to be fitting/ positioned poorly with the front portion of seat sticking out 4-5 inches leaving a large enough gap for urine to get on person, clothes and on the floor. During an interview on 8/9/18, at 1:56 p.m. HK-B stated there are different size high rise commodes and they do not fit correctly over the toilet so they have problems with urine getting on	F 921	Maintenance remains current. *All staff were educated on the Environmental issues cited including the door issue as well as the removal of high rise commodes used over the toilet on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented by: *5 visual audits will be conducted weekly on various units x 90 days to assure bathroom doors in working order as well as raised toilet seats are not ill fitting. The results of these audits will be shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *Maintenance Director/Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 48	F 921		

the floor. HK-B stated the seats do not go back far enough and this had been a problem for months.

R54's quarterly MDS dated 5/17/18, indicates good cognition, had diagnoses of diabetes, depression, and renal insufficiency.

During interview on 8/9/18, at 11:45 a.m. R54 stated she used the highrise commode and does not get urine on the floor. R54 stated she shares a bathroom and the bathroom roommate urinates on the floor. R54 stated the high rise commode is for her own use, not her bathroom roommate use. R54 stated the urine gets on the floor because the highrise commode does not fit properly, the lid of the toilet gets in the way and it sticks to far out leaving a gap.

R5's annual MDS dated 5/3/18, indicates good cognition, and had diagnoses including diabetes, hypertension, dementia, depression and a urinary track infection.

During an interview on 8/9/18 at 11:49 a.m. R5 stated the high rise commode is out to far and she urinates on the floor, and it happened every time she goes to the bathroom. R5 stated she had to get down on the floor to clean it up. R5 stated she has to clean up urine every time she voids, and she had gotten her own pants wet as well. R5 stated she had told staff about it , however, only one registered nurse had helped get the commode over the toilet correctly so it fits properly when she used it. R5 stated she had reported the problem to housekeeping and other nurses but could not identify who these nurses were.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 49	F 921		

R114's diagnoses list indicated she was fully cognitive and was in facility short term for rehabilitation of her left surgical knee.

During an interview on 8/9/18, at 2:07 p.m. R114 stated she had been voiding on her self, legs, on the floor and on her clothes due to a high rise commode over the existing toilet in the bathroom. R114 shared the toilet with two other women, her roommate (R5) and the women in the next room (R54). R114 stated she does not need the high rise commode herself, it is for her room mate. However, she has to use it as well. R114 stated night time is the worst because she does not have the strength to remove the high rise commode off the toilet and she had urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and on self. R114 stated she had reported this to a couple of nursing assistants and trained medication assistants about the highrise commodes not fitting properly and urinating on self and floor. R114 stated they looked at it, but nothing was done, so she gave up.

A facility policy was requested and not received.

During a tour of the facility on 8/6/18, at 4:31 p.m. room 409's bathroom door was difficult to open for the surveyor. The resident in this room stated it was very difficult for the residents to open the bathroom door because the residents were in wheel chairs.

During an environmental tour on 8/10/18, at 2:09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 50 p.m. environmental service (EVS) manager stated room 409's bathroom door frame was rusted and the rust has swollen so the bathroom door is hard to open. The EVS manager demonstrated the bathroom door was difficult to open. The EVS manager stated it takes some time for rust to come like what is on room 409's bathroom door jamb. The EVS manager stated maintenance should be checking the doors after a deep clean and after someone leaves a room. The EVS manager stated no one had notified the EVS manager of room 409's bathroom door jamb sticking. The facility Room Readiness Checklist undated indicated maintenance would check room entry, and bathroom doors, jambs and hinges for signs of wear or rusting. If unable to fix immediately, report to EVS.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 9, 2018. At the time of this survey Evergreen Terrace 01 Main Building was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Evergreen Terrace is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 93 beds and had a census of 71 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

Electronically delivered
August 29, 2018

Mr. Lee Harwarth, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5495028 and H5495058

Dear Mr. Harwarth:

The above facility was surveyed on August 6, 2018 through August 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5495058 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement 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.

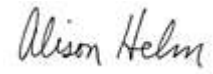
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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 Kathleen Lucas, Unit Supervisor at (320) 223-7338 or brenda.fischer@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.

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 6th-10th, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, a complaint investigation was also completed at the time of the licensing survey. An investigation of complaint H5495058 was completed. The complaint was not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement restorative nursing programs related to ambulation, range of motion and strengthening exercises for 4 of 4 residents (R46, R54, R35, R8). This had the potential to affect all 22 residents who received restorative nursing services. Findings include: See F688: The facility failed to routinely provide restorative exercises for 4 of 4 residents (R46,	2 800	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide(s) on 8/22/18. Education included updated documentation to be performed in POC from paper tool used for Restorative. *Residents #8, #35 and #46 were evaluated by OT on 8/19/18 and the results were to continue Resident #8 and #46 Programs ad Discontinue Resident #35 and #54 Program.	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 3 R54, R35, R8) reviewed with a restorative nursing program. R46's physical therapy progress note (PT PN) dated 7/15/18, analysis of functional outcome/clinical impression, indicated that R46 worked well with therapy. R46 will remain at long term care and will begin restorative nursing program (RNP). R46's electronic task tracking printed on 8/10/18, indicated restorative nursing section, starting 7/20/18 to 8/8/18. R46 was to use the Omni cycle for 15 minutes, 3 times per week, and arm bike for 15 minutes, 3 times per week. There was a total of 13 opportunities as indicated on the Restorative Treatment Schedule printed on 8/10/18, 3 of 13 opportunities were documented refused by R46, 1 of 16 opportunities was documented unable to participate, 9 of 13 opportunities were documented not applicable (NA). R46's Restorative Treatment Schedule printed on 8/10/18 revealed she received 0 out of 13 opportunities since starting RNP on 7/20/18. During interview on 8/10/18, at 10:00 a.m. restorative nursing assistant/ NA-A stated, "To be honest, I get pulled to the floor a lot and I just can't get to it all." NA-A went on to say, she gets pulled for appointments then she will sit at the clinic for two or more hours. NA-A went on to say, that it is her job to do the restorative programs and when she is pulled to the floor, or on vacation, there is no one to take her place. Review of the weekly restorative worksheet for R46's unit, indicated the frequency of the restorative aide having been reassigned from providing the services as indicated below:	2 800	Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative Program, which program, how often and a plan to assure these programs are provided by Restorative Aide or Nursing staff. *Those residents needing Restorative Programs will have updated information added to their Care Plan and POC Tasks Those assessed as being able to complete programs independently, non longer warranted, or not in need of a program as often will be updated and focus will be on ability to provide the programs to those in need. *All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. *In the case of the Restorative Aide being needed to work as a caregiver on the floor, the Restorative Coordinator will assure the Programs missed that day will be completed a different day that week. Date of completion: 9/21/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 4 -week of 7/16/18: NA-A on vacation this week. -week of 7/23/18: NA-A reassigned to floor two days, and on vacation two days. -week of 7/30/18: NA-A reassigned to floor one day. -week of 8/6/18: NA-A reassigned to floor two days, sent on appointment off campus one day. R54's task information on the computer dated 8/10/18, at 11:57 a.m. indicated R54 nursing rehab program was walking 10 to 20 feet in the parallel bars three times a week. A review of Unit 4 Restorative Treatment Schedule form dated 7/23/18 through 7/29/18, indicated R54 received RNP one day. The week of 7/30/18 through 8/5/18, indicated R54 received RNP one day. The week of 8/6/18 through 8/12/18, indicated R54 received RNP one day. During an interview on 8/10/18, at 1:02 p.m. NA-A stated when she was on vacation the RNP probably did not get completed. NA-A stated she would get pulled to work on the floor a couple of times a week for short staffing or ill calls. NA-A stated a walking program was attempted for the residents but it did not work because there were not enough staff or enough time to complete it. NA-A stated the most important thing for residents was a walking program for them to keep their independence. R35's Restorative Treatment Schedule from 7/9/18 to 7/29/18 directed the following for R35. AROM BLE hip flexion, extension and abduction 10 reps/joint. Left knee extension stretch of -20 degrees 5 times weekly.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 5 -7/9/18 to 7/15/18: no documented RNP was offered/completed on the 5 scheduled dates -7/16/18 to 7/22/18: no documented RNP was offered/completed on the 5 scheduled dates -7/23/18 to 7/29/18: R35 was offered and refused one time. No documentation RNP was offered/completed the remaining 4 scheduled dates. After 7/29/18, RNP schedule changed from 5 times weekly to twice weekly. -7/30/18 to 8/5/18: R35 documented ROM was completed or refused 2 of the 2 scheduled days. -8/6/18 to 8/12/18: R35 was scheduled for RNP on Tuesday and Thursday and was not offered/completed. R35's electronic Point of Care (POC) Response History task of restorative rehabilitation directed: AROM to right and left lower extremities hip flexion, extension and abduction, knee and ankle flexion and extension 10 reps per joint 2 times weekly. Left knee extension stretching for contracture of -20 degrees extension. From 7/12/18 to 8/9/18 (29 days) "not applicable" documented 20 times. The POC lacked documentation of completion or refusals of the ROM. During an interview on 8/10/18, at 9:07 a.m., when asked about ROM with moving legs, knee and ankle R35 laughed and stated, "I'm pretty much on my own." When asked the last time ROM therapy was offered R35 stated, "it has not been done for awhile." During interview on 8/10/18 at 9:24 a.m. NA-A reviewed the restorative nursing schedule from 7/9/18 to 8/9/18. -NA-A stated for the week of July 9th, ROM was not offered 5 out of the 5 scheduled times.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 6 -NA-A stated for the week of July 16th, ROM was not offered 5 out of 5 scheduled times, as she was on vacation. -NA-A stated for the week of July 23rd, R35 was offered and refused one time. R35 was not offered ROM the remainder of the 4 scheduled times. -NA-A stated for the week of July 30th, R35 was scheduled 2 times and was refused or completed the scheduled 2 times. -NA-A stated during the week of August 6th. ROM was not offered 2 of the 2 scheduled days. R8's physical therapy evaluation only form, dated 3/22/18, indicated current restorative nursing program (RNP) of standing frame x 10 minutes remains appropriate as R8 and restorative aide able to complete safely. Review of Unit 2's Restorative Treatment Schedule directed, "standing frame 10 to 15 minutes 3 times a week or omnicylcle for 15 minutes 3 times a week." Documentation revealed the following: -7/9/18 to 7/15/18: no documented RNP was offered or completed. -7/16/18 to 7/22/18: no documented RNP was offered or completed. -7/23/18 to 7/29/18: no documented RNP was offered or completed. -7/30/18 to 8/5/18: documented ROM completed 2 of the 3 scheduled days. -8/6/18 to 8/12/18: no documented RNP was offered or completed. R8's electronic Point of Care (POC) Response History task of nursing rehab from 7/13/18 to 8/9/18 (28 days) directed, "standing frame 10 -15 minutes 2 times week. If [R8] will not stand have	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 7 [R8}] complete 15 minutes on the onmicycle." Staff documented "Not Applicable" 17 times. RNP was completed one time during the 28 day time frame on 8/2/18. All dates were blank under resident refused. During an interview on 8/8/18, at 3:48 p.m. family member (FM)-J stated she visits almost every afternoon. FM-J stated at times staff have R8 riding the bicycle, but wished they would do it more often. FM-J stated "I think they have given up." FM-J stated she had not seen the stand platform in use. During an interview on 8/9/18, at 1:29 p.m. NA-A stated when working as the restorative aide, she gets pulled to work on the unit, sometimes up to 3 times a week. NA-A stated the restorative program does not get completed when she is pulled. NA-A stated it takes about 5 hours to complete the RNP for all 22 residents on the RNP list. NA-A stated the aides document under the electronic POC if the ROM is completed on the floor. NA-A reviewed the Restorative Treatment Schedule from 7/9/18 to 8/9/18. -NA-A stated for the week of July 9th, ROM was not completed. NA-A stated, "I must have been pulled." -NA-A stated for the week of July 16th, ROM was not offered/completed as she was on vacation. -NA-A stated for the week of July 23rd, ROM was not offered/completed. NA-A stated she must have been pulled to work on the unit and was on vacation on Friday. NA-A stated the ROM does not get completed when she gets pulled to work on the unit or is on vacation. -NA-A stated for the week of July 30th. ROM was offered and completed on July 30th. NA-A stated ROM was completed 2 of the 3 scheduled days. NA-A stated R8's ROM was not	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 8	2 800		

offered/completed on August 3rd, as she was pulled to work on the unit.
-NA-A stated for the week of August 6th, R8 was scheduled for ROM on the 6th and 8th. NA-A stated ROM was not offered to R8 as she "just got so busy helping on the wing." NA-A stated she plans on completing the ROM as scheduled the next day, 8/10/18.

During an interview on 8/10/18, at 11:13 a.m. registered nurse (RN)-A stated the restorative program is being changed from 7 days to 5 days. RN-A stated "sometimes" the restorative aide gets pulled to work on the floor or sent out to appointments with residents. RN-A stated the floor nursing assistants are to complete the restorative program and document the completion of the ROM in POC. RN-A stated the RNP was not consistently being completed. RN-A stated this is "partly staffing and busy." RN-A stated the facility was switching the restorative program from 7 days to 5 days and hired another restorative aide to help solve the issue.

During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed.

SUGGESTED METHODS OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure sufficient nurse staffing was available to complete restorative programs for residents who required restorative programs.
The DON or designee could develop monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 9 systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative nursing services to maintain mobility and range of motion for 3 of 3 residents (R46, R35, R8) reviewed for restorative nursing programs. Findings include: R46's 14 day prospective payment system (PPS) MDS on 7/11/18, indicated a brief interview for mental status (BIMS) score of 7 (severe cognitive	2 895	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide(s) on 8/22/18. Education included updated documentation to be performed in POC from paper tool used for Restorative. *Resident #8, #35, and #46 were evaluated by OT on 8/19/18 and the results were to continue resident #8 & #46 Programs and Discontinue Resident	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 10 impairment). R46's Diagnosis Report printed on 8/7/18, indicated the following diagnoses: encephalopathy unspecified (any disease or disorder of the brain), epilepsy, hemiplegia and hemiparesis following cerebral infarction (stroke). R46's 14 day MDS dated 7/11/18, indicated R46 required extensive assistance with bed mobility, locomotion on unit, locomotion off unit, dressing, toilet use and personal hygiene. During observation on 8/10/18, at 9:32 a.m. R46 was having difficulty propelling her wheelchair forward towards dining room. She required assistance of one staff to propel to her spot at the table for breakfast. After meal set up, R46 was able to complete her breakfast with minimal assistance. R46's Physical Therapy Plan of Care indicated start of care 6/25/18 with end of care 7/20/18, referred due to a decline in strength due to encephalopathy, UTI and epilepsy. R46's physical therapy progress note (PT PN) dated 7/15/18, analysis of functional outcome/clinical impression, indicated that R46 worked well with therapy. R46 will remain at long term care and will begin restorative nursing program (RNP). R46's PT PN dated 7/20/18, discharge plans and instructions indicated, R46 will remain in this skilled nursing facility on RNP. R46's Occupation Therapy Plan of Care indicated a start of care on 6/25/18 with end of care 7/20/18, referred due to a decline of self-cares and function mobility due to seizures, and encephalopathy.	2 895	#35 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative Program, which program, how often and a plan to assure these programs are provided by Restorative Aide or Nursing staff. *Those residents needing Restorative Programs will have updated information added to their Care Plan and POC Tasks. *All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents receiving a Restorative Program will be conducted weekly x 90 days to assure the Program is occurring and is documented. The results of the audits will be shared with the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 11 R46's occupational therapy progress note (OT PN) dated 7/17/18, update to treatment approach, indicated plan to address discharge plan and continue to educate restorative nursing on program prior to end of week discharge. R46's OT PN dated 7/20/18, discharged from OT services with home exercise program with RNP. R46's electronic task tracking printed on 8/10/18, indicated restorative nursing section, starting 7/20/18 to 8/8/18. R46 was to use the Omni cycle for 15 minutes, 3 times per week, and arm bike for 15 minutes, 3 times per week. There was a total of 13 opportunities as indicated on the Restorative Treatment Schedule printed on 8/10/18, 3 of 13 opportunities were documented refused by R46, 1 of 16 opportunities was documented unable to participate, 9 of 13 opportunities were documented not applicable (NA). R46's Restorative Treatment Schedule printed on 8/10/18, revealed she received 0 out of 13 opportunities since starting RNP on 7/20/18. During interview on 8/10/18, at 10:00 a.m. restorative nursing assistant/ NA-A stated that NA is documented when the restorative program is not completed for whatever reason, there is not any place to chart why it did not occur other than the resident refusal box or unable to participate box. NA-A stated, "To be honest, I get pulled to the floor a lot and I just can't get to it all." NA-A went on to say, she gets pulled for appointments then she will sit at the clinic for two or more hours, when she gets back it is time to help feed residents not leaving much time after lunch and then it is time for her to leave. NA-A went on to say, that it is her job to do the restorative programs and when she is pulled to the floor, or	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 12 on vacation, there is no one to take her place. NA-A stated registered nurse (RN)-A is aware she gets pulled to the floor, making it difficult to get restorative nursing completed. R46's PT plan of care dated 8/7/18, indicated an order for evaluation only after being hospitalized 8/2/18-8/4/18. Initial assessment revealed there was no functional decline noted and current restorative nursing program remain appropriate. R46's OT plan of care dated 8/8/18 indicated an order for evaluation only after being hospitalized 8/2/18-8/4/18. Evaluation indicates R46 does not demonstrate functional decline at this time. R46 has a restorative nursing program and will continue with this program. R35's quarterly MDS dated 6/28/18, indicated moderate cognitive impairment. R35 required extensive staff assistance with transfers. The MDS indicated R35 was not steady and only able to stabilize with staff assistance when moving from a seated to standing position and from the bed to a chair. The MDS further identified limitations to R35's range of motion (ROM) of upper and lower extremity on one side. R35's electronic Diagnosis Report dated 8/10/18, revealed diagnoses of hemiplegia, hemiparesis, and generalized weakness. R35's care plan dated 6/29/18, indicated R35 was on a RNP. The care plan directed active range of motion (AROM) to bilateral lower extremities (BLE) hip flexion, extension and abduction. Knee and ankle flexion and extension 10 repetition/joint 5 times weekly. Left knee extension stretching for contracture of -20 degree extension. The care	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 13 plan updated on 7/24/18, decreasing the frequency of the RNP program to 2 times weekly. The care plan directed one staff assisted R35 with transfers using a PAL (mechanical device to assist with transfers) and required extensive assistance of 1 staff with bed mobility. Review of Unit 2's Restorative Treatment Schedule from 7/9/18 to 7/29/18, directed the following: AROM BLE hip flexion, extension and abduction 10 reps/joint. Left knee extension stretch of -20 degrees 5 times weekly. -7/9/18 to 7/15/18: no documented RNP was offered/completed on the 5 scheduled dates -7/16/18 to 7/22/18: no documented RNP was offered/completed on the 5 scheduled dates -7/23/18 to 7/29/18: R35 was offered and refused one time. No documentation RNP was offered/completed the remaining 4 scheduled dates. After 7/29/18, RNP schedule changed from 5 times weekly to twice weekly. -7/30/18 to 8/5/18: R35 documented ROM was completed or refused 2 of the 2 scheduled days. -8/6/18 to 8/12/18: R35 was scheduled for RNP on Tuesday and Thursday and was not offered/completed. R35's electronic Point of Care (POC) Response History task of restorative rehabilitation directed: AROM to right and left lower extremities hip flexion, extension and abduction, knee and ankle flexion and extension 10 reps per joint 2 times weekly. Left knee extension stretching for contracture of -20 degrees extension. From 7/12/18 to 8/9/18, (29 days) "not applicable" documented 20 times. The POC lacked documentation of completion or refusals of the ROM.	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 14 During interview on 8/10/18 at 9:24 a.m. restorative nursing assistant/ NA-A reviewed the restorative nursing schedule from 7/9/18 to 8/9/18. -NA-A stated for the week of July 9th, ROM was not offered 5 out of the 5 scheduled times. -NA-A stated for the week of July 16th, ROM was not offered 5 out of 5 scheduled times, as she was on vacation. -NA-A stated for the week of July 23rd, R35 was offered and refused one time. R35 was not offered ROM the remainder of the 4 scheduled times. -NA-A stated for the week of July 30th, R35 was scheduled 2 times and was refused or completed the scheduled 2 times. -NA-A stated during the week of August 6th. ROM was not offered 2 of the 2 scheduled days. During an interview on 8/10/18, at 9:07 a.m. when asked about ROM with moving legs, knee and ankle R35 laughed and stated, "I'm pretty much on my own." When asked the last time ROM therapy was offered R35 stated, "it has not been done for awhile." R8's quarterly MDS dated 5/10/18, indicated short and long term memory impairment. R8 required extensive assistance with transfers. The MDS indicated R8 was not steady and only able to stabilize with staff assistance when moving from a seated to standing position and from the bed to a chair. The MDS further identified limitations to R8's ROM of lower extremity on one side. R8's electronic Diagnosis Report dated 8/10/18, revealed diagnoses of Alzheimer's disease and	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 15 generalized muscle weakness. R8's physical therapy evaluation only form, dated 3/22/18, indicated current RNP of standing frame x 10 minutes remains appropriate as R8 and restorative aide able to complete safely. R8's care plan dated 6/5/18, indicated R8 was on a RNP. The care plan directed to use a standing frame 3 times a week. If unable to use the standing frame, to complete 15 minutes on the omnicycle to maintain ROM. The care plan directed one staff assisted R8 with transfers using a PAL lift. Review of Unit 2's Restorative Treatment Schedule directed "standing frame 10 to 15 minutes 3 times a week or omnicylcle for 15 minutes 3 times a week." Documentation revealed the following: -7/9/18 to 7/15/18: no documented RNP was offered or completed. -7/16/18 to 7/22/18: no documented RNP was offered or completed. -7/23/18 to 7/29/18: no documented RNP was offered or completed. -7/30/18 to 8/5/18: documented ROM completed 2 of the 3 scheduled days. -8/6/18 to 8/12/18: no documented RNP was offered or completed. R8's electronic POC Response History task of nursing rehab from 7/13/18 to 8/9/18 (28 days) directed "standing frame 10 -15 minutes 2 times week. If [R8] will not stand have [R8}] complete 15 minutes on the onmicycle." Staff documented "Not Applicable" 17 times. RNP was completed one time during the 28 day time frame on 8/2/18. All dates were blank under resident refused.	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 16 During an interview on 8/8/18, at 3:48 p.m. family member (FM)-J stated she visits almost every afternoon. FM-J stated at times staff have R8 riding the bicycle, but wished they would do it more often. FM-J stated, "I think they have given up." FM-J stated she had not seen the stand platform in use. During an interview on 8/9/18, at 9:26 a.m. nursing assistant (NA)-D stated the nursing assistants working on the floor do not complete ROM for residents in the restorative program. NA-D stated the restorative aide completes the ROM program. NA-A stated if ROM is completed by the aide working on the unit, the completion is documented in POC. NA-D stated not applicable (NA) is documented when the ROM is not offered to the resident. During an interview on 8/9/18, at 1:29 p.m. restorative aide/ NA-A stated when working as the restorative aide, she gets pulled to work on the unit, sometimes up to 3 times a week. NA-A stated the restorative program does not get completed when she is pulled. NA-A stated it takes about 5 hours to complete the RNP for all 22 residents on the RNP list. NA-A stated the aides document under the electronic POC if the ROM is completed on the floor. NA-A reviewed the Restorative Treatment Schedule from 7/9/18 to 8/9/18. -NA-A stated for the week of July 9th, ROM was not completed. NA-A stated, "I must have been pulled." -NA-A stated for the week of July 16th, ROM was not offered/completed as she was on vacation. -NA-A stated for the week of July 23rd, ROM was not offered/completed. NA-A stated she must have been pulled to work on the unit and was on vacation on Friday. NA-A stated the ROM does	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 17	2 895		

not get completed when she gets pulled to work on the unit or is on vacation.
-NA-A stated for the week of July 30th. ROM was offered and completed on July 30th. NA-A stated ROM was completed 2 of the 3 scheduled days. NA-A stated R8's ROM was not offered/completed on August 3rd, as she was pulled to work on the unit.
-NA-A stated for the week of August 6th, R8 was scheduled for ROM on the 6th and 8th. NA-A stated ROM was not offered to R8 as she "just got so busy helping on the wing." NA-A stated she plans on completing the ROM as scheduled the next day, 8/10/18.

During an interview on 8/10/18 at 9:56 a.m. physical therapist (PT)-K was asked to complete a screening to identify if a decline had occurred since PT discontinued on R8 and R35. PT-K stated the restorative aide gets pulled out of the rehab department. When asked how often the aide is pulled, PT-K stated, "you would have to ask her, but it seems quite frequently." At 10:03 a.m. PT-K stated she screened R8 and R35 and neither resident had a decline.

During an interview on 8/10/18, at 11:13 a.m. RN-A stated the restorative program is being changed from 7 days to 5 days. RN-A stated "sometimes" the restorative aide gets pulled to work on the floor or sent out to appointments with residents. RN-A stated the floor nursing assistants are to complete the restorative program and document the completion of the ROM in POC. RN-A stated the RNP was not consistently being completed. RN-A stated this is "partly staffing and busy." RN-A stated the facility was switching the restorative program from 7 days to 5 days and hired another restorative aide to help solve the issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 18 During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed. The Restorative Nursing Program policy revised 1/18, indicated restorative nursing staff will document the program performed on the point of care computer. Documentation of the resident's restorative progress will be assessed and documented quarterly by the RN manager in the progress notes. Restorative nursing job summary indicated responsible to work with resident needing restorative nursing measure to gain or maintain highest functional level. Responsible for providing consistency between therapist's work and carry over on a daily basis. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for range of motion and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 915		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 19 comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative nursing services to maintain ability to ambulate for 1 of 1 resident (R54) reviewed for restorative nursing programs and have ability to ambulate. R54's quarterly Minimum Data Set (MDS) dated 5/17/18, indicated R54's cognition was intact. R54 needed extensive assistance of one staff for transfers, moving from seated surface to standing position, and walking. R54 had lower extremity impairment on both sides. R54's care plan dated 6/5/18, indicated a restorative nursing program (RNP) for R54 was to ambulate 40 feet in the parallel bars with assist of one staff with stand by assist (SBA), use a transfer belt and wheelchair three times a week	2 915	Immediate corrective action: *Education on alerting supervisor if unable to provide Restorative Program on any day scheduled was provided to Restorative Aide on 8/22/18. *Resident #54 was evaluated by OT on 8/19/18 and it was determined the resident was able to perform her Functional Maintenance exercised independently and no longer needed the existing FNP. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed and remains current. *All residents will be reviewed to determine need for Restorative program, which program, how often and a plan to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 20 for four weeks. R54's Diagnosis Report provided 8/10/18, indicated R54's diagnoses included diabetes, right humerus fracture, and left leg below the knee amputation. During an observation and interview on 8/10/18, at 11:42 a.m. R54 was sitting in the wheelchair in R54's room. R54 stated once in a while nursing assistant (NA)-A comes in to help with her restorative program. R54's task information on the computer dated 8/10/18, at 11:57 a.m. indicated R54's nursing rehab program was walking 10 to 20 feet in the parallel bars three times a week. A review of Unit 4 Restorative Treatment Schedule form dated 7/23/18 through 7/29/18, indicated R54 received RNP one day. The week of 7/30/18 through 8/5/18, indicated R54 received RNP one day. The week of 8/6/18 through 8/12/18, indicated R54 received RNP one day. During an interview on 8/10/18, at 1:02 p.m. NA-A stated, "When I was on vacation RNP probably did not get completed." NA-A added, "I will get pulled to work on the floor a couple of times a week for short staffing or ill calls." NA-A stated a walking program was attempted for the residents but it did not work because there were not enough staff or enough time to complete it. NA-A stated the most important thing for residents was a walking program for them to keep their independence. During an interview on 8/10/18, at 11:53 a.m. interim director of nursing (IDON)-A stated she was unaware of concerns with the RNP not being	2 915	assure these programs are provided by Restorative Aide or Nursing staff. All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents receiving a Restorative Program will be conducted weekly x 90 days to assure the Program is occurring and is documented. The results of the audits will be shared with the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 21 completed. IDON-A stated if staff have difficulty completing the RNP, the nurse managers or restorative aides are to contact her so a plan can be made to ensure the RNP gets completed. The Restorative Nursing Program policy revised 1/18, indicated restorative nursing staff will document the program performed on the point of care computer. Documentation of the resident's restorative progress will be assessed and documented quarterly by the RN manager in the progress notes. Restorative nursing job summary indicated responsible to work with resident needing restorative nursing measure to gain or maintain highest functional level. Responsible for providing consistency between therapist's work and carry over on a daily basis. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for restorative nursing programs and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 915		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 22 and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary bathrooms related to improperly fitted commodes for 4 of 4 residents (R28, R54, R5, R114) reviewed for safe and sanitary environment. In addition, failed to ensure proper working order of a bathroom door (room 409). Findings include: R28's admission Minimum Data Sets (MDS) dated 6/3/18, indicated moderate cognitive impairment and had diagnoses of anemia, malnutrition, bipolar disease and a urinary track infection. During interview and observation on 8/9/18, at 10:52 a.m. R28 stated her toilet was flooded and she could not use it. R28 further stated it had been flooding for the last month, so she had to use a public bathroom. R28's bathroom had water on the floor. The housekeeper (HK)-A over heard R28 talking, came into her room and bathroom to check out the water on the floor. HK-A stated it was not water on the floor it was urine. HK-A cleaned up the bathroom. During an interview and observation on 8/9/18, at 11:03 a.m. HK-A stated the facility had a problem with the high rise commodes in the facility not fitting properly over the existing toilets. HK-A stated the seat can not go back far enough because of the toilet lid. HK-A stated one person in the room may need the high rise toilet and the other may not, and when it gets moved around, it	21695	Immediate corrective action: *The door for bathroom #409 was repaired on 9/5/18. *the high rise commodes that are ill-fitting will be removed and replaced with a better option based on the resident need. Action as it applies to others: *The Procedure for Preventive Maintenance remains current. *all staff were trained on resident dignity on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented by: *5 visual audits will be conducted weekly on various units x 90 days to assure bathroom doors in working order as well as raised toilet seats are not ill fitting. The results of these audits will be shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: *Maintenance Director/Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 23	21695		

does not fit properly (she demonstrated the gap) and urine and feces gets on the floor. HK-A stated they have problems with other residents voiding all over the bathroom floors as well. The highrise commode was noted to be fitting/ positioned poorly with the front portion of seat sticking out 4-5 inches leaving a large enough gap for urine to get on person, clothes and on the floor.

During an interview on 8/9/18, at 1:56 p.m. HK-B stated there are different size high rise commodes and they do not fit correctly over the toilet so they have problems with urine getting on the floor. HK-B stated the seats do not go back far enough and this had been a problem for months.

R54's quarterly MDS dated 5/17/18, indicates good cognition, had diagnoses of diabetes, depression, and renal insufficiency.

During interview on 8/9/18, at 11:45 a.m. R54 stated she used the highrise commode and does not get urine on the floor. R54 stated she shares a bathroom and the bathroom roommate urinates on the floor. R54 stated the high rise commode is for her own use, not her bathroom roommate use. R54 stated the urine gets on the floor because the highrise commode does not fit properly, the lid of the toilet gets in the way and it sticks to far out leaving a gap.

R5's annual MDS dated 5/3/18, indicates good cognition, and had diagnoses including diabetes, hypertension, dementia, depression and a urinary track infection.

During an interview on 8/9/18 at 11:49 a.m. R5 stated the high rise commode is out to far and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 24	21695		

she urinates on the floor, and it happened every time she goes to the bathroom. R5 stated she had to get down on the floor to clean it up. R5 stated she has to clean up urine every time she voids, and she had gotten her own pants wet as well. R5 stated she had told staff about it , however, only one registered nurse had helped get the commode over the toilet correctly so it fits properly when she used it. R5 stated she had reported the problem to housekeeping and other nurses but could not identify who these nurses were.

R114's diagnoses list indicated she was fully cognitive and was in facility short term for rehabilitation of her left surgical knee.

During an interview on 8/9/18, at 2:07 p.m. R114 stated she had been voiding on her self, legs, on the floor and on her clothes due to a high rise commode over the existing toilet in the bathroom. R114 shared the toilet with two other women, her roommate (R5) and the women in the next room (R54). R114 stated she does not need the high rise commode herself, it is for her room mate. However, she has to use it as well. R114 stated night time is the worst because she does not have the strength to remove the high rise commode off the toilet and she had urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and on self. R114 stated she had reported this to a couple of nursing assistants and trained medication assistants about the highrise commodes not fitting properly and urinating on self and floor. R114 stated they looked at it, but nothing was done, so she gave up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 25 A facility policy was requested and not received. During a tour of the facility on 8/6/18, at 4:31 p.m. room 409's bathroom door was difficult to open for the surveyor. The resident in this room stated it was very difficult for the residents to open the bathroom door because the residents were in wheel chairs. During an environmental tour on 8/10/18, at 2:09 p.m. environmental service (EVS) manager stated room 409's bathroom door frame was rusted and the rust has swollen so the bathroom door is hard to open. The EVS manager demonstrated the bathroom door was difficult to open. The EVS manager stated it takes some time for rust to come like what is on room 409's bathroom door jamb. The EVS manager stated maintenance should be checking the doors after a deep clean and after someone leaves a room. The EVS manager stated no one had notified the EVS manager of room 409's bathroom door jamb sticking. The facility Room Readiness Checklist undated indicated maintenance would check room entry, and bathroom doors, jambs and hinges for signs of wear or rusting. If unable to fix immediately, report to EVS. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for care equipment placement and provide education to the staff on reporting improperly fitting devices. In addition, the maintenance department could check all bathroom doors to ensure proper working order.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 26 The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified environment for 1 of 1 residents (R114) who had a poor fitting high rise commode resulting in urinating on self and on the floor. Findings include: R114's Minimum Data Set (MDS) had not been completed as R114 was recently admitted to facility for a short term stay following a right knee revision. She required rehabilitation and strengthening of left knee. R114's Care Plan indicated R114 was cognitively intact, makes own decisions, communicate needs, independent with activities of daily living, assist of one but transfers self with walker, and	21805	Immediate Corrective Action: Resident #114 was discharged on 8/27/18. Action as it applies to others: *The Policy and Procedure for Resident dignity was reviewed and remains current. *The residents who could be affected who's bathrooms have high rise commodes, will have them removed and if needed replaced with a better option. *All nursing staff were trained on resident dignity on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented by: *Audits of 5 random residents will be interviewed weekly x 90 days to assure	9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 27 continent of bowel and bladder. During an interview and observation on 8/9/18, at 11:03 a.m. housekeeper (HK)-A stated the facility has a problem with the high rise commodes not fitting properly over the existing toilets. HK-A stated the seat does not go back far enough because of the lid. HK-A stated one person in the room may need the high rise toilet and the other may not, and when it gets moved around (she demonstrated the gap) urine and feces get on the floor. HK-A stated they have problems with other residents voiding all over the bathroom floors related to commodes not fitting properly. HK-A stated the high rise commodes do not fit properly and are not steady. Two high rise commodes were currently in use, one in the bathroom of R114 which was shared with her room mate and a resident from another room. The other high rise commode was in a bathroom shared by 2 residents in 204-1 and 204-2. Both bathroom commodes were observed to be fitting/positioned poorly with the front portion of the commode seat sticking out 4-5 inches from the front of the toilet, leaving a large gap. During an interview on 8/9/18, at 1:56 p.m. HK-B stated there are different size high rise commodes and they do not fit correctly over the toilet so they have problems with urine getting on the floor. HK-B stated the seats do not go back far enough and this has been a problem for months. During an interview on 8/9/18, at 2:07 p.m. R114 stated she has been voiding on her self, legs, on the floor and on her clothes due to the high rise commode over the existing toilet in the bathroom. R114 stated she shares the toilet with two other women, her room mate and a women in the next	21805	their resident rights regarding dignity are being met and the results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: *Social Services/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 28 room. R114 stated the high rise commode also hurts her surgical leg when she sits on it, she has a healing incision with staples and a dressing following a left total knee revision from the week prior. R114 stated she does not need the high rise commode herself, it is for her room mate. However, since it is over the existing toilet she has to use it. R114 stated at night it is the worse because she does not have the strength to remove the high rise commode off the toilet and she has urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and self. R114 stated she has wiped up the urine on the floor with her own clothes because she is embarrassed when she voids on herself. R114 stated she did not want to tell anybody that she voided all over the floor and self, which was why she cleaned it up herself using her own clothes. R114 stated she feels like a child afraid of getting in trouble and that she was ashamed of herself. R114 stated she does not believe the commode is safe for her as she could slip on the urine that is on the floor. R114 stated she had reported this to a couple of nursing assistants and trained medication administration assistants about the high-rise commodes not fitting properly and urinating on self and floor, however, she does not recall who she talked to. R114 stated they looked at it, but nothing was done, so she gave up. The facility Resident Rights and Dignity for all Nursing Procedures policy dated March 2013, indicates residents are to be treated with dignity and respect.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 29 SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for dignity and provide education to the staff on providing a dignified environment. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		