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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PX4Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00771

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245451**

2.STATE VENDOR OR MEDICAID NO.
(L2) **545740800**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTHRIDGE RESIDENCE**
(L4) **1075 ROY STREET**
(L5) **ORTONVILLE, MN** (L6) **56278**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 02/10/2014 (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 **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(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):
Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal certification regulations. Please refer to the CMS 2567B. Effective January 20, 2014, the facility is certified for 64 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gail Anderson, HFE NEII 02/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/25/2014 (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
04/01/1987
(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
02/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5451 April 25, 2014

Mr. Rick Ash, Administrator
Northridge Residence
1075 Roy Street
Ortonville, Minnesota 56278

Dear Mr. Ash:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 20, 2014 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Rick Ash, Administrator
Northridge Residence
1075 Roy Street
Ortonville, MN 56278

RE: Project Number S5451024

Dear Mr. Ash:

On January 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 20, 2014 and therefore remedies outlined in our letter to you dated January 8, 2014, will not be imposed.

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,

Gail Anderson BT

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-332-5140 Fax: 218-332-5196

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245451	A. Building B. Wing	2/10/2014

Name of Facility	Street Address, City, State, Zip Code
NORTHRIDGE RESIDENCE	1075 ROY STREET ORTONVILLE, MN 56278

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/07/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/07/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **01/20/2014**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **01/17/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/17/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **01/17/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency ✓	**Reviewed By** 10562	**Date:** 2/24/14	**Signature of Surveyor:** 10562	**Date:** 2/24/14
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/12/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245451	NORTHRIDGE RESIDENCE

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 28034	02/10/14	02/10/14	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours	0.25
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	N

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PX4Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00771

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245451**

2.STATE VENDOR OR MEDICAID NO.
(L2) **545740800**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTHRIDGE RESIDENCE**
(L4) **1075 ROY STREET**
(L5) **ORTONVILLE, MN** (L6) **56278**

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 **12/12/2013** (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 **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NE II 01/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/03/2014 (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 **04/01/1987** (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

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245451

At the time of the standard survey completed December 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7852

January 8, 2014

Mr. Rick Ash, Administrator
Northridge Residence
1075 Roy Street
Ortonville, Minnesota 56278

RE: Project Number S5451024

Dear Mr. Ash:

On December 12, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Telephone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 12, 2014 (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 June 12, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697
Enclosure
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
	245451	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENCE	1075 ROY STREET ORTONVILLE, MN 56278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	A mandatory nurse meeting was held on 12/17/13. At this meeting, the Social Worker explained to the nurses the importance of all reportable incidents to administration. She explained what a reportable incident is and that it needs to be reported to OHFC within 24 hours of happening. At this meeting, the Vulnerable Adult policy was reviewed. There was a mandatory all staff meeting on 1/7/14 to discuss what incidents need to be reported to the state agency (OHFC) and the timeliness of contacting the administration and administrator. At this meeting, The Vulnerable Adult policy was reviewed.	1/7/14

OK 1/30/14 addendum Sa

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 1-21-14

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.

RECEIVED
JAN 2 4 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENCE	1075 ROY STREET ORTONVILLE, MN 56278

(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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate, immediately report to the administrator and immediately report to the State agency (SA) potential neglect of care for 3 of 3 occurrences of falls for R26 who had a history of falls. Findings include: The quarterly Minimum Data Set (MDS) dated 11/22/13, identified R26 had diagnoses which included anemia and hypertension. The MDS identified R26 had severe cognitive impairment, and required assistance with all activities of daily living (ADL). Review of the quarterly fall assessment dated 11/22/13, revealed R26 had 3 falls in the past quarter, once in the bathroom, twice self transferring and identified R26 continued to be at risk for further falls. R26's care plan revised 12/7/13 identified various interventions for fall prevention which included	F 225	A Performance Improvement has been developed to ensure that all incidents and falls reports are reviewed daily (within 24 hours) and determined if it needs to be reported to OHFC and to administration. This Performance Improvement will be done on all incident and falls reports, daily and reported to Performance Improvement Committee monthly. This Performance Improvement will continue ongoing to ensure compliance is being met. This will be monitored by Social Worker, Case Managers and Director of Nursing.	

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F 225	Continued From page 2 use of landing strip by bed, tabs alarm on in bed and wheelchair, directed staff to push slow in wheelchair, and do not leave alone to toilet, hand her call light, but stand outside for privacy, observe discreetly. Review of R26's Resident Fall Reports and follow up revealed the following: - 7/3/13, at 12:20 a.m. R26 was found lying on the floor beside her bed, resident stated she hit her head. No injuries noted. The report also identified the fall had been possibly preventable if bed alarm and motion sensor were on. The report listed various types of equipment possibly in use and pertinent to fall and both the tabs unit and motion sensor had been checked to indicate the tabs unit and motion sensor had been off at the time of fall. Further, the report identified to turn on alarms as a reasonable intervention to prevent further falls. The fall assessment dated 7/5/13 indicated R26 had rolled out of bed and the careplan had been reviewed, no further new interventions were identified. Further, the assessment lacked documentation of reason as to why the alarms were not functioning. Review of the 48 hour Report Wing 4 form dated 7/3/13 identified R26 utilized personal safety alarms, had fallen out of bed at 12:20 a.m. The form identified no alarms were on at the time of the fall. -7/24/13, at 10:30 a.m., R26 was found resident lying on her right side, by the other resident's bed across the room with head by foot of bed. the report identified the alarms were not sounding. The Fall assessment dated 7/26/13 identified R26 had tried to self transfer from the bed and a high	F 225		

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F 225	Continued From page 3 low bed was to be utilized. The report also identified staff were to stay with R26 in the bathroom. The analysis lacked documentation of the reason for the alarm not sounding. Review of the form titled Nurses Notes, dated 7/24/13,had the following statement "Due to cognition, do not leave R26 alone in the BR (bathroom) for safety reasons." The form revealed 18 staff members had initialed the form to indicate education had been recieved - 9/2/13 at 1:55 p.m., R26 was found sitting on the bathroom floor in front of the toilet, resident stated she slipped off. Fall assessment form dated 9/3/13 identified a new intervention that R26 should not be left alone on the toilet. Further, R26's care plan was revised on 9/3/13, and directed staff to not leave alone to toilet, hand her the call light but stand outside door for privacy. Observe discreetly. Review of the 48 Hour Report Wing 4 forms from 9/2/13 to 9/4/13, revealed on 9/2/13 R26 had fell off toilet and per family, not to be left in the bathroom alone. The 9/4/13 report form identified "fell off toilet-not to be left alone in bathroom and DO NOT leave alone on toilet!" On 12/11/13 at 2:49 p.m. the DON stated she was aware the alarms were not functioning at the time of the 7/3/13 fall for R26. She states when family member (FM) came to the facility the next day, the DON and FM checked the alarms and found them to be functioning at that time. She confirmed she did no further investigation of the fall and did not know why the alarms were not sounding at the time of the fall. She confirmed she had not immediately reported to the	F 225		

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F 225	Continued From page 4 administrator or State Agency the 7/3/13 fall. The DON stated R26's FM had requested that staff stay with R26 when she was on the toilet because the FM was concerned she would fall asleep and fall off of the toilet. The DON stated facility staff had been educated on not leaving R26 alone on the toilet and confirmed this intervention was intended for safety. The intervention was started on 7/24/13 and stated it should have been placed on the careplan at that time. The DON confirmed staff were not following the appropriate interventions for R26 at the time of the 9/2/13 fall in the bathroom. Further, the DON confirmed R26 had an unwitnessed fall in the bathroom on 9/2/13. She confirmed the facility utilized the 48 Hour Report Form as a communication tool for all shifts of staff in the facility. She confirmed R26's resident fall reports dated 7/3/13, 7/24/13 and 9/2/13 and stated on 9/2/13 R26 had been placed on the toilet, had call light in her hand but "unfortunately she was left alone." She stated she would expect staff to follow appropriate interventions at all times. On 12/12/13 at 9:02 a.m., the executive director (ED) confirmed the current facility policy and confirmed the falls on 7/3/13, 7/24/13 and 9/2/13 for R26 had not been immediately reported to her. She stated the usual facility practice was to immediately notify the administrator, SA, and conduct a thorough investigation when a resident was injured as a result of a fall. She confirmed because R26 had not been injured as a result from the falls, the facility had not considered these falls falls as a reportable event.	F 225		

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F 225	Continued From page 5 Review of the facility policy titled Prohibition of Abuse: Maltreatment of Vulnerable Adults/Reporting, revised 6/13, prohibit the maltreatment of residents and indicated incidents of potential abuse were to be thoroughly investigated, the policy identifed the immediate notification to the administrator and immediately report to the State Agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse and Preventive plan to thoroughly investigate, immediately report to the administrator and immediately report to the State agency (SA) potential neglect of care for 3 of 3 occurrences of falls for R26 who had a history of falls. Findings include: Review of the facility policy titled Prohibition of Abuse: Maltreatment of Vulnerable Adults/Reporting, revised 6/13, prohibited the maltreatment of residents and indicated incidents of potential abuse were to be thoroughly investigated, and the policy identified immediate notification to the administer and immediately	F 226	A mandatory nurse meeting was held on 12/17/13. At this meeting, the Social Worker explained to the nurses the importance of all reportable incidents to administration. She explained what a reportable incident is and that it needs to be reported to OHFC within 24 hours of happening. At this meeting, the Vulnerable Adult was reviewed. There was a mandatory all staff meeting on 1/7/14 to discuss what incidents need to be reported to the state agency (OHFC) and the timeliness of contacting administration and the administrator. At this meeting, the Vulnerable Adult policy was reviewed. A Performance Improvement has been developed to ensure that all incidents and falls reports are reviewed daily (within 24 hours) and determined if it	1/7/14

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F 226	Continued From page 6 report to the state agency. The quarterly Minimum Data Set (MDS) dated 11/22/13, identified R26 had diagnoses which included anemia and hypertension. The MDS identified R26 had severe cognitive impairment, and required assistance with all activities of daily living (ADL). Review of the quarterly fall assessment dated 11/22/13, revealed R26 had 3 falls in the past quarter, once in the bathroom, twice self transferring and identified R26 continued to be at risk for further falls. R26's care plan revised 12/7/13, identified various interventions for fall prevention which included use of landing strip by bed, tabs alarm on in bed and wheelchair, directed staff to push slow in wheelchair, and do not leave alone to toilet, hand her call light, but stand outside for privacy, observe discreetly. Review of R26's Resident Fall Reports and follow up revealed the following: - 7/3/13, at 12:20 a.m. R26 was found lying on the floor beside her bed, resident stated she hit her head. No injuries noted. The report also identified the fall had been possibly preventable if bed alarm and motion sensor were on. The report listed various types of equipment possibly in use and pertinent to fall and both the tabs unit and motion sensor had been checked to indicate the tabs unit and motion sensor had been off at the time of fall. Further, the report identified the reasonable intervention to be put in place after the fall was to turn the alarms on. The fall assessment dated 7/5/13 indicated R26 had	F 226	needs to be reported to OHFC and to administration. This Performance Improvement will be done on all incident and falls reports, daily and reported to Performance Improvement Committee monthly. This Performance Improvement will continue ongoing to ensure compliance is being met. This will be monitored by Social Worker, Case Managers and Director of Nursing.	

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F 226	Continued From page 7 rolled out of bed and the care plan had been reviewed, no new interventions were identified. Further, the assessment lacked documentation of reason as to why the alarms were not functioning. Review of the 48 hour Report Wing 4 form dated 7/3/13 identified R26 utilized personal safety alarms, had fallen out of bed at 12:20 a.m. The form identified no alarms were on at the time of the fall. -7/24/13, at 10:30 a.m. R26 was found resident lying on her right side, by the other resident's bed across the room with head by foot of bed. The report identified the alarms were not sounding. The Fall assessment dated 7/26/13 identified R26 had tried to self transfer from the bed and a high low bed was to be utilized. The report also identified staff were to stay with R26 in the bathroom. The analysis lacked documentation of the reason for the alarm had not been sounding. Review of the form titled Nurses Notes, dated 7/24/13,had the following statement "Due to cognition, do not leave R26 alone in the BR (bathroom) for safety reasons." The form revealed 18 staff members had initialed the form to indicate education had been received - 9/2/13 at 1:55 p.m., R26 was found sitting on the bathroom floor in front of the toilet, resident stated she slipped off. Fall assessment form dated 9/3/13 identified a new intervention that R26 should not be left alone on the toilet. Further, R26's care plan was revised on 9/3/13, and directed staff to not leave alone to toilet, hand her the call light but stand outside door for privacy. Observe discreetly.	F 226		

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F 226	Continued From page 8 Review of the 48 Hour Report Wing 4 forms from 9/2/13 to 9/4/13, revealed on 9/2/13 R26 had fell off toilet and per family, not to be left in the bathroom alone. The 9/4/13 report form identified "fell off toilet-not to be left alone in bathroom and DO NOT leave alone on toilet!" On 12/11/13 at 2:49 p.m. the DON stated she was aware the alarms were not functioning at the time of the 7/3/13 fall for R26. She stated when family member (FM) came to the facility the next day, the DON and FM checked the alarms and found them to be functioning at that time. She confirmed she did no further investigation of the fall. She confirmed she did not report to the administrator or SA the 7/3/13 fall. She confirmed R26 alarms were not sounding on 7/24/13 fall. The DON stated R26's FM had requested that staff stay with R26 when she was on the toilet because the FM was concerned she would fall asleep and fall off of the toilet. The DON stated facility staff had been educated on not leaving R26 alone on the toilet and confirmed this intervention was intended for safety. The intervention was started on 7/24/13 and she confirmed staff were not following the appropriate interventions for R26 at the time of the 9/2/13 fall in the bathroom. Further, the DON confirmed R26 had an unwitnessed fall in the bathroom on 9/2/13. She stated R26 had been placed on the toilet, had call light in her hand but "unfortunately she was left alone." The DON indicated the 7/3/13, 7/24/13,9/2/13 falls had not been thoroughly investigated and immediate reporting to administrator and not immediately reported to the SA. She stated she would expect staff to follow	F 226		

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F 226	Continued From page 9 appropriate interventions at all times. On 12/12/13 at 9:02 a.m., the executive director (ED) confirmed the current facility policy and confirmed the falls on 7/3/13, 7/24/13 and 9/2/13 for R26 had not been immediately reported to her. She stated the usual facility practice was to immediately notify the administrator, SA, and conduct a thorough investigation when a resident was injured as a result of a fall. She confirmed because R26 had not been injured as a result from the falls, the facility had not considered these falls as a reportable event.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide an opportunity for 1 of 1 resident, (R51) to make a choice regarding on how she would like her food served at meal times. Findings Include: R51's quarterly MDS dated 9/4/13 indicated R51	F 242	Resident R51 expressed dislike of receiving food on a tray will be offered to have all dishes removed from tray and placed on table. An all staff meeting was held on 1/7/14 to discuss meal choice of serving food to each resident. The resident has the choice of having the food left on the tray or having meal taken off of the tray. The certified dietary manager and dietician will interview all residents that are able to be interviewed and ask their preference of the use of trays or to have their dishes placed directly on the table by 1/20/14. Those residents preferring no trays will be identified on the residents' menu. Staff will remove all dishes for those requesting no trays. A master list of residents and their	1/20/14

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F 242	Continued From page 10 was cognitively intact and required extensive assistance with transfers, toileting, personal hygiene and was independent with eating. The MDS identified R51 had diagnoses which included anemia, high blood pressure (HTN) and depression. On 12/9/13, at 6:04 p.m. 42 residents were observed at the supper meal in the main dining room of the facility. All 42 residents were seated at tables with individual plates with food portions, silverware and beverage containers on cream colored plastic trays. During dining observations on 12/11/13 at 12:01 p.m. a table was observed in the middle of the 200 wing in the day room. Eight residents, including R51, were seated at the table with trays holding plates, beverage glasses and silverware for each resident in front of them. At 12:19 p.m. R51 and the other tablemates continued to eat their lunch meal from dishware on the individual hard plastic trays. During interview on 12/10/13 at 3:50 p.m., R51 stated meals are consistently served on trays and stated "I think it is awful." R51 stated she would prefer not to have food served on trays. R51 stated she feels it is not home like when her food is served on a tray. R51 stated she did not like to eat her meals on a tray and indicated it bothered her when other residents trays touched her tray during a meal. Review of the Dietary Meeting Minutes dated 4/4/13, revealed a resident had voiced concern	F 242	preferences will be recorded on a flow sheet and maintained by staff and will be located in the dietary department. This will allow staff to make updates as needed. Residents' preferences for tray use will be reviewed on admission by the initial care conference and quarterly at care conferences. This choice can be changed any time by the request of the resident. A Performance Improvement will be developed to ensure resident choices of meal delivery are being followed per each individual resident request. Dietary Manager will monitor this through direct meal observation. Dietary Manager will audit three trays per week for three months or until 100% compliant. Random audits will be completed to ensure compliance is being met. Dietary Manager will monitor this Performance Improvement.	

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F 242	Continued From page 11 about eating off trays and indicated that placemats would be nice. On 12/12/13 at 8:40 a.m., the dietary manager (DM) stated she had discussed the use of trays for meals with residents a long time ago and felt they wanted trays. She stated she had not spoken to each individual resident regarding their preferences. DM confirmed all residents in the facility were served meals every day on plastic trays. On 12/12/13 at 10:30 a.m., DM confirmed the facility policy and stated R51 had voiced her concerns regarding eating meals off of trays in the past. DM stated she had been aware of R51's request for placements but because the majority of the residents did not voice a concern, she decided to not make changes for R51. Review of the facility policy titled Table Setting, reviewed on 9/20/13, revealed individuals would be provided with an attractive table setting that enhances the dining experience and all meals will be served on individualized trays per resident request.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the initial care plan related to the use of personal safety alarms for fall prevention for 1 of 1 resident (R80)	F 281	Resident R80 care plan was reviewed at an all staff meeting on 1/7/14. Resident R80 had a TABS alarm attached to wheelchair and back of resident shirt on 12/11/13. R80 received doctor order for being independent in facility with cane on 1/8/14. The care plan was updated to reflect new order. The care plan, TABS alarm and falls policies were reviewed at this	1/17/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 at risk for falls. Findings include: Review of R80's temporary care plan dated 12/6/13, identified R80 required assistance to transfer from bed to chair and walk in his room. The care plan directed that a personal safety tab alarm was to be utilized while R80 was seated in a wheelchair, recliner and in bed. This alarm would sound to alert facility staff if R80 attempted to rise from the chair or bed and attempt to ambulate independently. On 12/11/13 the following observations were made: At 7:57 a.m., R80's room was dark and he was standing up at his bedside with both hands on a wheeled walker. R80 then walked to the bathroom and seated himself on the toilet. No alarm was sounding. At 8:03 a.m. the surveyor inquired if R80 was to be up in his room independently. Licensed practical nurse (LPN)-A stated R80 was not to be up independently and requested registered nurse (RN)-A to assist R80. At 8:04 a.m., RN-A utilized the wheeled walker to assist R80 to walk from the bathroom to the bed. RN-A then utilized the wheel chair to assist R80 to the facility dining room. A personal safety alarm was not attached to R80 or the wheel chair. At 8:11 a.m., R80 was seated in the wheel chair at a table in the facility dining room. A personal safety alarm was not attached to R80 or the wheel chair. At 8:41 a.m., R80 was seated in a wheelchair in the facility therapy department while physical	F 281	meeting. It was discussed at this meeting the importance of following each individual care plan. All initial care plans will be implemented and followed. All care plans will be reviewed/updated to reflect current care within the next quarter. A Performance Improvement has been developed to ensure care plans are implemented and followed. This PI will be done by direct auditing of two care plans a week by Director of Nursing/Case Manager. This audit will then be taken to direct nursing staff to ensure all individual care plans are being followed. This PI will be done for 3 months or until 100% compliant. This will be monitored by the Director of Nursing.	

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	245451	A. BUILDING _____ B. WING _____	12/12/2013

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F 281	Continued From page 13 therapy assistant (PTA)-A assisted R80 with leg strengthening exercises. A personal safety alarm was not attached to R80 or the wheel chair. At 9:20 a.m., R80 was seated in the wheel chair in his room watching TV A personal safety alarm was not attached to R80 or the wheelchair. On 12/11/13, at 9:47 a.m., LPN-A and RN-A confirmed R80 did not utilize a personal safety alarm and after checking R80's room, indicated a alarm was not available for staff to use. On 12/11/13, at 9:52 a.m., nursing assistant (NA)-B stated she had worked with R80 and was not aware of any direction for the utilization of personal safety alarms for R80. On 12/11/13, at 9:55 a.m., occupational therapy assistant (OT)-A stated she had worked with R80 on 12/10/13, and had not seen a personal safety alarm utilized. OT-A stated she had concerns with R80's safety due to his cognition. On 12/11/13, at 9:55 a.m., RN-A attached a personal safety alarm to R80's wheel chair and clipped the cord extending from the alarm unit to the back of R80's shirt. RN-A confirmed the current temporary care plan and verified that R80 was to have a personal safety alarm in place when R80 was in bed, in a wheel chair, or in a reclining chair. RN-A stated R80 had previous attempts to self transfer and indicated the alarm was to alert facility staff to prevent R80 from falling. On 12/12/13, at 8:31 a.m., LPN-B stated R80 was to have a personal safety alarm because R80 was weak and attempted to self transfer and was at risk for falls.	F 281		

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F 281	Continued From page 14 Review of R80's physician' orders dated 12/5/13, included orders for a personal safety alarm to be utilized when R80 was in bed, wheel chair and chair. Review of R80's Safety Risk evaluation dated 12/5/13, revealed R80 was to have a personal safety tabs alarm on in a chair and in bed for fall prevention and safety. The analysis of the assessment identified R80 was at risk for falls due to significant heart history, stroke, dementia and previous falls. Fall interventions included a personal safety alarm. On 12/12/13, at 8:44 a.m., the director of nursing (DON) confirmed R80's temporary care plan and verified it would be expected R80 would have a personal safety alarm on, as directed in the care plan, to prevent falls.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that bilateral grab bars were removed for 1 of 1 resident (R26) in the sample whose plan of care indicated no side rail use. In addition, the facility failed to implement bilateral splint devices for 1 of 1 resident (R13) reviewed who required splints.	F 282	The grab bars were removed on resident R26 bed on 12/11/13. Bilateral splints were put on R13 on 12/12/13. All grab bars/siderails were assessed on 12/17/13 and reflected on individual care plan. A mandatory all staff meeting was held on 1/7/14. At this meeting, it was discussed the importance of following each resident care plan. All care plans will be reviewed/updated to reflect current cares within the next quarter. The care plan, siderail/grab bars and orthotic policies were reviewed at	1/17/14

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F 282	Continued From page 15 Findings include: R26 care plan was not followed regarding the use of siderails The care plan revised 12/7/13, identified various interventions for fall prevention for R26 which included use of landing strip by bed, TABS alarm on in bed and wheelchair, push slow in wheelchair, and do not leave alone to toilet, hand her call light, but stand outside for privacy, observe discreetly. In addition, the care plan identified siderails had been totally removed from R26's bed on 11/6/13. Review of the nurses notes from 11/4/13 to 12/16/13, revealed a note dated 11/27/13 which indicated recent falls precipitated removal of siderails from R26's bed. On 12/11/13, at 7:10 a.m., R26 was observed asleep, lying on her right side in a high low bed which was positioned low to the floor. Two vertical, tan colored grab bars was observed attached to the upper half of the bed,and the bed was up against the wall on the right side. The bar measured approximately 10 inches wide,and had two openings on the bar which measured 3 1/2 inches. The grab bar was approximately 12 inches from the headboard of the bed. On 12/11/3 at 9:56 a.m., R26 was observed lying in bed on her right side resting, and two vertical grab bars remained in place on the bed. On 12/11/3, at 11:15 a.m., R26 was again observed lying in her bed, and the two vertical grab bars remained in place on the bed.	F 282	this meeting. A new nurse report sheet has been developed covering a seven day look back period to include that all alarms, splints, devices, grab bars are being implemented per each individual resident care plan. A Performance Improvement has been developed to ensure care plans are implemented and followed. This PI will be done by direct auditing of two care plans a week by Director of Nursing/Case Manager. This audit will then be taken to direct nursing staff to ensure all individual care plans are being followed. This PI will be done for 3 months or until 100% compliant. This will be monitored by the Director of Nursing.	

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F 282	Continued From page 16 On 12/11/3 at 1:23 p.m., nursing assistant (NA)-C indicated R26 utilized the grab bars consistently and stated the grab bars were in the up position at all times. NA-C indicated R26 utilized the grab bar when sitting on the edge of the bed. On 12/11/3, at 2:30 p.m., NA-B confirmed R26 consistently had two grab bars on her bed and stated the grab bars were always in the up position. On 12/11/13, at 3:45 p.m., registered nurse (RN)-B confirmed R26's care plan and stated R26 did not utilize grab bars on her bed. She stated the grab bars had been removed in the past ensure "no risk of her being entangled." At 3:49 p.m., RN-B and surveyor entered R26's room and RN-B confirmed the two grab bars were in place. She stated the facility had conducted an inventory of the building in the recent past and felt that because R26 did not use her rails, the rails should be removed to prevent "any risk" for R26. RN-B indicated she was not aware when the rails had been replaced on R26's bed. On 12/11/13 at 4:05 p.m., NA-E stated she had switched R26's bed with another resident approximately two weeks prior because the mechanical lift did not fit under the other resident's bed. She confirmed the rails were on the other resident's bed, and she switched that bed to be utilized for R26 at that time. On 12/11/13 at 4:10 p.m., the director of nurses (DON) confirmed R26's care plan, and stated R26 was at "high risk" for injury due to the rails being in place on her bed. The DON confirmed R26 had not been assessed for safety with the	F 282		

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F 282	Continued From page 17 siderails and indicated the siderails should not be utilized on R26's bed. No facility policy was provided for the use of siderails. Bilateral hand splints were not utilized per R13's care plan. R13's care plan revised 11/9/13, revealed R13 had a self care deficit that required staff assistance with all areas of daily living (ADL). The care plan directed staff to provide hand splints on both hands when R13 "was up." During observation on 12/11/13 at 7:12 a.m., R13 was propelled in her reclining wheel chair by staff to the activity room. R13 was dressed in a sweater, dark colored pants, white anklet stockings and shoes. Both hands were drawn together in fists with fingernails pressed into the palms. No splints were observed in use for R13. During observation on 12/11/13 at 7:24 a.m., NA-F propelled R13 in her wheel chair to the dining room. R13's hands remain closed tightly in to fists held closely to her body, and no splints were in place. During observation on 12/11/13 at 8:38 a.m., R13 sat in the wheel chair in her room. R13's hands	F 282		

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F 282	Continued From page 18 remained closed tightly into fists and no splints were in place. During observation on 12/11/13 at 8:50 a.m. and again at 9:30 a.m., R13 laid in bed on her left side, with her lower body covered with a blanket. R13's hands remained tightly closed into fists no splints in place. During observation on 12/11/13 at 2:03 p.m., R13 again was in bed with no hand splints in place, her hands remained in tight fists. During interview on 12/11/13 at 2:09 p.m., NA-B confirmed she had not applied the palm splints to R13's hands today. NA-B stated R13 did not need hand splints on during the day . During interview on 12/12/13 at 11:29 a.m., the DON confirmed R13's current care plan. The DON stated she expected staff to follow the doctors orders to prevent contractures. The DON further stated R13's hand splints were to prevent further contractures because R13 has pain with movement and would not straighten them herself. A requested policy regarding splint use was not provided.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	Resident R13 had bilateral splints put on 12/12/13. An all staff meeting was held on 1/7/14 to discuss the need to implement bilateral splint devices to prevent further contractures on all residents that have a doctor order for splints. The orthotic policy was reviewed. It was discussed at this	1/17/14

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F 318	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement bilateral splint devices to prevent further contractures for 1 of 1 resident (R13) reviewed who required splints. Findings include: The initial Minimum Data Set (MDS) dated 5/9/13, identified R13 had severe cognitive impairment, required total assistance with all activities of daily living (ADL), and had limitation of mobility in both hands. The current physician orders dated 11/29/13, directed splints to be worn on both hands daily when up. R13's care plan revised 11/9/13, revealed R13 had a self care deficit that required staff assistance with all areas of daily living (ADL). The care plan directed staff to provide hand splints on both hands when R13 "was up." During observation on 12/11/13 at 7:12 a.m., R13 was propelled in her reclining wheel chair by staff to the activity room. R13 was dressed in a sweater, dark colored pants, white anklet stockings and shoes. Both hands were drawn together in fists with fingernails pressed into the palms. No splints were observed in use for R13. During observation on 12/11/13 at 7:24 a.m., NA-F propelled R13 in her wheel chair to the dining room. R13's hands remain closed tightly in to fists held closely to her body, and no splints were in place.	F 318	meeting the importance of following care plans for each resident. A Performance Improvement will be developed to ensure bilateral splints are being used when ordered to prevent further contractures. This PI will be done by direct auditing two care plans a week by Director of Nursing/Case Manager and following up with direct nursing staff to ensure all individual care plans are being followed. This PI will be done for 3 months or until 100% compliant. This will be monitored by the Director of Nursing.	

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F 318	Continued From page 20 During observation on 12/11/13 at 8:38 a.m., R13 sat in the wheel chair in her room. R13's hands remained closed tightly into fists and no splints were in place. During observation on 12/11/13 at 8:50 a.m. and again at 9:30 a.m., R13 laid in bed on her left side, with her lower body covered with a blanket. R13's hands remained tightly closed into fists no splints in place. During observation on 12/11/13 at 2:03 p.m., R13 again was in bed with no hand splints in place, her hands remained in tight fists. During interview on 12/11/13 at 2:09 p.m., NA-B confirmed she had not applied the palm splints to R13's hands today. NA-B stated R13 did not need hand splints on during the day . During interview on 12/11/13 at 2:37 p.m., RN-B confirmed R13's care plan directed hand splints to be in place when R13 was up. During interview on 12/11/13 at 2:59 p.m., RN-C confirmed R13's current care plan, and its directed use of hand splints during the day. During interview on 12/12/13 at 11:29 a.m., the DON confirmed R13's current care plan. The DON stated she expected staff to follow the doctors orders to prevent contractures. The DON further stated R13's hand splints were to prevent further contractures because R13 has pain with movement and would not straighten them herself. A requested policy regarding splint use was not	F 318		

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F 318	Continued From page 21 provided.	F 318		

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F 318	Continued From page 22	F 318		

The initial minimum data set (MDS) dated 5/9/13 , identified R13 had sever cognitive impairment, required total assist for all activities of daily living (ADL), and had limitation of mobility in both hands. The current physician orders dated 11/29/13, directed splints to be worn on both hands daily when up.

R13's care plan with revision dated 11/9/13, revealed R13 had a self care deficit that required staff assistance with all areas of daily living (ADL). The care plan directed staff to provide hand splints on both hands when R13 "was up."

The initial minimum data set (MDS) dated 5/9/13 , identified R13 had sever cognitive impairment, required total assist for all activities of daily living (ADL), and had limitation of mobility in both hands. The current physician orders dated 11/29/13, directed splints to be worn on both hands daily when up.

During observation on 12/11/13, at 7:12 a.m. R13 was propelled in her reclining wheel chair by staff to the activity room. R13 was dressed in a sweater, dark colored pants, white anklet stockings and shoes. Both hands were drawn together in fists with fingernails pressed into the palms.

During observation on 12/11/13, at 7:24 a.m. nursing assistant (NA)-F propelled R13 in her

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F 318	Continued From page 23 wheel chair to the dinning room. R13's hands remain closed tightly in to fists held closely to her body. During observation on 12/11/13, at 8:38 a.m. R13 sat in the wheel chair in her room. R13's hands remained closed tightly into fists. During observation on 12/11/13, at 8:50 and again at 9:30 a.m. R13 lay in bed on her left side, with her lower body covered with a blanket. R13's hands remained tightly closed into fists. During observation on 12/11/13, at 2:03 p.m. R13 again was in bed with no hand splints in place, her hands remained in tight fists. During interview on 12/11/13, at 2:09 p.m. NA-B confirmed she had not applied the palm protectors to R13's hands today. NA-B stated R13 did not need hand splints on during the day . During interview on 12/11/13, at 2:37 p.m registered nurse (RN)-B ,Confirmed R13's care plan directed hand splints to be in place when R13 was up. During interview on 12/11/13, at 2:59 p.m RN-C confirmed R13's current care plan, and its directed use of hand splints during the day. During interview on 12/12/13, at 11:29 a.m. the director of nursing (DON) confirmed R13's current care plan. The DON stated she expected staff to follow the doctors orders to prevent contractures. The DON further stated R13's hand splints are to prevent further contracture because R13 has pain with movement and would	F 318		

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F 318	Continued From page 24 not straighten them herself. A requested policy regarding splint use was not provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the risk of entrapment with the use of grab bars for 1 of 1 resident (R26) and failed to consistently implement appropriate interventions to prevent further falls for 2 of 4 residents (R26, R80) with a history of falls. Findings include: R26 had not been assessed for safety with the use of siderails The quarterly Minimum Data Set (MDS) dated 11/22/13, identified R26 had diagnoses which included anemia and hypertension. The MDS identified R26 had severe cognitive impairment, and required assistance with all activities of daily living (ADL). Review of the quarterly fall assessment dated 11/22/13, revealed R26 had 3	F 323	Grab bars on resident R26 bed were removed on 12/11/13. Resident R26 and R80 had interventions put in place to help prevent further falls on 12/11/13. All grab bars/siderails were assessed according to each resident care plan on 12/17/13. Resident R26 interventions were using a landing strip pad by bed, TABS alarm on in bed and wheelchair. Wheelchair pedals were added to resident R26 wheelchair on 12/12/13 for transferring long distances and then remove pedals when arriving at destination. Pedals will be stored in a bag behind resident wheelchair. Care plan has been updated to reflect interventions. Resident R80 has a TABS alarm attached to the wheelchair and the back of resident shirt on 12/11/13. R80 received a doctor order to be independent in facility with cane on 1/8/14. Care plan updated to reflect changes in care. A mandatory all staff	1/17/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 falls in the past quarter, once in the bathroom, twice self transferring and identified R26 continued to be at risk for further falls. The fall assessment lacked documentation of the use of siderails for R26. The care plan revised 12/7/13, identified various interventions for fall prevention for R26 which included use of landing strip by bed, TABS alarm on in bed and wheelchair, push slow in wheelchair, and do not leave alone to toilet, hand her call light, but stand outside for privacy, observe discreetly. In addition, the care plan identified siderails had been totally removed from R26's bed on 11/6/13. Review of the nurses notes from 11/4/13 to 12/16/13, revealed a note dated 11/27/13 that recent falls precipitated removal of siderails from R26's bed. However, the clinical record lacked documentation of an assessment for safety with the use of siderails for R26. On 12/11/13, at 7:10 a.m., R26 was observed asleep, lying on her right side in a high low bed which was positioned low to the floor. Two vertical, tan colored grab bars was observed attached to the upper half of the bed,and the bed was up against the wall on the right side. The bar measured approximately 10 inches wide,and had two openings on the bar which measured 3 1/2 inches. The grab bar was approximately 12 inches from the headboard of the bed. In addition, a flat, gray, rubber mat was on the floor next to the bed, with a motion sensor box in front of the mat. A bed sensor alarm was observed attached to bed.	F 323	meeting was held on 1/7/14 to discuss the use of grab bars/siderails and the risk for entrapment. Discussion of implementing interventions to prevent falls were discussed. At this meeting the grab bars/siderail, falls and TABS alarm policies were reviewed. A Performance Improvement will be developed for the use of grab bars/siderails and interventions are in place to prevent further falls. This PI will be done by direct auditing of two care plans a week by Director of Nursing/Case Manager and following up with direct nursing staff to ensure all individual care plans are being followed. This PI will be done for 3 months or until 100% compliant. This will be monitored by the Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENCE	1075 ROY STREET ORTONVILLE, MN 56278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 On 12/11/3 at 9:56 a.m., R26 was observed lying in bed on her right side resting, and two vertical grab bars remained in place on the bed. On 12/11/3, at 11:15 a.m., R26 was again observed lying in her bed, and the two vertical grab bars remained in place on the bed. On 12/11/3 at 1:23 p.m., nursing assistant (NA)-C indicated R26 utilized the grab bars consistently and stated the grab bars were in the up position at all times. NA-C indicated R26 utilized the grab bar when sitting on the edge of the bed. On 12/11/3, at 2:30 p.m., NA-B confirmed R26 consistently had two grab bars on her bed and stated the grab bars were always in the up position. On 12/11/13, at 3:45 p.m., registered nurse (RN)-B confirmed R26's care plan and stated R26 did not utilize grab bars on her bed. She stated the grab bars had been removed in the past ensure "no risk of her being entangled." At 3:49 p.m., RN-B and surveyor entered R26's room and RN-B confirmed the two grab bars were in place. She stated the facility had conducted an inventory of the building in the recent past and felt that because R26 did not use her rails, the rails should be removed to prevent "any risk" for R26. RN-B indicated she was not aware when the rails had been replaced on R26's bed. On 12/11/13 at 4:05 p.m., NA-E stated she had switched R26's bed with another resident approximately two weeks prior because the mechanical lift did not fit under the other resident's bed. She confirmed the rails were on the other resident's bed, and she switched that	F 323		

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F 323	Continued From page 27 bed to be utilized for R26 at that time. On 12/11/13 at 4:10 p.m., the director of nurses (DON) confirmed R26's care plan, and stated R26 was at "high risk" for injury due to the rails being in place on her bed. The DON confirmed R26 had not been assessed for safety with the siderails and indicated the siderails should not be utilized on R26's bed. No facility policy was provided for the use of siderails. Interventions had not been implemented for R26 to prevent falls in the bathroom, and no assessment had been completed after a fall to attempt to prevent further falls from the wheelchair. Review of R26's Resident Fall Reports and follow up revealed the following: -7/24/13, at 10:30 a.m. R26 was found resident lying on her right side, by the other resident's bed. No injury was noted. The post fall analysis identified R26 had tried to self transfer from the bed and a high low bed was to be utilized. The report also identified staff were to stay with R26 in the bathroom. - 9/2/13 at 1:55 p.m., R26 was found sitting on the bathroom floor in front of the toilet, resident stated she slipped off. Fall assessment form dated 9/3/13 identified a new intervention that R26 should not be left alone on the toilet. Further, R26's care plan was revised on 9/3/13, and directed staff to not leave alone to toilet, hand her	F 323		

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F 323	Continued From page 28 the call light but stand outside door for privacy. Observe discreetly. Review of the 48 Hour Report Wing 4 forms from 9/2/13 to 9/4/13, revealed on 9/2/13 R26 had fell off toilet and per family, not to be left in the bathroom alone. the 9/4/13 report form identified "fell off toilet-not to be left alone in bathroom and DO NOT leave alone on toilet!" Review of the form titled Nurses Notes, dated 7/24/13,had the following statement "Due to cognition, do not leave (resident name) alone in the BR(bathroom) for safety reasons." The form revealed 18 staff members had initialed the form when they had been given the education. On 12/11/13 at 2:49 p.m., the DON confirmed R26 had an unwitnessed fall in the bathroom on 9/2/13. She confirmed the facility utilized the 48 Hour Report Form as a communication tool for all shift of staff. She confirmed R26's resident fall reports dated 7/24/13 and 9/2/13 and stated on 9/2/13 R26 had been placed on the toilet, had call light in her hand but "unfortunately she was left alone." Further, the DON stated R26's family member(FM) had spoken with her on 7/3/13 and had requested that staff stay with R26 when she was on the toilet because the FM was concerned she would fall asleep and fall off of the toilet. The DON confirmed the 7/24/13 educational form utilized and stated facility staff had been educated on not leaving R26 alone on the toilet and confirmed this intervention was intended for safety. She also verified the intervention was not documented on the care plan until 9/3/13, although the intervention was started on 7/24/13	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENCE	1075 ROY STREET ORTONVILLE, MN 56278

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F 323	Continued From page 29 and stated it should have been placed on the care plan at that time. The DON confirmed staff were not following the care plan for R26 at the time of the 9/2/13 fall in the bathroom. R26 had not been assessed for further interventions after a fall, to prevent further injury. Review of R26's Resident Fall Reports and follow up revealed the following: -10/10/13, at 10:00 p.m., R26 found lying on the floor next to her bed, on her right side. The care plan was revised to include the use of a landing strip beside bed when in bed and move R26 closer to the wall when in bed. -12/6/13 at 4:45 p.m., while being wheeled back from dining room by staff, R26 put her feet down, and resulted in R26 fell forward out of wheelchair. R26 sustained a 4 centimeter "goose egg" to forehead and reported back pain. The post fall assessment dated 12/7/13, identified staff need to push her very slow, may need to put pedals on chair but still self propels with her feet little and this would take away some independence. The assessment identified this would be monitored and reevaluated in 2 weeks. During observation on 12/11/13, at 6:57 a.m., R26 was seated in her wheelchair in the hallway across from the nurses desk. The wheelchair had no foot pedals, and both R26's feet in tennis shoes were resting on the floor. At 7:00 a.m., trained medication aide (TMA)-A wheeled R26 into the activity room, at a normal walking pace. Prior to pushing the wheelchair, TMA-A instructed R26 to lift up her feet, at which time R26 crossed her feet at the ankles and held them up	F 323		

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F 323	Continued From page 30 approximately 3 inches from the floor. At 7:26 a.m., the DON assisted R26 into the main dining room by pushing her wheelchair. The DON was pushing R26's wheelchair at a normal walking pace, and during this time, R26's feet were approximately 1 inch from the floor with her feet crossed over each other. When R26's wheelchair was turned to position her under the table, R26's right tennis shoe caught on the floor, resulting in a jerking motion during the positioning. On 12/11/13, at 2:36 p.m., NA-B stated R26 did not utilize foot pedals on her wheelchair, and confirmed R26 had fallen out the wheelchair after putting her feet down during locomotion. On 12/12/13, at 9:39 a.m., the DON confirmed R26's current care plan and confirmed R26 had put her feet down during transport to the dining room during observation period on 12/11/13. The DON confirmed she would expect staff to follow the care plan for R26 to try to avoid R26's feet catching on the floor. She confirmed the facility had not re evaluated R26 since 12/7/13 for safety with wheelchair use. Review of the facility policy titled Falls, revised 8/13, revealed the purpose of the policy was to promote safety and identify residents who were at risk and intervene. If risk factors were identified, preventative measures were to be put in place. All members were responsible for implementing fall prevention measures creating a safe environment. The policy identified various interventions which included the use of a personal safety monitor.	F 323		

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F 323	Continued From page 31	F 323		

R80's initial care plan had not been implemented for use of a personal safety alarm

Review of the Diagnoses Index Report revealed R80 had a current admission date 12/5/13 and a medical history which included a recent heart attack, stroke with long-time use of blood thinners, peripheral neuropathy, (a condition involving nerve damage, usually in the hands and feet, causing weakness and pain), and dementia.

R80's nursing Minimum Data Set (MDS) summary charting, dated 12/5/13, identified R80 was moderately cognitively impaired and had short and long-term memory problems. The MDS further identified R80 required cues and supervision due to poor decision making skills.

Review of R80's temporary care plan dated 12/6/13, identified R80 required assistance to transfer from bed to chair and walk in his room. The care plan directed that a personal safety tab alarm was to be utilized while R80 was seated in a wheelchair, recliner and in bed. This alarm would sound to alert facility staff if R80 attempted to rise from the chair or bed and attempt to ambulate independently.

On 12/11/13 the following observations were made:

At 7:57 a.m., R80's room was dark and he was standing up at his bedside with both hands on a wheeled walker. R80 then walked to the bathroom and seated himself on the toilet. No

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F 323	Continued From page 32 alarm was sounding. At 8:03 a.m. the surveyor inquired if R80 was to be up in his room independently. Licensed practical nurse (LPN)-A stated R80 was not to be up independently and requested registered nurse (RN)-A to assist R80. At 8:04 a.m., RN-A utilized the wheeled walker to assist R80 to walk from the bathroom to the bed. RN-A then utilized the wheel chair to assist R80 to the facility dining room. A personal safety alarm was not attached to R80 or the wheel chair. At 8:11 a.m., R80 was seated in the wheel chair at a table in the facility dining room. A personal safety alarm was not attached to R80 or the wheel chair. At 8:41 a.m., R80 was seated in a wheelchair in the facility therapy department while physical therapy assistant (PTA)-A assisted R80 with leg strengthening exercises. A personal safety alarm was not attached to R80 or the wheel chair. At 9:20 a.m., R80 was seated in the wheel chair in his room watching TV A personal safety alarm was not attached to R80 or the wheelchair. On 12/11/13, at 9:47 a.m., LPN-A and RN-A confirmed R80 did not utilize a personal safety alarm and after checking R80's room, indicated a alarm was not available for staff to use. On 12/11/13, at 9:52 a.m., nursing assistant (NA)-B stated she had worked with R80 and was not aware of any direction for the utilization of personal safety alarms for R80. On 12/11/13, at 9:55 a.m., occupational therapy assistant (OT)-A stated she had worked with R80 on 12/10/13, and had not seen a personal safety alarm utilized. OT-A stated she had concerns with R80's safety due to his cognition.	F 323		

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F 323	Continued From page 33 On 12/11/13, at 9:55 a.m., RN-A attached a personal safety alarm to R80's wheel chair and clipped the cord extending from the alarm unit to the back of R80's shirt. RN-A confirmed the current temporary care plan and verified that R80 was to have a personal safety alarm in place when R80 was in bed, in a wheel chair, or in a reclining chair. RN-A stated R80 had previous attempts to self transfer and indicated the alarm was to alert facility staff to prevent R80 from falling. On 12/12/13, at 8:31 a.m., LPN-B stated R80 was to have a personal safety alarm because R80 was weak and attempted to self transfer and was at risk for falls. Review of R80's physician hospital discharge summary dated 12/5/13, revealed R80 had been intermittently confused and had limitations due to deconditioning and ambulation. Review of R80's physician' orders dated 12/5/13, included orders for a personal safety alarm to be utilized when R80 was in bed, wheel chair and chair. Review of R80's nursing admission assessment dated 12/5/13, revealed R80 had fallen three to four times in the previous 31-180 days prior to admission to the facility. The admission Vulnerable Adult assessment revealed R80 was confused, had mobility difficulty, used assistive devices, and was physically dependent. Review of R80's Safety Risk evaluation dated 12/5/13, revealed R80 was to have a personal safety tabs alarm on in a chair and in bed for fall	F 323		

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F 323	Continued From page 34 prevention and safety. The analysis of the assessment identified R80 was at risk for falls due to significant heart history, stroke, dementia and previous falls. Fall interventions included a personal safety alarm. Review of R80's nurses' notes dated 12/5/13, identified R80 had dementia and a personal safety alarm was applied due to risk of falls. On 12/12/13, at 8:44 a.m., the director of nursing (DON) confirmed R80's temporary care plan and verified it would be expected R80 would have a personal safety alarm on, as directed in the care plan, to prevent falls. Review of the facility policy titled Falls, dated 11/2001, revealed the purpose of the policy was to promote resident safety and identify residents who were at risk and intervene. If risk factors were identified, preventative measures were to be put in place. All staff members were responsible for implementing fall prevention measures and creating a safe environment. Options for fall prevention included a personal safety monitor.	F 323		

Northridge Residence Plan of Correction

Exit 12/12/13

Addendum

F225 A mandatory nurse meeting was held 12/17/13. At this meeting, the social worker explained to the nurses the importance of all reportable incidents to administration **immediately.** She explained what a reportable incident is and that it needs to be reported to OHFC **immediately** or no later than 24 hours of happening.

This Performance Improvement will be done on all incident and falls reports , daily and reported to Performance Improvement committee monthly **to review results of audit.**

F226 A mandatory nurse meeting was held 12/17/13. At this meeting, the social worker explained to the nurses the importance of all reportable incidents to administration **immediately.** She explained what a reportable incident is and that it needs to be reported to OHFC **immediately** or no later than 24 hours of happening.

This Performance Improvement will be done on all incident and falls reports , daily and reported to Performance Improvement committee monthly **to review results of audit.**

F242 The dietary manager will audit three trays per week for three months or until 100% compliant. The dietary manager will monitor this Performance Improvement **and review results at monthly Performance Improvement meeting.**

F281 All care plans will be reviewed/updated to reflect current care with within the next quarter **and to ensure all new admissions will have an initial care plan and staff will follow this until full care plan is developed.**

This will be monitored by director of nursing, **and results will be reviewed at the monthly Performance Improvement meeting.**

F282 All **residents** with grab bars/side rails and hand splints were assessed on 12/17/13.

This PI will be done for three months or until 100% compliant by the director of nursing **and results will be reviewed at monthly PI meeting.**

F318 **All residents with hand splints were assessed on 12/17/13.**

This PI will be done for three months or until 100% compliant by the director of nursing **and results will be reviewed at monthly PI meeting.**

F323 **All residents with grab bars/side rails and TABS alarms were assessed on 12/17/13.**

This PI will be done for three months or until 100% compliant by the director of nursing **and results will be reviewed at monthly PI meeting.**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHRIDGE RESIDENCE	**1075 ROY STREET** **ORTONVILLE, MN 56278**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Northridge Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Northridge Residence was constructed in 1977, is a 1-story building with no basement and determined to be of Type V(111) construction. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detectors in the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 56 at the time of the survey.	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.