

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q7V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245428		3. NAME AND ADDRESS OF FACILITY (L3) HOMESTEAD REHABILITATION & LIVING CENTER (L4) 115 10TH AVENUE NORTHEAST (L5) DEER RIVER, MN (L6) 56636		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 618245301		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 2/26/2014 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12.Total Facility Beds 32 (L18)		13.Total Certified Beds 32 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 32 (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 Tammy Williams, HFE NE II		Date : 03/16/2014 (L19)		18. STATE SURVEY AGENCY APPROVAL Kate JohnsTon, Enforcement Specialist 3/17/2014 (L20)	

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS Posted 03/26/2014 CO. Q7V7	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 01/16/2014 (L33)		DETERMINATION APPROVAL	

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Provider Number: 24-5428

Item 16 Continuation for CMS-1539

At the time of the standard survey completed November 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Pursuant to the scope and severity of the deficiencies found, the State exercises its prerogative to impose:

-State Monitoring effective February 16, 2014. (42 CFR 488.422)

On January 17, 2014, the Minnesota Department of Health and on January 29, 2014, the Minnesota Department of Public Safety completed a revisit which found that the facility had not achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013.

Pursuant to the failure to correct all deficiencies, we recommended to CMS and they concurred that Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance, therefore CMS and this Department notified the imposition of:

-Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 3, 2014. (42 CFR 488.417 (b))

-Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 3, 2014.

On February 26, 2014, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 17, 2014. Findings determine the facility has corrected the deficiencies issued pursuant to our PCR, completed on January 17, 2014, as of February 26, 2014 resulting in the following:

-Discontinuance of the Category 1 remedy of state monitoring effective February 26, 2014 (42 CFR 488.422 (b))

-Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 3, 2014, be rescinded. (42 CFR 488.417 (b))

-NATCEP prohibition did not go into effect due to the DOPNA triggering remedy not being imposed, therefore it is also rescinded

Please refer to the CMS 2567B. Effective February 26, 2014, the facility is certified for 32 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245428

March 17, 2014

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Dear Mr. Stampohar:

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 February 26, 2014, the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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,

A handwritten signature in black ink, which appears to read "Kate Johnston", is positioned below the word "Sincerely,".

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 15, 2014

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428023

Dear Mr. Stampohar:

On December 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 17, 2014, the Minnesota Department of Health and on January 29, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our visit we have determined your facility has not corrected the deficiencies issued pursuant to our November 7, 2013 standard survey.

As a result of the January 17, 2014 visit, we recommended to the CMS Region V Office concurred and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 3, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 3, 2014. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 3, 2014.

On February 26, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 6, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 17, 2014, as of February 26, 2014. As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective February 26, 2014.

Homestead Rehabilitation & Living Center

March 15, 2014

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In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of February 11, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 3, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 3, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 3, 2014, is to be rescinded.

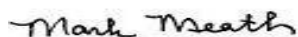
In our letter of February 11, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 3, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 26, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5428r14_2ndpcr.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245428	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/26/2014
Name of Facility HOMESTEAD REHABILITATION & LIVING CENTER		Street Address, City, State, Zip Code 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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 F0241 Reg. # 483.15(a) LSC	Correction Completed 02/26/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 02/26/2014	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 02/26/2014
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 02/26/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 02/26/2014	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/LB	Date: 03/16/2014	Signature of Surveyor: 32603	Date: 02/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/7/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q7V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245428		3. NAME AND ADDRESS OF FACILITY (L3) HOMESTEAD REHABILITATION & LIVING CENTER (L4) 115 10TH AVENUE NORTHEAST (L5) DEER RIVER, MN (L6) 56636		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) 618245301		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY 01/17/2014 (L34)		8. ACCREDITATION STATUS: 01/29/2014 (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: ____ 1. Acceptable POC ____ 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)			
12. Total Facility Beds 32 (L18)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)			
13. Total Certified Beds 32 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 32 (L37) (L38) (L39) (L42) (L43)					
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks					
17. SURVEYOR SIGNATURE Tammy Williams, HFE NE II		Date : 02/12/2014		18. STATE SURVEY AGENCY APPROVAL Kate JohnsTon, Enforcement Specialist 03/25/2014	
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY					
19. DETERMINATION OF ELIGIBILITY <u>X</u> 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 02/01/1987 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS Posted 03/26/2014 CO. Q7V7	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 01/16/2014 (L33)		DETERMINATION APPROVAL	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q7V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5428

On January 17, 2014, the Minnesota Department of Health and on January 29, 2014, the Minnesota Department of Public Safety completed a revisit which found that the facility had not achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. Based on the revisit, we have determined the facility has not achieved substantial compliance. The deficiencies not corrected are as follows:

F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

As a result of the revisit findings, this Department imposed the Category 1 remedy of State monitoring effective February 16, 2014.

In addition, this Department recommended the following remedy to the CMS Region V Office for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions, effective March 3, 2014.

If Mandatory Denial of Payment goes into effect, the facility would be Prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years beginning March 3, 2014.

Please refer to the CMS 2567 along with the provider's plan of correction and CMS 2567b.



Protecting, Maintaining and Improving the Health of Minnesotans

February 11, 2014

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428023

Dear Mr. Stampohar:

On December 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 17, 2014, the Minnesota Department of Health and on January 29, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 6, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 7, 2013. The deficiencies not corrected are as follows:

F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective February 16, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 3, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 3, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 3, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Homestead Rehabilitation & Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 3, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2104

Fax: (218) 308-2122

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.

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 remedy be imposed:

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 May 7, 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

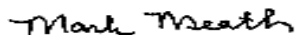
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5428r1_14.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245428	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 1/17/2014
Name of Facility HOMESTEAD REHABILITATION & LIVING CENTER		Street Address, City, State, Zip Code 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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 <u>F0164</u> Reg. # <u>483.10(e), 483.75(l)(4)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0166</u> Reg. # <u>483.10(f)(2)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0176</u> Reg. # <u>483.10(n)</u> LSC _____	Correction Completed 01/17/2014
ID Prefix <u>F0242</u> Reg. # <u>483.15(b)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0247</u> Reg. # <u>483.15(e)(2)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0249</u> Reg. # <u>483.15(f)(2)</u> LSC _____	Correction Completed 01/17/2014
ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed 01/17/2014
ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0318</u> Reg. # <u>483.25(e)(2)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix <u>F0431</u> Reg. # <u>483.60(b), (d), (e)</u> LSC _____	Correction Completed 01/17/2014
ID Prefix <u>F0465</u> Reg. # <u>483.70(h)</u> LSC _____	Correction Completed 01/17/2014	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By MM/LB	Date: 02/06/2014	Signature of Surveyor: 18619	Date: 01/17/2014		
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:		
Followup to Survey Completed on: 11/7/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245428	(Y2) Multiple Construction A. Building B. Wing 01 - NURSING HOME	(Y3) Date of Revisit 1/29/2014
Name of Facility HOMESTEAD REHABILITATION & LIVING CENTER	Street Address, City, State, Zip Code 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	

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 _____ Reg. # NFPA 101 LSC K0038	Correction Completed 11/08/2013	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
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 MM/PS	Date: 02/06/2014	Signature of Surveyor: 03006	Date: 01/29/2014		
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:		
Followup to Survey Completed on: 11/7/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

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

PRINTED: 02/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ FEB 12 2014 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/17/2014
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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	(F 000)			
(F 241) SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R14, R10,) who were dependent upon staff for eating were assisted in a dignified manner. Findings include: R14 was dependent on staff for eating and did not receive assistance in a dignified and timely manner. R14's Resident Admission Record dated 4/17/09, indicated R14 was diagnosed with schizophrenia and depressive disorder. R14's significant change Minimum Data Set (MDS) dated 10/16/13, indicated R14 had severe cognitive impairment and was totally dependent upon staff for all activities of daily living. R14's plan of care (POC) dated 5/21/13, directed staff to assist R14 with meals. On 1/16/14, at 12:00 p.m. R14 was observed seated at the dining room table with R38, waiting	(F 241)	Element # 1 R14 and R10 were not harmed as a result of this deficiency. R14 is now being served at the same time as others at her table. R10 is being provided assistance at the same time others at her table are eating. Element # 2 A baseline audit was performed and identified 4 residents who require assistance with meals. An audit was performed of the sequence of serving meals at each table. Element # 3 The meal service protocol has been reviewed and revised. A hostess is now assigned to meals to assure (a) all residents at each table are served at the same time unless there is a joiner (who will be served when seated) and (b) assistance is provided to those residents who are in need of assistance when the meal is served. Education has been provided to clinical staff, dietary staff, and interdisciplinary team.	2/6/14 Approved 2/12/14 SB	

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 instruction 1.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 241}	Continued From page 1 for their noon meal. - At 12:04 p.m. dietary aide (DA)-B was observed to serve R38 the noon meal in which R38 was observed to independently eat. R14 was not served the meal. During this time, three nursing assistants (NA's) were present in the facility. NA-C was observed assisting another resident in the dining room. NA-B and NA-E were observed assisting other residents in the bathroom, near the dining room. Licensed practical nurse (LPN)-A was observed passing medications and registered nurses (RN)-B and RN-C were observed at the nurses station. -At 12:18 p.m. NA-E asked DA-B for R14's meal. -At 12:20 p.m. R38 had finished her meal and NA-E had begun to assist R14 with her meal. On 1/16/14, at 12:21 p.m. DA-A stated R38 was one of the first residents to receive her meal due to her history of behaviors. She stated R14 could not be served her meal until there was a staff member present who would be able to assist R14 with the meal. She confirmed R38 had finished her meal prior to R14 being served. She added this was because the facility did not have enough staff to assist with meal. On 1/16/14, at 12:25 p.m. DA-B stated the facility routinely had problems with serving all of the residents at one table, at the same time. She stated the residents who were dependent upon staff for assistance, were not served their meals until there was a staff member present to assist them to eat. R10 was dependent of staff for eating and was	{F 241}	Element # 4 Audits will be performed of meal service and assistance to residents during mealtime. Audits will be conducted by the DON/Designee daily x 7 days, weekly x 3 weeks, monthly x 2 months, and at least quarterly ongoing. Corrective action will be taken to ensure the residences' needs are met. Variances and corrective actions will be reported to the Administrator and reviewed at QAPI at least quarterly.		

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{F 241}	Continued From page 2 not provided assistance in a dignified manner. On 1/16/14, at 12:04 p.m. R10 was observed seated at the dining table with three other residents. R10 was observed to have been served a small container of yogurt, 6 oz. of water, milk and juice. Two of R10's tablemate's had been served their full meal which consisted of macaroni and cheese, potato wedges, and mixed vegetables. Both tablemate's were observed to independently consume their meal. - At 12:16 p.m. The third tablemate, R43 was served her meal and was observed to eat independently. The other two tablemate's were observed to have independently consumed 80% of their meal. -At 12:20 p.m. R10 was served her meal. The two other tablemate's were observed to have consumed 100% of their meal. On 1/16/14, at 12:45 p.m. nursing assistant (NA)-E stated the NA's were able to assist in the dining room as soon as they were done assisting with all the resident cares that were required before lunch. On 1/17/14, at 8:35 a.m. the director of nursing stated residents sitting at the same table should be served at the same time in order to maintain a dignified dining experience. On 1/17/14, at 10:35 a.m. registered nurse (RN)-A verified all residents seated at the same table should be served at the same time. RN-A added, the facility would be reviewing their dining schedule.	{F 241}			

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{F 241}	Continued From page 3	{F 241}			
{F 282} SS=D	The Dining and Meal Service policy dated 1/16/14, directed staff to provide assistance as required to all residents as needed and to pay attention to the safety, comfort and dignity of the residents to make the meal a pleasant experience. 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 provide services in accordance with the resident's written plan of care (POC) for 2 of 3 residents (R20, R25) who required assistance with ambulation. Findings include: R20 did not receive ambulation services as directed by the individual POC. R20's POC dated 12/3/12, directed staff to provide ambulation assistance to meals each day per the restorative rehab services program. Review of R20's monthly Restorative Services documentation forms revealed the following: -November 2013, indicated R20 ambulated 4 out of 90 opportunities.	{F 282}	Element # 1 R25 and R20 have been assessed to have no decline in ambulation as a result of this deficiency. Each care plan has been updated to reflect an appropriate ambulation program to be provided by qualified staff. Element # 2 A baseline audit was performed of all residents who have an ambulation program. Care plans have been reviewed and updated to reflect the appropriate program.	2/6/14	

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{F 282}	Continued From page 4 -December 2013, indicated R20 ambulated 1 out of 93 opportunities. -January 1-15th, 2014, indicated R20 ambulated 4 out of 42 opportunities. On 1/16/14, at 1:45 p.m. nursing assistant (NA)-B and NA-E stated R20 should have been walking to meals. On 1/17/14, at 10:10 a.m. registered nurse (RN)-A verified R20 had not received ambulation services as directed by the POC. R25 was not provided restorative nursing services for ambulation as directed by the individual POC. R25's POC dated 10/12/13, indicated R25 was at risk for falling related to weakness and impaired balance. The POC directed two staff to assist R25 to ambulate with a walker in the hallway or own room. The Restorative Services recommendation form dated 12/26/13, indicated R25 was to receive contact guard assist of two staff to ambulate 80-100 feet twice a day with a front wheeled walker. Review of R25's monthly Restorative Services documentation forms revealed the following: - December 2013, indicated R25 had received assistance with ambulation once a day on 14 of 31 days. - January 2014, (1/1/14 - 1/15/14) indicated R25 had received assistance to ambulate once a day on 5 of 16 days. On 1/16/14, at 1:28 p.m. NA-B stated R25's	{F 282}	Element # 3 Program and schedules have been reviewed and adjusted as necessary and care plans have been updated to allow qualified staff to accommodate resident needs. A determination was made of who is qualified to implement and provide services for the program. Qualified staff are licensed or certified to provide ADL care, ambulation and assist residents with eating. Clinic staff has received education regarding updated care plans and ambulation program. Element # 4 The ambulation program will be audited by DON/Designee daily x 7 days, weekly x 3 weeks, monthly x 2 months, and at least quarterly ongoing. Corrective action will be taken to ensure the residences' needs are met. Variances and corrective action will be reported to the Administrator and reviewed at QAPI at least quarterly.		

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{F 282}	Continued From page 5 ambulation schedule had been changing. She stated for a while the NA's on the floor had been walking with R25, then R25 was ambulating with only the restorative NA and was informed on 1/15/14, that restorative staff no longer ambulated R25. NA-B stated she was not sure who was to ambulate R25. On 1/16/14, at 1:50 p.m. RN-B verified R25 was to receive ambulation assistance twice a day as directed by the therapy recommendation and R25's POC. RN-B confirmed R25 had not received assistance with ambulation as directed by R25's POC.	{F 282}			
{F 311} SS=D	Policies were requested for Restorative Nursing and Range of Motion and none were provided. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and / or maintain the resident's ability to ambulate for 2 of 3 residents (R20, R25) in the sample who were on an ambulation program. Findings include: R20 was not provided restorative nursing for	{F 311}	Element # 1 R25 and R20 have been assessed to have no decline in ambulation as a result of this deficiency. The Restorative care plan has been reviewed for each resident and updated to reflect an appropriate ambulation program provided by qualified staff. Element # 2 A baseline audit was performed of all residents who have an ambulation program. Care plans have been reviewed and updated as necessary to reflect an appropriate ambulation program to be provided by qualified staff.	2/6/14	

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(F 311)	Continued From page 6 ambulation as recommended. R20's annual Minimum Data Set (MDS) dated 12/3/13, indicated R20 was diagnosed with a cardiovascular attack (CVA) with hemiplegia (paralysis of one side of the body/extremity). The MDS also indicated R20 had moderate cognitive impairment, utilized a wheel chair and ambulated with a walker with staff assistance. The MDS indicated R25 had ambulated in the hallways/corridors of the facility once or twice during the 7 day review. R20's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 12/3/13, indicated R20 was at risk for falls, required physical assist of one staff to get in and out of bed and off toilet due to hemiplegia and inability to independently lock both wheel chair brakes. The ADL CAA also indicated R20 required assistance of one staff to ambulate with use of a walker. R20's plan of care (POC) dated 12/3/12, indicated R20 was at risk for falling related to weakness and impaired balance. The POC directed staff to provide ambulation to meals daily per the restorative nursing rehab program. The Restorative Nursing Recommendation form completed by the physical therapy department, dated 1/11/12, indicated R20 was to be encouraged to ambulate to meals with a 4 wheeled walker with staff assist. The 9/19/12, Restorative Nursing program for the nursing assistants (NA) directed the NA's to ambulate R20 to meals with a walker with staff assist.	(F 311)	Element # 3 The ambulation program has been reviewed, schedules adjusted as necessary and care plans have been updated to allow qualified staff to provide for residents needs. Education of care plans and program has been provided to clinical staff. Element # 4 The ambulation program will be audited by DON/Designee daily x 7 days, weekly x 3 weeks, monthly x 2 months, and at least quarterly ongoing. Corrective action will be taken to ensure the residences' needs are met. Variances and corrective action will be reported to the Administrator and reviewed at QAPI at least quarterly.		

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{F 311}	Continued From page 7 Review of R20's monthly Restorative Services documentation forms revealed the following: -November 2013, indicated R20 ambulated 4 out of 90 opportunities. -December 2013, indicated R20 ambulated 1 out of 93 opportunities. -January 1-15th, 2014, indicated R20 ambulated 4 out of 42 opportunities. On 1/15/14, at 6:55 p.m. R20 was observed in her room sitting in her wheel chair. R20 stated she did not get to walk because nobody offered to walk her. R20 stated she thought she had walked 3 times in the past week. R20 stated she would like to walk everyday, however, they say they are short of staff. On 1/16/13, at 7:00 a.m. NA-H was observed to wheel R20 to the dining room in her wheel chair. At 11:20 a.m. NA-H verified R20 was wheeled to the dining room this morning and stated it was due to being short of staff. NA-H stated she was aware that R20 was to ambulate to meals. On 1/16/14, at 1:40 p.m. NA-E stated the night NA was responsible to ambulate R20 to breakfast. NA-E added, R20 was to be ambulated up to 4 times a day. On 1/16/14, at 1:45 p.m. NA-B and NA-E stated R20 should have been walking to meals. Both NA's confirmed that being so busy with the a.m. routine, it was very difficult to fit in R20's ambulation. Both NA's stated "We do the best we can." On 1/17/14, at 10:10 a.m. registered nurse (RN)-A verified R20's ambulation program was correct and confirmed R20 was not receiving	{F 311}			

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{F 311}	Continued From page 8 ambulation services as directed by the POC. RN-A also stated the Rehabilitation Nursing program was to be assessed during each quarterly MDS assessment and verified it was not reassessed / completed. RN-A stated the last time R20's Rehabilitation Restorative program was reviewed and assessed was 9/20/13. RN-A verified R20's medical record also lacked documentation as to why R20 had not received the ambulation services. R25 was not provided restorative nursing services for ambulation as recommended. R25's quarterly MDS dated 10/8/13, indicated R25 was diagnosed with a stroke with left sided weakness. The MDS also indicated R25 had moderate cognitive impairment and required minimal staff assistance to ambulate in his room. The MDS also indicated R25 had not ambulated in the hallways / corridors of the facility. R25's POC dated 10/12/13, indicated R25 was at risk for falling related to weakness and impaired balance. The POC directed two staff to assist R25 with ambulation with use of a walker in own room and hallway. The Restorative Services recommendation form dated 12/26/13, indicated R25 was to receive contact guard assist of two staff to ambulate 80-100 feet twice a day with a front wheeled walker. Review of R25's monthly Restorative Services documentation forms revealed the following: - December 2013, indicated R25 had received assistance with ambulation once a day on 14 of	{F 311}			

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{F 311}	Continued From page 9 the 31 days. - January 2014, (1/1/14 - 1/16/14) Indicated R25 had received assistance to ambulate once a day on 5 of the 16 days. The RN progress note dated 1/5/14, entitled Restorative Indicated repeated R25's current plan to work with restorative nursing for ambulation. However, the restorative review documentation, did not indicate the frequency of how often R25 was to receive the restorative services and lacked an evaluation of how R25 was progressing with the goal. On 1/16/14, at 1:15 p.m. R25 was observed seated in the wheelchair independently propelling self in the day room. When asked if he received assistance with ambulation, R25 stated he primarily used the wheelchair for mobility because he needed assistance with walking. On 1/16/14, at 1:28 p.m. NA-B stated R25's ambulation schedule had been changing. She stated for a while the NA's on the floor had been walking R25, then R25 was ambulating with the restorative nursing and on 1/15/14 was informed restorative nursing was no longer walking R25. NA-B She stated she was not sure who was to be ambulating R25. NA-B stated she had assisted R25 to ambulate from his room to the dining room for breakfast. On 1/16/14, at 1:50 p.m. RN-B stated R25 was to receive assistance with ambulation twice a day as directed by the therapy recommendation and R25's POC. On 1/17/14, at 8:40 a.m. the DON stated R25 was to receive assistance as directed by his	{F 311}			

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{F 311}	Continued From page 10 POC. The DON also stated she was unaware R25's restorative documentation lacked an evaluation of restorative progress. She stated the facility did not have a policy regarding ambulation services or restorative evaluations by the RN's but she would expect the staff to provide restorative services as ordered and identify any concerns.	{F 311}			
{F 353} SS=F	On 1/17/13, at 9:30 a.m. NA-B and NA-A were observed to assist R25 to ambulate 80 feet with a front wheeled walker. 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	{F 353}	Element # 1 Staff ratios have been reviewed and determined appropriate in number to meet resident needs to maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by the resident care plan. Element # 2 Interdisciplinary staff (department heads/front line staff) have come together to identify shared duties such as meal service and specialized duties such as ambulation requiring qualified staff. Shared staff are to assist with non specialized duties so qualified staff can provide specialized care such as ambulation and assisting residents with eating.		2/6/14

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(F 353)	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff were available to meet resident needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 28 residents residing in the facility. Findings include: The facility failed to provide a dignified dining experience for 2 of 3 residents (R14, R10,) who were dependent upon staff for eating. See F241. The facility failed to provide services in accordance with the resident's written plan of care for 2 of 3 residents (R20, R25) who required assistance with ambulation. See F282. The facility failed to provide the necessary treatment and services to improve and / or maintain the resident's abilities to ambulate for 2 of 3 residents (R20, R25) in the sample who were on an ambulation program. See F311. On 1/16/14, at 11:20 a.m. the director of nursing (DON) stated the facility's normal staffing pattern was as follows: The day shift consisted of three nursing assistants (NA) assigned to provide resident care from 6:00 a.m. to 2:30 p.m. One NA assigned to restorative nursing from 7:00 a.m. to 3:30 p.m., a licensed nurse working from 6:00 a.m. to 2:30 p.m. and one to two registered nurses (RN) working from 8:00 a.m. to 4:30 p.m. -The afternoon consisted of two NA's working	(F 353)	Element # 3 Interdisciplinary staff and qualified staff have been educated to participate in non specialized roles to enhance the experience of residents and provide a culture of team work. Element # 4 Audits will be performed to ensure that all staff (qualified and non-qualified) are assisting residents as appropriate. The audits will be performed by the DON/Designee daily x 7 days, weekly x 3 weeks, monthly x 2 months, and at least quarterly ongoing. Corrective action will be taken to ensure the residences' needs are met. Variances and corrective action will be reported to the Administrator and reviewed at QAPI at least quarterly.		

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{F 353}	Continued From page 12 from 2:15 p.m. to 10:45 p.m., one NA working from 3:00 p.m. to 9:00 p.m. and one licensed nurse working from 2:15 p.m. to 10:45 p.m. -The night shift consisted of two NA's with one working from 10:30 p.m. to 7:00 a.m. and the other NA working from 11:30 p.m. to 8:00 a.m. and one licensed nurse working from 10:00 p.m. to 6:30 a.m. The staffing report for December 17-31, 2013, (15 days) identified the facility had experienced nursing staff shortages of one to two staff members per day. In January 1-16, 2014, (16 days), the facility had one day without shortages (1/2/14) and 16 days in which the nursing staff was short one to two nursing assistants. On 1/16/14, at 11:25 a.m. the DON stated the facility had been trying to hire more staff to cover the nursing shortage. She stated the facility was fully staffed for RN's and LPN's but was still short of nursing assistants. She stated she was working closely with the Human Resource recruiter and had been able to hire a few new NA's, however, the facility was not getting enough qualified applicants applying to fill the positions. On 1/16/14, at 7:20 a.m. NA-E stated the facility was short staffed. She stated, in the past two months the facility had hired additional NA's but the same number of staff had also left the facility. She stated it was hard to keep up with the cares. On 1/16/14, at 8:25 a.m. RN-C stated the facility was usually short staffed. She stated the staff worked hard, but they were "short." On 1/16/14, at 11:24 a.m. NA-H stated she had been working since 11:30 p.m. on 1/15/14, and	{F 353}			

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{F 353}	Continued From page 13 was just leaving the facility. She explained she had to stay to help with morning cares. NA-H stated this was not a daily occurrence rather, on occasion. She stated the nurses, one NA and the NA assigned to restorative activities would have to provide resident cares until the afternoon shift arrived at the facility. On 1/16/13, at 12:21 p.m. dietary aide (DA)-A stated the facility did not have enough staff to assist with meals. On 1/16/14, at 12:25 p.m. DA-B stated the meals occasionally would be served late because there were not enough NA's to assist in the dining room. She stated when this occurred, the dietary staff would run behind on their schedules. On 1/16/14, at 1:54 p.m. RN-B stated the facility was usually at least one NA short on the day and evening shift. She stated as an RN she assisted with providing resident personal cares and was not able to complete some of the RN tasks to the best of her ability due to running out of time. She stated the facility was losing staff members and was not able to replace them. On 1/16/14, at 3:00 p.m. NA-C and NA-D, stated staffing was getting better than it had been in the past several months however, there were still days when staffing was not good. On 1/17/14, at 8:22 a.m. the DON confirmed the facility had one day since 12/17/13, in which they were fully staffed. On 1/17/14, at 11:18 a.m. the facility administrator	{F 353}			

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{F 353}	Continued From page 14 confirmed he was aware the facility continued to be short nursing assistants to provide patient care. He stated a consultant/cooperate RN would be working with the DON to assist with nursing shortages. He stated the facility was trying to get to the root cause as to why they have not been receiving applications for employment. He stated he received reports from the DON regarding the cares and services being provided by the staff in the facility, but confirmed he had not completed any type of monitoring to ensure the facility had the appropriate number of staff members. On 1/15/14, at approximately 5:20 p.m. licensed practical nurse (LPN)-A stated staffing was not good, staff were working short and it was difficult to get all the cares done. LPN-A stated if anything happened or went wrong during a shift, it was almost impossible to get all the work done. LPN-A stated staff were getting exhausted and are mandated to work into the next shift because the facility does not have enough staff.	{F 353}			
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	{F 441}	Element # 1 IC surveillance system was reviewed and a new system has been implemented. An infection control nurse has been identified. Element # 2 A baseline audit was performed of all residents and staff with communicable infections from the month of December 2013. Analysis was performed and new system implemented.		2/6/14

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{F 441}	Continued From page 15 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop, implement and maintain an infection control program related to the surveillance, investigation and analysis of resident and staff illnesses and infections in order to recognize, control and prevent to the extent possible the onset and spread of infection within the facility. This had the potential to affect all 28 residents residing in the facility. Findings include:	{F 441}	Element # 3 A system has been implemented per regulatory guidelines that includes a surveillance program with information related to resident and employee infections, tracking, trending, and analysis. The infection control nurse has been educated on the surveillance system. Element # 4 Resident and employee surveillance forms will be audited by the DON/Designee daily x 7 days, weekly x 3 weeks, monthly x 2 months, and at least quarterly ongoing. Corrective action will be taken to ensure the residences' needs are met. Variances and corrective action will be reported to the Administrator and reviewed at QAPI at least quarterly.		

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{F 441}	Continued From page 16 On 1/16/14, at 1:18 p.m. the director of nursing (DON) stated she had implemented an employee illness report form which was to be completed when a staff person missed work due to illness and upon return to work the staff person was to complete an employee illness form. The DON stated had a summary of staff illnesses written on a piece of paper, however, had not yet created a surveillance spread sheet in order to investigate and analyze the data. The DON verified she had not monitored, tracked or trended nor analyzed employee illness as required. On 1/17/14, at 8:40 a.m. The facility's Infection Reports Log 2013 was reviewed with the DON and facility nurse consultant. The log identified resident infection tracking from 12/31/12, through 10/19/13. The DON stated she had not started a tracking log for 2014 as she had not always received the facility infection report forms from staff, therefore, she had not created a surveillance spreadsheet in order to identify trends/patterns, monitor and analyze staff / resident illnesses. The nurse consultant stated the facility did not have a policy or procedure in place for the surveillance, investigation and analysis of resident and staff illnesses and stated the facility was going to have to develop policies for this. On 2/17/14, at 9:55 a.m. review of the "order report by category" dated 10/19/13-1/17/14, identified the following residents who had who had infections and received antibiotic treatment during that period and not included on the facility Infection Reports Log 2013. - On 12/2/13, R14 was diagnosed with	{F 441}			

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{F 441}	Continued From page 17 pneumonia and prescribed the following antibiotics: Rocephin 1.0 gram daily for three days. On 12/3/12, R14 was prescribed Azithromycin 500 milligrams (mg) one dose and on 12/4/13, 250 mg of Azithromycin for four days. - On 10/14/13, R26 was prescribed Bactrim DS 800-160 mg for diagnosis (DX) of leg cellulitis/abscess. - On 11/7/13, R7 was prescribed Gentamycin cream 0.1%, to open areas on toes. - On 10/22/13, R23 was prescribed Augmentin (amoxicillin-pot clavulante) 875-125 mg twice daily for 14 days to treat bronchitis. - On 1/16/14, R37 was prescribed Zithromax Z-Pak 250 mg, 500 mg day one, then 250 mg days 2-5. DX: upper respiratory infection. - On 10/25/13, R10 was prescribed Cipro 250 mg every other day and to discontinue on 10/26/13, DX: urinary tract infection (UTI) -On 11/26/13, R10 was prescribed amoxicillin 250 mg twice daily for five days. DX: UTI -On 10/19/13, R30 was prescribed Cipro 500 mg twice daily for seven days. DX: Biliary duct inflammation. -On 11/1/13, R30 was prescribed Cipro 500 mg twice daily for seven days. DX: Biliary duct inflammation. -On 11/19/13, R30 was prescribed Cipro 500 mg twice daily for seven days. DX: Biliary duct inflammation. -On 10/31/13, R38 was prescribed Cipro 500 mg give every 12 hours for seven days DX: UTI -On 12/6/13, R43 was prescribed erythromycin ointment to be applied three times a day for seven days. DX: conjunctivitis -On 12/26/13, R11 was prescribed Clindamycin HCl 300 mg. give three times a day for seven days. DX: not provided.	{F 441}			

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{F 441}	Continued From page 18 On 1/17/13, at 11:15 a.m. the DON stated she was unaware of the above infections and antibiotic treatments and also stated she was unaware of the ability to generate the infection / antibiotic report forms off the computer. The DON verified she had not implemented a resident / employee infection / illness surveillance program as required.	{F 441}			

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q7V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5428

At the time of the standard survey completed November 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.

Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6121

December 9, 2013

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428023

Dear Mr. Stampohar:

On November 7, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104
Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 17, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 February 7, 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 May 7, 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

Homestead Rehabilitation & Living Center

December 6, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script, reading "Kate Johnston". The signature is fluid and elegant, with a long horizontal flourish extending to the right.

Kate Johnston, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

XZ0U

Homestead Rehabilitation & Living Center

December 6, 2013

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

PRINTED: 12/06/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	MULTIPLE A BLDG B WING		CONSTRUCTION — DEC 23 2013	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 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 VERIFICATION OF 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.	F 000				
F 164 SS=D	483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	HRLC does ensure the residents right to privacy and confidentiality is maintained. The family of R35 was notified of the baby monitor before its use. This was confirmed during a care conference that occurred during the survey. Subsequent review of monitor use determined monitor did not enable staff to hear noises in room. After discussion with family, the monitor was discontinued. Resident is checked visually. No other devices are in use at this time. Future use of device will require written consent for use of a device. DON must be notified of any noise monitoring device being used/considered in resident care.		12/17/13	

Approved
11/4/14
JLB
Addendum

LABORATORY DIRECT, OR IS OR PROVIDER/SUPP R REPRE NTATIVES SIGNATURE

[Signature]

TITLE

Admin

(X6) DATE

12-20-2013

Any deficiency statement ending with Sri ast () 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.

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

PRINTED: 12/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	CONSTRUCTION COMPLETED B. WING		(X3) DATE SURVEY 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the residents representative prior to the implementation of a baby monitor in a room for 1 of 1 resident (R35) reviewed for privacy concerns. Findings include: R35's diagnosis included Alzheimer's disease.. The quarterly Minimum Data Set (MDS) dated 9/27/13, indicated R35 rarely/never made decisions, had severely impaired cognitive skills for daily living, and did not speak. R35's plan of care (POC) dated 9/2/13, indicated R35 was vulnerable due to her inability to speak and care for her own activities of daily living (ADLs), and had restrictions on visitors. On 11/4/13, at 5:40 p.m., R35's family member (FM)-A and also R35's power of attorney and primary decision maker was interviewed and stated the facility had placed a baby monitor in R35's room, and did not ask her permission. FM-A stated the baby monitor was placed in the	F 164	HRLC has developed a policy on the use of monitoring devices. Staff have been educated on the new policy. Consent form was developed for use of monitoring. Written consent will be obtained before using devices in the future. DON/designee will perform weekly check for any monitoring device in place will occur for one month, biweekly times two months, monthly times six. Quarterly report will be reviewed by the Quality Committee.		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ W/RE ABLING CONSTRUCTION B. WING		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 164	Continued From page 2 room several months ago, and staff could listen to conversations at the desk. On 11/5/13, at approximately 8:15 a.m. a baby monitor was observed at the nurse's station. At 8:58 a.m., a baby monitor was observed to be on the nightstand in R35's room. The baby monitor was on at the desk and in R35's room. When interviewed on 11/7/13, at 9:35 a.m. the director of nursing (DON) confirmed the baby monitor in R35's room, and stated it was to monitor for unwelcome visitors. The DON confirmed FM-A had not been consulted prior to the baby monitors placement.	F 164			
F 166 SS-D	The facility was unable to provide a policy and procedure on privacy and the use of baby monitors. 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 resident (R8) family who had voiced a concern regarding assistance with vehicle transfers.	F 166	F166 HRLC has a grievance policy and ensures prompt responses to grievances. At the time of the event for R8, transfers were evaluated by the physical therapist. However, this evaluation was not recorded in the resident's chart. After survey, HRLC offered the resident and her family reassessment of transfer to the car. The family has declined the offer until the weather has improved in the spring. Per Family request transfers will be reassessed before/in May 2014 when the weather is warmer. The Care Plan was reviewed and updated.	12/17/13	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246428	MULTIPLE A BUILDING B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11610TH AVENUE NORTHE AS DEER RIVER, MN 56636 T			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE	
F 166	Continued From page 3 Findings include: When interviewed on 11/6/13, at 7:00 a.m. R8's family member (FM)-B stated last summer family had taken R8 for a ride in a car. Upon return to the facility, FM-B had requested staff assistance from staff to transfer R8 out of the car. An unknown staff member refused to assist, indicating this would be a liability for the facility. FM-B stated he then spoke with the director of nursing (DON) and was told R8 required a mechanical lift for safe transfers, and this was not possible with a vehicle transfer and any transfers outside of the facility would be family's responsibility. FM-B indicated it was important to R8 to get out of the facility at times. R8's quarterly Minimum Data Set (MDS) dated 9/10/13, indicated R8 had diagnoses of depression and heart failure, was cognitively intact and required extensive assistance of two staff for transfers. R8's plan of care (POC) dated 9/3/13, indicated R8 required two staff assist and the use of a standing lift for all transfers. However, the POC did not identify how to transfer R8 to a vehicle when she went out with family. When interviewed on 11/7/13, at 3:25 p.m. the DON stated she was aware of R8's family member concerns about being denied assistance with vehicle transfers. However, R8 required a mechanical standing lift for transfers and they could not use the lift outside of the facility, therefore staff were unable to assist with the transfer. The DON also stated the family would be responsible for all transfers outside of the	F 166	HRLC has mailed the Grievance Policy to families/residents. The Grievance Policy was reviewed at the Resident Council Meeting on December 5, 2013. Staff were educated on the Grievance Policy and who is to be notified when a grievance is brought to their attention. Grievances are entered into the Essential Health Risk Management Database. The DON is notified of grievances via staff report and the risk management software. Grievances are resolved by the RN, SW, or DON within seven days if they are not resolved at the time of the grievance. Corporate Risk Management reviews grievance resolution. The DON will report the number of grievances to the Quality Committee on a quarterly basis.			

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FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C17V711

Facility ID: 00296

If continuation sheet Page 5 of 69

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	QUALITY CONSTRUCTION A BLDG C O M P L E T E D B WING		(X3) DATE SURVEY 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 176	Continued From page 5 practice of self-administration of medications was safe for 1 of 1 resident (R26) who self-administered medications, Findings include: R26 diagnoses included diabetes mellitus, renal (kidney) failure and personality disorder. The annual Minimum Data Set (MDS) dated 10/29/13, indicated R26 was cognitively intact. R26's plan of care (POC) dated 10/17/13, included self administration of medication at bedside and in the dining room and R26 may keep metered dose inhalers, Turns and NitroStat (an antianginal medication) at bedside. The POC directed staff to complete periodic teaching and remind R26 of the importance of compliance with self-administration. R26's Physician Order Report dated 10/24/13, included: an order for nitroglycerine (NitroStat) which read: "May self administer at dialysis or in room at bedside with assist of nurse," ProAir (an inhaler) which included, "May self administer at dialysis or at bedside," Turns as needed and "May self administer at bedside," and an order for a Combivent (Inhaler) which did not include a self administration order. R26's Medication/Treatment Self-Administration Assessment form dated 10/17/13, indicated R26 had the ability to self administer medications and was able to keep the medications secure in her purse.	F 176	amounts of medication used is suspected. The physician has been contacted to confirm that Combivent may be self-administered. The resident has a locked drawer in her room for keeping her medications or the medications may be kept in the resident's purse when she is outside of the facility. Resident has a key to lock medications in her bedside stand. If the resident is unable to follow policy the self-administration will be evaluated and revised as needed. The self-administration may be discontinued if the resident is unable to follow policy and does not keep the medications in a locked location. No other residents are self-administering at this time. Any resident desiring/eligible for self-administration will be assessed according to the policy. The policy was updated for self-administration. Staff were educated on the new procedures.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
E & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	MULTIPLE A BUILDING B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID FREE X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 176	Continued From page 6 On 11/4/13, at 3:50 p.m. two metered dose Inhalers (Combivent and Albuterol) and a bottle of Turns with a few tablets remaining was observed sitting on R26's overbed table in her room. R26 was not observed to be in the room. A system to keep the medications locked was not observed in the room. On 11/5/13, at 5:50 p.m. R26's room was again observed to have medications sitting on the over the bed table. R26 was not observed in the room. When interviewed on 11/6/13, at 6:50 a.m. R26 stated she had the red Inhaler (Albuterol) but she did not know where the orange (Combivent) inhaler was. R26 stated she was allowed to have the inhalers, Turns and NitroStat with her at all times. R26 also stated she had not been instructed to keep the medications secured when she was not in her room. R26 stated she could not recall the nursing staff asking her how often she was using the medications. When interviewed on 11/6/13, at 12:25 p.m. registered nurse (RN)-A stated R26 had the ability to keep the inhalers, Turns and NitroStat at bedside. She stated R26 had been offered a key to the top drawer of her night stand, but R26 had refused the key. RN-A stated the medications were to be kept in her purse which she carried with her at all times. RN-A was not aware R26 was leaving the medications in her room unattended.	F 176	The DON/designee will audit documentation of the safe medication storage and use of medications on a weekly basis times 4, then every 2 weeks times four, then monthly times three and then quarterly times 3. Deviations will be reported to the Quality Committee.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDICAID SERVICES

PRINTED: 12/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ ALTERNATE CONSTRUCTION A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 DEER 10TH AVENUE NORTHEAST RIVER, MN 56636		
(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 176	Continued From page 7 When interviewed on 11/7/13, at 10:00 a.m. RN-B stated she had entered R26's room and removed an empty bottle of Turns and the Albuterol Inhaler. She confirmed R26 was to keep the medications in her purse and not unattended in her room. She stated the bottle of Turns was empty and did not know when R26 had taken the medications. Review of the November 2013 Medication Administration Record (MAR) lacked a tracking system for the use of the bedside medications. When interviewed on 11/7/13, at 10:16 a.m. licensed practical nurse (LPN)-A stated the facility did not have a system to monitor how often R26 was using the medications kept at bedside. The Self-Administration of Medication policy dated 9/15/95, directed staff to ensure if a resident was keeping medications at bedside, a locked box must be kept for the storage of drugs if they are kept at bedside. The policy also directed staff to observe the resident and check the count of the medications on hand and document the findings. When interviewed on 11/7/13, at 11:33 a.m. the director of nursing (DON) stated R26 had the ability to keep medications at bedside, but the facility did not have a system to monitor R26 on how often she was using the medications or ensuring that R26 was able to store the medications safely in her room. The DON	F 176			

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

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FORM APPROVED OMB
NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ MULTIPLE BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 176 F 241 SS=E	Continued From page 8 followed: 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY - The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R27, R12, R14) who were dependent upon staff for eating, were assisted in a dignified manner. In addition, the facility failed to ensure 1 of 1 resident (R26) who had requested assistance with cares, was treated in a dignified manner when she had to wait for an extended period of time for this assistance. Findings include: R27, R12, and R14 were not provided a dignified dining experience when nursing assistant (NA)-J moved from resident to resident and stood over the residents to feed them. R27's diagnosis included Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 11/2/13, indicated R27 had severe cognitive impairment and required total staff assistance with eating. R12's diagnosis included Alzheimer's dementia. The significant change MDS dated 9/6/13,	F 176 F 241	F 241 HRLC promotes the dignity and respect of its residents and their individuality. Seating for meals was reassessed and residents were moved on November 7, 2013 to facilitate feeding residents in a dignified manner, to be able to encourage nearby residents to eat, and to monitor consumption before residents leave the table. Resident consumption is documented after each meal. Staff have been instructed to make sure that resident dignity and respect is maintained during meals/cares. The call light of R26 was answered within three minutes by the DON, the NAR admitted that she forgot the request for R26. Dining arrangements are reviewed continuously for all residents. Seating arrangements are reassigned to facilitate meals being served in a dignified manner and to enable staff to monitor resident eating as identified by resident need. No more than 2 residents are fed at one time by a staff person. Any staff may notify the RN or RD of a request to change the location of a resident. The RN is able to make changes as needed.	12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ MULTIPLE A BLIND CONSTRUCTION B WING		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115107H AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 9 indicated R12 had severe cognitive impairment and required total staff assistance to eat. R14's diagnosis included Alzheimer's dementia. The significant change MDS dated 10/25/13, indicated R14 had severe cognitive impairment and required total staff assistance to eat. During the evening meal observation on 11/5/13, at 6:15 p.m. NA-J was observed standing in front of R27 feeding her the meal. At 6:21 p.m. NA-J was observed to walk over to R12 who was located at the same table, gave her a bite of food, then walked over to R14 who was also seated at the same table and gave her a bite of food and a drink. NA-J continued to walk to each resident (R14, R12, and R27), feeding for only a few bites each, occasionally sitting down next to the resident momentarily before getting up to feed the next resident. This continued until 6:34 p.m. when NA-F arrived in the dining room to assist with feeding. When interviewed on 11/5/13, at 8:05 p.m. NA-J and NA-F stated they were the only two nursing assistants working this evening and stated they did not have enough help to get everyone fed so they had to feed several residents at once, or it wouldn't get done. When interviewed on 11/7/13, at 9:30 am. the director of nursing (DON) stated staff should not stand up when they are feeding the residents.	F 241	A blind call light audit was conducted over a one week period; monitoring was conducted on different shifts and by different staff. The average time for answering a call light and meeting the need of the resident was five minutes. The feeding policy was reviewed and revised. Staff were educated on the policy changes. Staff were educated on the results of the call light audit and the need to be responsive to resident preferences and needs. Staff observed to be moving around the tables, standing over residents while feeding, not responding to call lights will be redirected on appropriate behavior and reminded to honor the dignity and respect of residents. The DON/RN's observed feeding on a daily basis for one week, twice a week times two weeks, weekly times four weeks and monthly thereafter to monitor for staff moving around the table or standing to feed a resident or other condition that does not promote dignity/respect of the residents. Call light audit will be reported at the Quarterly Quality Assurance Committee meeting.	12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	WING CONSTRUCTION A BLDG _____ B WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE DEER RIVER, MN 55336 NORTHEAST		
(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 241	Continued From page 10 R14 did not have a dignified dining experience during the breakfast meal on 11/6/13, when her table mates were being assisted, and she was left with food sitting in front of her, unable to feed herself. During the morning meal observation on 11/6/13, at 8:10 a.m. R14 was served breakfast, along with two table mates. NA-A was observed to sit down between R14's tablemate's and assisted them with eating. R14 stared at her food, unable to feed herself. NA-A did not offer to assist R14. At 8:25 a.m. dietary aide (DA)-A placed a cover eating. R14 sat looking at her food and table mates eating until 8:30 am. when registered nurse (RN)-A sat next to her and assisted her to eat. This was a full 20 minutes after her meal had been served and her tablemate's had been assisted. When interviewed on 11/6/13, at 12:00 p.m. RN-A stated R14 should not have had to wait so long to be assisted with eating. RN-A also confirmed this was not a dignified dining experience for her. R26 did not receive assistance in a dignified manner when she had to wait 55 minutes for staff assistance. R26 diagnoses included diabetes and renal (kidney) failure. The annual MDS dated 10/29/13, indicated R26 was cognitively intact and required extensive assistance with all				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 241	Continued From page 11 activities of daily living (ADL's). R26's plan of care (POC) dated 10/17/13, directed staff to assist with personal cares. During observation on 11/4/13, at 6:50 p.m. R26 turned on her call light. The DON answered the light at 6:53 p.m. The DON was observed to go to the dining room and inform NA-H that R26 wanted to go to bed. At 7:15 p.m. R26 continued to sit in her room waiting to receive assistance to go to bed. R26 stated she had requested assistance and her light was answered, but nobody had come in to assist her. R26 stated this was distressing to her. At 7:40 p.m, R26 continued to wait for assistance. When interviewed on 11/4/13, at 7:40 p.m. NA-H stated she had been informed by the DON that R26 wanted to go bed, but was busy assisting other resident and had forgotten R26's request for assistance. NA-H also stated there were only two nursing assistants working and it was difficult to complete all of the cares and assist the residents timely. At 7:45 p.m. NA-H entered R26's room to assist " her with cares, 55 minutes after the request. When interviewed on 11/7/13, at 12:00 p.m. the DON confirmed R26 had not received assistance with cares in a timely, dignified timely manner. A facility policy was requested, but not received from the facility.				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 242 F 242 SS=D	Continued From page 12 483.15(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 residents the opportunity to Make choices about bathing and/or when to get up in the morning, for 3 of 11 residents (R21, R35, and R23) interviewed for preferences and previous life routines. Findings include: R21 was not provided with her bathing choice of a bath. R21's annual Minimum Data Set (MDS) dated 10/16/13, included a diagnosis of depression. The MDS also indicated R21 was cognitively intact, required transfer assistance only for bathing and indicated it was somewhat important for R21 to chose the type of bathing she received. R21's plan of care (FOC) dated 10/10/13, did not address bathing needs or preference. When interviewed on 11/6/13, at 10:10 a.m. R21 stated she preferred a tub bath, but received a shower most of the time, only getting a bath once	F 242 F 242	F 242 Resident preference interviews were conducted and preferences noted in the care plan. Care plans for affected residents were reviewed and updated as needed. Staff were educated on allowing resident's choice and meeting their preferences. Resident preferences are reviewed at admission and at quarterly care conferences. If a resident requests/or states a preference at any other time, the preference is to be communicated to the RN who will assess and document the change requested. The Care Assignment Sheet indicated resident preference. Resident preferences will be assessed on admission by Social Services and Activities. The DON/designee will conduct random audits of resident preferences and care received on a monthly basis for six months. Results will be reported to the Quality Committee.	12/17/13	

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 71510TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 242	Continued From page 13 when all the showers were full. R21 stated, "It takes longer to give us a bath, that is why they like to give you a shower. They don't ask you what you want, they tell you what your going to get." R21 stated she has let staff know she would like a tub bath rather than a shower, but she did not want to make More work for the staff. When interviewed on 11/6/13, at 9:45 a.m. nursing assistant (NA)-F stated R21 received a shower. NA-F stated she knew R21 likes baths, and they will give her a bath if they have time to do it, but bathing took longer than a shower. NA-F stated staff were not informed of resident preferences regarding bathing and stated the only time they would know is if the resident told them. The facility's undated Bath Schedule indicated R21's name was listed on the bath schedule under Monday am., but did not indicate if R21 liked a shower or a bath. The undated nursing assistants Work Assignment Sheet did not indicate if R21 preferred of a shower or a bath. When interviewed on 11/6/13, at 11:00 a.m. the director of nursing (DON) stated R21's bathing preference should have been assessed at some point. When interviewed on 11/6/13, at 11:02 am., registered nurse (RN)-E stated resident preferences are addressed upon admission and quarterly. RN-E also stated residents were asked	F 242					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ODA IDENTIFICATION NUMBER: 245428	(X2) WING CONSTRUCTION _____ B. WING _____		(X3) DATE SURVEY 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 242	Continued From page 14 at that time if they want anything changed. In addition, RN-E verified the facility did not have any system in place to ensure the nursing assistants were informed of resident bathing preferences. R35 was not provided with her bathing choice of a shower for more than four weeks nor was her usual customary routine of being out of bed in the morning honored by staff. R35's quarterly MDS dated 9/27/13, indicated R35 was diagnosed with Alzheimer's disease, had severe cognitive impairment and was totally dependent upon staff for bathing. R35's admission MDS dated 4/3/13, included a staff assessment of daily activity preferences, this indicated R35 preferred receiving a shower. R35's POC dated 9/21/13, did not identify R35's bathing preference of a shower, nor did it direct staff on any previous life routine such as when to get up in the morning. When interviewed on 11/4/13, at 5:20 p.m. family member (FM)-A stated R35 had preferred a shower, however, had only received a bed bath for the last four weeks and had not had her hair washed. FM-A stated when staff were asked why R35 had only received a bed bath she stated she was told the facility's shower chair "pinched" R35 when seated on it therefore they were not using it. FM-A stated she was informed staff would use the adjoining hospital's shower chair, but then was told they could not find one there. In addition, FM-A stated R35 liked to get up in the recliner in the morning, however, the facility did not get her out of bed until around 10:00 a.m.	F 242			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11510TH AVENUE, NORTHEAST DEER RIVER, MN 56636			
(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 242	Continued From page 15 On 11/6/13, at 6:05 a.m. R35 was observed in bed, fully dressed for the day. When interviewed on 11/6/13, at 6:18 a.m. NA-K stated she worked the night shift and verified R35 was washed and dressed at 4:30 a.m. and laid back down in bed. NA-K stated she did not know what time the day shift assisted R35 out of bed. On 11/6/13, at 10:15 am. R35 was observed out of bed and sitting in her recliner. When interviewed on 11/7/13, at 10:11 a.m. the DON verified R35 had not received a shower for several weeks. The DON stated the facility had ordered a new shower chair. In addition, the DON stated she was not aware the night shift got R35 up and dressed at 4:30 a.m. only to lie her back down until 10:00 a.m. The DON confirmed this probably would not have been R35's previous life routine. R23 was not given the opportunity to choose when to wake up in the morning. R23's diagnoses included Alzheimer disease, dementia and hearing loss. The quarterly MDS dated 10/21/13, identified R23 as being cognitively intact and required limited assistance with dressing. The annual MDS dated 7/19/13, indicated R23 was cognitively intact and it was very important to R23 to be able to make daily choices about her daily routine.	F 242				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 71510TH AVENUE NORTHE AST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	Continued From page 16 When interviewed on 11/4/13, at 5:15 p.m. R23 stated she did not get a choice as to when to wake up each morning. R23 explained her room mate received medications between 5:00 a.m. and 5:30 a.m. which wakes her up. R23 stated while she was at home, she got up around 7:00 am. but since she was at the facility, she was awakened too early. On 11/6/13, at 6:23 a.m. R23 was observed to be sitting on the edge of her bed drinking coffee. R23 stated she had been up since about 5:30 a.m. because the staff had been in to assist her room mate. When interviewed on 11/6/13, at 8:35 a.m. licensed practical nurse (LPN)-A stated R23 did not receive early medications but confirmed her room mate did. R23's medical record lacked indication of R23's usually daily routine nor indication R23's preference with daily life routines had been discussed with her. When interviewed on 11/6/13, at 12:14 p.m. RN-A stated the residents had the right to get up whenever they choose. She stated if a resident wanted to stay in bed longer, all they would have to do is tell the staff and they would allow them to stay in bed. RN-A stated she was not aware of any type of assessment which would indicate a residents previous life routines RN-A also stated	F 242			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, city, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 66636		
(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 242	Continued From page 17 the activity assessments may include the routines and if so this information was not passed on to nursing. When interviewed on 11/7/18, at 11:00 a.m. the licensed social worker (LSW) stated she did not review previous life routines with the residents. She stated she was not aware R23 was being woken by the nursing staff assisting her roommate. The LSW stated R23 had not expressed this concern to her. When interviewed on 11/7/13, at 11:28 a.m. activity aide (AA)-A stated activity staff reviewed concerns such as what interests the residents had to ensure they were able to assist the residents with activities of interests. She stated she did not ask the residents about previous daily activity routines which may include usual time to get up. AA-A stated the nursing staff may question the residents on this topic. On 11/7/13, at 11:46 a.m. the DON stated the admission assessments may or may not include the residents preferences on when to get up. She stated she was not aware R23 was unable to choose when to get up because of the roommate receiving medications. The DON confirmed R23's clinical record lacked an assessment of R23's previous life routine. She confirmed if R23's routine had been reviewed, R23's choice of when to wake up would have been respected by the staff. A facility policy was requested, but not received	F 242			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246428	(X2) FULLY A BUILDING B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 242	Continued From page 18 from the facility.	F 242				
F 247 SS=D	483.15(02) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform 1 of 1 (R23) resident in advance of a room mate change. Findings include: R23's diagnoses included Alzheimer disease, dementia and hearing loss. R23's quarterly Minimum Data Set (MDS) dated 10/21/13, indicated R23 was cognitively intact and required limited staff assistance with dressing. R23's annual MDS dated 7/19/13, also indicated R23 was cognitively intact and it was very important to R23 to be able to make daily choices about her daily routine. When interviewed on 11/4/13, at 5:30 p.m, R23 stated she had recently had a new roommate move in. However, R23 stated she had not been informed previously informed of this and found out only when the roommate had entered the room with staff. R23's roommate's record indicated an admission date of 11/8/13. R23's medical record lacked any	F 247	Resident 23 was informed of a new roommate by the Social Worker prior to that person being admitted. Resident 23 does have memory loss and may not remember the discussion. The Social Worker has been instructed to make a late entry regarding roommate discussion. Resident 23 and the roommate were involved in discussion regarding a change. Resident 23's roommate was moved on November 18, 2013. No roommate changes have been requested since the time of the survey. Changes will be considered and changed as resident requests and opportunities exist. A roommate change form has been developed and is used whenever a roommate change occurs. The policy was reviewed and updated to reflect current practice. The Social Worker and RN's were educated regarding documentation of room/roommate change notification. The DON and Social Worker are notified of needed roommate changes. The DON/designee will investigate changes made without proper notification and will report to the Quality Committee.		12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2842	(X2) MULTIPLE CONSTRUCTION A BLDG _____ B WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56836		
(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 247	Continued From page 19 documentation of R23 being informed she would be getting a new room mate. When interviewed on 11/7/13, at 11:00 a.m. the social worker (LSW) stated she normally informed the potential room mate prior to the resident arriving at the facility. The LSW recalled informing R23 of the new room mate, but then was unable to find documentation of this.	F 247			
F 249 Ss=c	A facility policy was requested, but not received from the facility. 483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure the activity program had a qualified activities	F 249 F249	Activities for this resident (R35) were reviewed by the facility COTA. The facility COTA is acting as the Interim Activities Director. Activity assessments have been reviewed by the acting director. An interview was conducted on 11/29/13. The job description has been reviewed and revised. The facility continues to seek a qualified applicant for the position. DON checks weekly with Human Resources for qualified applicants for the position. Results will be reported to the Quality Committee. DON/designee meets with COTA weekly to discuss needs within activity department.		12/17/13

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 118 10TH AVENUE NORTHEAST DEER RIVER, MN 56638		
(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 249	Continued From page 20 director for 1 of 1 resident (R35) reviewed for activities. This practice had the potential to affect all 29 residents residing in the facility. Findings include: On 11/7/13, at 2:47 p.m. activity aide (AA)-A stated either her or one of the other three activity aides completed activity assessments on new residents, completed the activity calendar and documented on each resident's activity record. During interview on 11/5/13, at 3:19 p.m. the director of nursing (DON) verified the facility did not have an activities director overseeing the resident activity program. The DON stated the activity program director job position had been vacant since 5/13, and the facility had advertised the position and had not received any qualified applicants.	F 249			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	Resident R7 was assessed for safety while bathing unattended. Resident R7 was identified to be able to be left alone while bathing because he will use the call light provided. Guardian has approved this activity. Staff are checking on R7 frequently (approx. every 10 minutes) during the bath. Safety interventions will be used while bathing. Resident R21 was interviewed for bathing preference. R21 is offered her choice of bath or shower and she does make a choice. The care plan has been updated.	12/17/13	

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 55636		
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F 279	Continued From page 21 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care (POC) for 1 of 1 resident (R7) who was bathing unattended. In addition, the facility failed to develop a POC regarding bathing concerns for 1 of 2 residents (R21) reviewed for bathing. Findings include: R7's independently soaked in the whirlpool tub and R7's POC did not address the independent bathing. R7's diagnoses included a stroke with left side paralysis and aphasia (inability to speak). R7's quarterly Minimum Data Set (MDS) dated 10/3/13, indicated R7's memory was intact, he required limited assistance with transfers and required total staff assistance with bathing. R7's plan of care (POC) dated 7/16/13, directed staff to assist R7 with weekly tub baths or shower. The POC did not address R7 soaking in the bath tub unattended. R7's POC dated 7/16/13, directed staff to assist	F 279	Staff were educated on offering resident's choices in ADL's at the time of giving cares to a resident. Care will not be at staff convenience, it will be based on resident preference and choice. Staff were instructed to review the care plan for resident preferences and abilities. Residents are reassessed at least annually, quarterly as indicated by rule and more frequently as needs are identified. The DON/designee will conduct random audits of resident preferences and care received. Audits will be conducted on a weekly basis for one month and then monthly for six months. The DON/designee will conduct Care Plan audits on a quarterly basis. Deviations/results will be reported to the Quality Committee.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 279	Continued From page 22 R7 with a weekly tub bath or shower. The POC did not address R7 soaking in the bath tub unattended. On 11/8/13, at 8:00 a.m. nursing assistant (NA)-B informed NA-F that she had to check on R7 as he was soaking in the tub. NA-B stated R7 liked to soak in the tub for awhile by himself. She stated R7 had the call light and would call for assistance when he was ready to get out but until then, the staff checked on him to ensure he was safe every 10 minutes or so. She stated R7 had not had any problems while sitting in the tub by himself. NA-B confirmed R7 had to be assisted in and out of the tub by staff. On 11/8/13, at 11:50 a.m. registered nurse (RN)-A stated R7 enjoyed soaking in the tub. She confirmed R7 had aphasia and was not able to vocalize his needs, but was able to use the call light appropriately while in the tub. She stated R7 had not had any problems while in the tub by himself. RN-A confirmed R7's POC did not address R7's wishes to soak in the tub unattended. R21's POC did not address R21's bathing needs or preferences. R21's diagnoses included depression, glaucoma and heart disease. R21's annual Minimum Data Set (MDS) dated 10/11/13, indicated R21 was cognitively intact, required staff assist with transferring when bathing and choosing between bathing preferences was important to her. R21's POC reviewed on 10/10/13, lacked indication of R21's bathing needs or preferences.	F 279			

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F 279	Continued From page 23 The 24 Hour Initial Admission Nursing questions dated 10/5/12, under customary routine, a shower was underlined. This was not addressed or followed up on anywhere else in R21's record. The facility bath schedule indicated R21's received a bath on Monday's, however, it did not indicate whether R21 preferred a shower or bath. Review of the nursing assistants Work Assignment Sheet did not include if R21 preferred a shower or a bath. On 11/6/13, at 10:10 a.m. R21 stated she had told staff that she liked / preferred a bath. On 11/6/13, at 9:45 a.m. NA-F verified R21 was bathed in the shower. However, NA-F confirmed R21 sometimes preferred a bath, if staff had time. On 11/6/13, at 11:00 a.m. RN-E stated bathing preferences were assessed on admission and quarterly there-after. RN-E stated at those times each resident is asked if they desired any changes in bathing preferences. RN-E also stated she she did not know how the nursing assistants would know the bathing preference of each resident. RN-E reviewed the bath sheets and R21's POC and confirmed R21's bathing preference was not identified.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE OP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F280 Resident R3 is able to feed self and prefers to do so. She does have 1-2 meals per day that she is less interested in eating.	12/17/13	

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F 280	Continued From page 24 Incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise care plans for 2 of 2 residents (R3, R22) who required assistance with eating. In addition, the facility failed to develop a plan of care for 1 of 2 residents (R25) reviewed for ambulation. Findings include: R3's diagnoses included status post stroke with left sided paralysis and aphasia. R3's admission Minimum Data Set (MDS) dated 7/24/13, indicated R3 had severe cognitive impairment and was independent in feeding herself. R3's POC dated 11/6/13, indicated R3 was able to feed herself. The POC did not indicate R3	F 280	The care plan of 7/23/13 includes a goal for the resident to "continue to feed herself". Resident R3 will choose not to eat at some meals, especially if she is in pain. Staff are assessing R3's pain level before meals. When R3 is choosing not to eat. Her weight is monitored 3 times per week at this time due to her cardiac diagnosis and she had a recent history of weight gain that has required the discontinuation of her extra calories. Meal consumption is documented. The care plan for R3 has been updated to include staff encouragement/assessment of why R3 is noted to not be eating. Resident R22 is independent in eating her meal and will not accept assistance with her meal. She has been observed by the ST and RD and nursing staff to stop eating as soon as you get close to her or look at her. Pocketing of food by R22 has been assessed and the care plan has been reviewed and revised to include assistance with eating. Resident R22 is checked after each meal for pocketing of food and oral cares are provided. Resident weights are checked monthly. If significant weight loss is noted, the RD and RNs determine the need and frequently of reassessment and treatment. Care plans and resident care sheets have been reviewed and updated to include assistance with eating and ambulation.		

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F 280	Continued From page 25 required assistance with meals. R3's plan of care (POC) dated 11/6/13, indicated R3 was independent with eating. The POC did not indicate R3 required assistance with meals. On 11/6/13, at 6:15 p.m. R3 was observed in the dining room, seated at a table with her food. placed in front of her. R3 was not observed to be eating. At no time during the meal did R3 attempt to feed herself or receive assistance or encouragement from staff to eat the meal. At 6:30 p.m. R43, a table mate to R3 was observed to verbally encourage R3 to eat her meal. R3 did not respond and did not follow the cues of R43. At 6:40 p.m. nursing assistant (NA)-D wheeled R3 out of the dining room. R3 was not encouraged to eat her meal or assisted by the staff prior to being assisted out of the dining room. R22's POC did not address needed assistance with dining. R22's diagnoses included status post stroke with left sided paralysis and muscle weakness. R22's quarterly MDS dated 8/10/13, indicated R22 had severe cognitive impairment and was able to feed herself after the meal tray was set up. R22's POC dated 11/2/13, indicated R22 was able to feed herself after set up and directed staff to assist with meals as she allowed. The POC did not specifically direct the staff to assist R22 with the meals, nor did it address R22's habit of	F 280	Care plans will be revised as Resident condition changes. Care plans are reviewed on a quarterly basis and any significant change. Policy was developed on the updating and revision of care plans. Nursing staff were educated on updating care plans and documentation of care plans. Clinical nursing staff were educated on providing the services indicated in the care plan. Residents are reassessed as required by rule and at least annually or more frequently as needs are identified. The DON/designee will audit care plans and care sheets on a weekly basis for one month, monthly basis for six months and then on a quarterly basis. Deviations will be acted on as discovered. Deviations will be reported to the Quality Committee.		

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F 280	Continued From page 26 pocketing food after meals. On 11/5/13, at 6:15 p.m. R22 was observed in the dining room with her meal placed in front of her. R22 was observed to take a few bites of the meal and was observed to pocket some of the food in her right cheek. Other than the few bites, R22 was not observed to eat anymore food. At 6:24 p.m. R37 was observed to wheel him/herself next to R22 and verbally encourage her to eat the meal. R22 did not respond to R37's encouragement. R22's right cheek remained distended due to pocketing of the food. At 6:36 p.m. nursing assistant (NA)-C was observed to remove R22 away from the meal table and out of the dining room. NA-C was not observed to encourage R22 to eat the meal. R22's right cheek remained distended due to the pocketing of the food as she left the dining room. On 11/5/13, at 8:05 p.m. NA-C stated R22 frequently pocketed food during meals. She also stated in the evening it was not uncommon to find food in R22's mouth when her dentures were removed during bedtimes cares. On 11/6/13, at 12:35 p.m. registered nurse (RN)-A stated R3 and R22 were usually independent with eating but occasionally required assistance. She confirmed the POC's did not reflect their occasional need for assistance assistance to eat and stated the POCs needed some revision. On 11/7/13, at 11:53 a.m. the director of nursing (DON) confirmed the POC's had not been revised to indicated a need for assistance with dining or	F 280			

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F 280	Continued From page 27 that R22 occasionally pocketed food after meals. She confirmed the POC's were in need of revision. A policy regarding revision of the care plans was requested, but not provided. R25's POC of was not revised to include a current ambulation restorative program. R25's diagnosis included a stroke with left side weakness. R25's quarterly MDS dated 10/8/13, indicated R25 had moderate cognitive impairment and required minimal staff assistance to ambulate in his room. The MDS also indicated R25 had not ambulated in the hallways / corridors of the facility. R25's POC care did not identify R25's restorative ambulation program. The Restorative Services recommendation form dated 7/19/13, indicated R25 was to receive restorative program services which included stand by assistance, contact guard assistance at a minimum depending on the day and R25's ability. The form also indicated R25's ambulation distance varied from day to day. The form indicated R25's restorative services include weekly-Biodex seated elliptical for 10 minutes three times a week. The restorative program was also to include upper and lower extremity exercises to maintain strength to ambulate independently. On 11/6/13, at 9:13 am. NA-A stated R25 participated in rehab three times a week which included stationary bike and active range of	F 280			

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F 280	Continued From page 28 motion exercises to both extremities. NA-A also stated R25 performed well with the program. On 11/7/13, at 10:45 a.m. The DON verified R25's POC did not include R25's involvement in restorative nursing program and should have. Policies were requested related to restorative nursing and care planning and were not provided.	F 280			
F 282 SS=E	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 provide services in accordance with the resident's written plan of care for 2 of 3 residents (R8, R12) who required assistance with repositioning, for 2 of 2 residents (R14, R12) in the sample who required assistance with toileting and for 1 of 2 residents	F 282	F 282 Residents R8 and R12 were reassessed for turning, reposition and Residents R14 and R12 were assess for toileting and incontinence care. R2 was assessed for ROM. The residents are turned, repositioned and toileted according to the assessment. The Care Plans were reviewed and updated according to the findings. Restorative cares are provided to R2 as directed by the care plan.	12/17/13	

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F 282	Continued From page 29 (R2) who require assistance with range of motion. Findings include: R8 was not repositioned every hour as directed by the POC. R8's POC dated 6/8/13, indicated R8 was at risk for pressure ulcers and directed staff to reposition R8 every hour when in the wheelchair or easy chair. On 11/6/13, was continually observed seated in a wheelchair from 6:38 a.m. until 10:00 a.m. R8 was not observed to receive assistance with reposition. (a total of three hours and 22 minutes). The nursing assistants Assignment work sheet indicated R8 was to be repositioned every one to one and half hours when sitting. On 11/6/13, at 6:28 a.m. Nursing assistant(NA)-B was observed to transfer R8 from bed and into the wheelchair via a mechanical standing lift. R8's skin on the buttocks was observed to be clear and intact. After cares NA-B was observed to assist R8 into the dining room. At 7:10 a.m. a family member was observed to assist R8 to her room for approximately 10 minutes and returned R8 to the dining room. R8 was observed to remain in the dining room until 9:15 a.m. at which time the activity staff person assisted R8 into the day room. At 10:00 a.m. NA-B was observed to assist R8 via a standing lift into the bathroom and onto the toilet. R8's buttocks was observed to have a six inch, round, purplish area. At 8:20 a.m. At 10:50 a.m. NA-B confirmed R8 was to be repositioned every hour to hour and half as her	F 282	The Restorative forms were located and put into the documentation book during the survey. An audit was performed for residents who need assistance with turning, repositioning, incontinence care and ROM. Care plans have been updated to reflect the current plan of care. Staff has been educated on providing cares as per the Care Plan. The DON/designee will audit care and the documentation of care to assure follow through of care plans. Results will be reported to the Quality Committee.		

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F 282	Continued From page 30 work assignment sheet directed. NA-B verified R8 was not repositioned for 3 hours and 22 minutes. On 11/7/13, at 3:15 p.m. registered nurse (RN)-A verified R8's POC was not followed as it directed staff to reposition R8 every one to one and a half hours. R14 did not receive timely assistance with incontinence cares on the evening of 11/5/13, or the morning of 11/6/13, as directed by the POC. R14's POC dated 10/24/13, directed staff to assist R14 with incontinence cares every two hours. On 11/5/13, at 4:40 p.m. R14 NA-C was observed to assist R14 via wheelchair from her room into the living room. R14 was observed to remain in the living room until 5:25 at which time she was wheeled into the dining room. At 6:40 p.m. R14 was observed to be assisted from the dining room back into the living room. At 7:45 p.m. R14 was wheeled to her room. At 7:55 p.m. NA-C and NA-D was observed to transfer R14 from the wheelchair into bed with a full body mechanical lift. R14's incontinent brief was observed wet. On 11/5/13, at 8:00 p.m. NA-C verified R14 had last been assisted with incontinence cares at 4:40 p.m. a total of 3 hours and 10 minutes earlier. On 11/6/13, at 7:45 a.m. NA-B and NA-F was observed providing R14 morning cares which included incontinence cares.	F 282			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 282	Continued From page 31 At 7:50 a.m. NA-B and NA-F was observed to transfer R14 from the bed to the wheelchair via a fully body mechanical lift. R14 was then wheeled from her room to the dining room. At 9:20 a.m. R14 was observed to be assisted from the dining room into the living room. R14 remained in the living room until 10:20 a.m. at which time she was assisted into the activity room for Bingo. At 10:38 a.m. NA-B was observed to assist R14 into to her room. At 10:44 a.m. NA-B and NA-F was observed to transfer R14 into bed. R14's incontinent brief was observed wet. At 10:50 a.m. NA-B confirmed R14 had not been assisted with incontinence cares since 7:50 a.m. when assisted out of bed, a total of 3 hours and 5 minutes earlier. A-B verified R14 was to receive assistance with incontinence cares every two hours as directed by the POC On 11/6/13, at 12:00 p.m. RN-A confirmed R14 was to receive assistance with incontinence cares every two hours as directed by the POC. R12 did not receive timely assistance with repositioning on the evening of 11/5/13. Additionally, R12 did not receive timely assistance with incontinence cares and repositioning the morning of 11/6/13. R12's POC dated 9/14/13, directed staff to assist R12 with incontinence cares every two hours and repositioning every 2.5 hours. On 11/5/13, at 4:21 p.m. R12 was observed in the activity room seated in her wheelchair.	F 282			

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F 282	Continued From page 32 At 5:22 p.m. NA-C was observed to assist R12 into the dining room. At 6:15 p.m. R12 received the evening meal. At 6:50 p.m. R12 was observed to be assisted from the dining room into the living room area. At 7:00 p.m. NA-D was observed to wheel R12 to her room. At 7:17 p.m. NA-C and NA-D was observed to transfer R12 wheelchair into bed via a full body mechanical lift. R12's skin was observed clear and intact. R12 was observed to be continent. At 7:30 p.m. NA-C stated R12 was assisted out of bed at 3:45 p.m. a total of 3.5 hours earlier. On 11/6/13, at 7:16 a.m. R12 was observed seated in her wheelchair and assist from her room to the dining room. At 8:20 a.m. R12 received assistance with her breakfast meal. At 9:10 a.m. R12 was wheeled into the living room. At 10:00 a.m. NA-B was observed to assist R12 into the bathroom. R12's incontinent brief was observed wet. At 10:06 a.m. NA-B confirmed R12 was to receive assistance with repositioning every 2.5 hours and incontinence cares every two hours. NA-B confirmed R12 had not received assistance since 7:15 a.m. a total of 2 hours and 45 minutes earlier. On 11/6/13, at 12:10 p.m. RN-A confirmed R12 should have received assistance with repositioning and incontinence as directed by the POC.	F 282			

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F 282	Continued From page 33 R2 did not receive range of motion (ROM) services as directed by the individual POC. R2's diagnoses included a traumatic brain injury and anxiety. R2's POC directed staff to provide passive ROM two-three times per week per the restorative rehab services program. The Restorative Services monthly documentation sheets indicated the following: -October 2013: ROM Services were provide 4 times -November 2013: No forms were available in the medical record or the restorative nursing book for review. On 11/6/13, at 9:10 a.m. NA-A verified the NA staff were to provided ROM services for R2, however, stated she had not provided those services. She added, the evening shift do that. On 11/7/13, at 8:51 a.m. The DON verified R2 had not received ROM services as directed by the POC. Policy's were requested for Restorative Nursing and Range of Motion and none were provided. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 282			
F 311 SS=b					

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F 311	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary treatment and services to improve and maintain the resident's ability to ambulate for 1 of 2 residents (R26) in the sample who were on an ambulation program and for 2 of 2 (R22 and R3) who did not receive assistance with meals. Findings include: R26 was not provided restorative nursing for ambulation as recommended. R26's quarterly Minimum Data Set (MDS) dated 10/8/13, indicated R26 was diagnosed with a stroke with left sided weakness. The MDS also indicated R26 had moderate cognitive impairment and required minimal staff assistance to ambulate in his room. The MDS also indicated R26 had not ambulated in the hallways / corridors of the facility. R26's POC dated 10/19/13, indicated R26 was at risk for falling related to weakness and impaired balance. The POC directed staff to give R26 verbal reminders not to ambulate without assistance. The POC did not identify an ambulation program. The Restorative Services recommendation form dated 7/19/13, indicated R26 was to receive stand by assistance and minimum contact guard assistance for ambulation with a front wheeled walker at least 50 feet. The form also indicated R26's ambulation distance varied. The recommended restorative program included a	F 311	The ambulation program for Resident R25 has been assessed and the restorative program and care plan has been revised and needed. R25 is being ambulated per the program in place at this time. R25 was seen by the physician on 12/10/13 and noted that decline in strength and coordination may be due to neuropathy. In addition to the current restorative program, R25 is currently receiving therapy services for strengthening. Therapy will modify the current ambulation program as needed after completion of their therapy. The need of Residents R22 and R3 are assessed for assistance with meals. R3 is able to feed self and prefers to do this. She does have 1-2 meals/day that she is less interested in eating. The care plan of 7/23/13 includes a goal for the resident to "continue to feed herself". R3 will choose not to eat at some meals, especially if she is in pain. R3 is assessed for pain prior to a meal. When staff notes that R3 is choosing not to eat, they inquire as to why and notify the nurse if intervention is needed. Her weight is monitored three times per week due to her cardiac diagnosis and she has a recent history of weight gain that has required the discontinuance of her extra calories. Meal consumption is documented at each meal. The care plan for R3 has been updated to include staff encouragement/assessment of why R3 is noted to be eating.	12/17/13	

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F 311	Continued From page 36 Blodex seated elliptical machine for ten minutes and active assist range of motion exercises three times a week. R26's goal was to maintain strength for independent ambulation. Review of R26's monthly Restorative Services documentation forms revealed the following: -September 2013, documentation form could not be found. -October 2013, indicated R26 received assistance with ambulation for a total of 20 feet on 10/7/13. The rest of the monthly form was blank. -November 2013, documentation form could not be found. On 11/6/13, at 6:25 a.m. R26 was observed seated in the wheelchair independently propelling self into the dining room. When asked if he received assistance with ambulation, R26 stated he primarily used the wheelchair for mobility. R26 was observed to stay seated in the wheelchair until 10:15 a.m. when the DON wheeled him into the activity area. R26 was not observed to ambulate. On 11/6/13, at 9:13 a.m. nursing assistant (NA)-A for rehab verified R26 was to receive restorative rehab services three times a week. NA-A stated R26 rode a stationary bike and completed range of motion exercises to all extremities. NA-A also stated the nursing staff was responsible to assist R26 with ambulation. On 11/6/13, at 9:30 a.m. NA-B stated R26 had become too hard to transfer and ambulate so it "just doesn't get done." NA-B also stated she was supposed to report R26's difficulty with ambulation to the rehab aide and verified she had	F 311	Resident R22 is independent in eating her meal and will not accept assistance with her meal. She has been observed by the ST, RD, and nursing staff to stop eating as soon as you get close to her or look at her. She has a history of 2 poor meals per day. Breakfast is her best meal. Her weight has been stable for over a year. Pocketing of food by R22 has been assessed and the care plan has been reviewed and revised to include assistance with eating. R22 is checked after each meal for pocketing of food and oral cares are provided. Seating changes in the dining room enable staff to observe Residents who are not eating and offer encouragement. Resident weights are monitored monthly by the RD and discussed with the RN and care team. Weights are taken more often as needed. The protocol for weight monitoring was updated. The protocol for recording intakes was updated to include notifying the RN of residents that are not eating. Resident intakes are discussed at the morning team meeting with the RD or dietary manager as needed. The restorative documentation was located and put into the documentation book during the survey.		

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F 311	Continued From page 36 not. On 11/7/13, at 9:48 a.m. NA-E stated she had never assisted R25 with ambulation in the hall rather only a few feet into R25's bathroom. On 11/7/13, at 10:45 a.m. the DON verified R25's medical record lacked restorative documentation for September and November 2013. In addition, the DON verified R25 had not received ambulation assistance as recommended and stated staff was expected to document when and why a resident did not ambulate. The DON verified R25's medical record also lacked documentation as to why R25 had not received ambulation assistance. On 11/7/13, at 10:58 a.m. the DON, NA-B and NA-E were observed to assist R25 with ambulation for a total of 60 feet. On 11/7/13, at 11:08 a.m. NA-A stated staff had never reported to her R25 was having trouble ambulating. R22 and R3 did not receive assistance during meals as needed. R3's diagnoses included status post stroke with left sided paralysis, aphasia and depressive disorder. R3's admission MDS dated 7/24/13, indicated R3 had severe cognitive impairment and was independent in feeding herself. R3's POC dated 11/6/13, indicated R3 was able to feed herself. The POC did not indicate R3 required assistance with meals. Review of R3's dietary intake report indicated R3	F 311	Clinical nursing staff have been educated regarding restorative, feeding toileting, positioning and ROM programs and the need to provide and document the cares provided. RN's are to review restorative care documentation on a weekly basis. The DON is to be notified if treatment/documentation is not occurring. Residents are reassessed at least annually, quarterly as indicated by rule and more frequently as needs are identified. The DON/designee will review restorative documentation daily for one week, weekly times three weeks, monthly times two months and quarterly ongoing. DON/designee will be conduct audits to monitor assistance with feeding/cares. Audits will be conducted weekly times 4, monthly times 3, and then quarterly. Deviations will be reported to the Quality Committee on a quarterly basis.		

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F 311	Continued From page 37 ate between 0% to 100% of meals with no pattern noted and R3's weight was stable. R3's clinical record lacked documentation related to poor meal intake. R22's diagnoses included status post stroke with left sided paralysis, depression and muscle weakness. R22's quarterly MDS dated 8/10/13, indicated R22 had severe cognitive impairment and was able to feed herself after the meal tray was set up. R22's POC dated 11/2/13, indicated R22 was able to feed herself after set up and directed staff to assist with meals as she allowed. The POC did not specifically direct the staff to assist R22 with the meals, nor did it address R22's habit of pocketing food in her cheeks. Review of R22's dietary intake report indicated R22 ate between 0% to 100% of meals with no specific pattern noted and R22's weight was stable. The clinical record lacked documentation related to poor meal intake. On 11/5/13, at 5:30 p.m. R22 and R3 were observed sitting in the dining room waiting for supper. A dietary staff member was observed to serve both residents Jello with whipped cream. Neither of the residents attempted to feed themselves the Jello. At 6:00 p.m. the dietary staff member was observed to serve R22 and R3 their evening meals. R22 received pureed pot roast, mashed potatoes and vegetable. R3 received regular textured pot roast and potatoes. Neither resident attempted to feed themselves the meal. At 6:10 p.m. NA-C and NA-D were observed to sit	F 311			

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F 311	Continued From page 38 at a table in another area with totally dependent residents and assisted them with their meals. At no time were the NA's observed to enter the main dining room and encourage or assist the other residents eating in there. R22 and R3 were observed to sit with their meals in front of them. At 6:24 p.m. R37 wheeled next to R22 and encouraged her to eat the meal. R22 did not respond to R37 as he wheeled out of the dining room. R22 was observed to have the right side of her face distended as food pocketed into the side of her cheek. At 6:30 p.m. R43, a table mate to R3 encouraged R3 to eat her meal. R3 did not respond and did not follow the cues of R43. At 6:36 p.m. NA-C wheeled R22 out of the dining room. NA-C was not observed to encourage R22 to eat any of her meal. She continued to have the right side of the cheek distended as she left the dining room. At 6:40 p.m. NA-D wheeled R3 out of the dining room. R3 was not encouraged to eat her meal. At 8:05 p.m. NA- D and NA-C stated they were the only staff members assigned to assist the residents in the dining room. They stated by the time they assisted the three residents who were totally dependent upon staff for eating, they had to start answering lights and assist other residents to bed. They indicated they did not have time to assist residents who may be having a bad day and were unable to feed themselves. They confirmed R3 and R22 had not eaten their meals or been offered assistance to complete the meals. NA-D also confirmed R22 frequently had	F 311			

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F 311	Continued From page 39 food pocketed in her mouth after meals. She stated the only oral cares provided for R22 was during morning and evening cares. She confirmed R22 may hold food in her cheek for several hours after a meal. On 11/6/13, at 8:17 a.m. R22 was observed sitting in the dining room eating applesauce. R22's right side of her cheek was observed to be distended with food. R22 was observed to wipe her mouth as apple sauce dripped from it. At 8:51 a.m. R22 was assisted out of the dining room. At no time were the staff observed to encourage R22 to remove the food which was pocketed in the side of her mouth. At 9:50 a.m. R22 was observed in the living room. At this time, NA-B was observed to check R22's for pocketed food. NA-B confirmed R22 continued to have breakfast food pocketed in the side of her mouth. NA-B verified R22 frequently pocketed food after meals and stated staff did not monitor R22 for the pocketed food after the mealtime. On 11/6/13, at 12:35 p.m. RN-A stated R3 and R22 were usually independent with eating. She stated on any given day they may need assistance and they were to receive assistance if needed. She stated if any resident was in need they were to receive staff assistance with their meals. In addition, RN-A stated if staff noticed a resident pocketing food after a meal, oral cares should be completed to prevent the resident from choking on the food. On 11/7/13, at 11:53 a.m. the DON stated all	F 311			

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F 311	Continued From page 40	F 311		12/17/13	
F 314 SS=D	residents who require assistance with meals should be given assistance. The DON stated she was unaware R22 was pocketing food after meals. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents identified at risk for pressure ulcers received assistance with repositioning to minimize the development of pressure related ulcers for 2 of 3 residents (R8, R12) in the sample identified at risk for pressure ulcers. Findings include: R8 was at risk for pressure related ulcers and the facility failed to provide reposition assistance on 11/6/13, as directed by the plan of care (POC). R8's quarterly Minimum Data Set (MDS) dated 9/3/13, indicated R8 was cognitively intact and required extensive assistance from two staff to transfer and was non ambulatory. The MDS also	F 314 HRLC does base its care on the comprehensive assessment of each resident working to assure that a resident that enters the facility without pressure ulcers does not develop pressure sores unless the individual's clinical condition demonstrates it is unavoidable. Resident R8 was reassessed for risk for skin breakdown and pressure ulcers. The Care plan and care sheet was revised as necessary. Other residents at risk of pressure ulcers have been reviewed and reassessed. Care plans and care sheets have been reviewed and revised as necessary. Nursing staff have been educated regarding the program for preventing pressure sore. Clinical Nursing staff have been instructed to follow the plan of care. Residents are reassessed at least annually, quarterly as indicated by rule and more frequently as needs are identified. DON/designee will be conduct audits to monitor the frequency of repositioning. Audits will conducted weekly times 4, monthly times 3, and then quarterly. Results will be acted on at the time of the audit. Deviations will be reported to the Quality Committee			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	CONSTRUCTION C O M P L E T E D B WING		(X3) DATE SURVEY 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 41 Indicated R8 was at risk for pressure ulcers. R8's Tissue Tolerance (a test to determine length of time skin can tolerate pressure without change) assessment form dated 3/3/13, indicated R8's skin could tolerate pressure for two and a half hours without changes. R8's Braden Scale Assessment(a tool to help to evaluate the risk of getting a pressure ulcer) dated 3/7/13, Indicated R8 was at moderate risk to develop pressure ulcers. R8's POC dated 6/8/13, Indicated R8 was at risk for pressure ulcers and directed staff to reposition R8 every one hour while in the wheelchair or recliner. The undated Nursing Assistant Assignment worksheet directed staff to reposition R8 every one to one and half hours when in the wheelchair or easy chair. On 11/6/13, at 6:28 a.m. nursing assistant(NA - B was observed to transfer R8 from the bed into the wheelchair. R8's buttocks were observed to be clear and intact. Upon completion of cares, NA-B was observed to assist R8 into the dining room for breakfast. At 7:10 a.m. a family member was observed to assist R8 to her room for approximately ten minutes and returned R8 to the dining room. R8 was observed to remain in the dining room until 9:15 a.m. when the activity staff person assisted R8 into the day room. At 10:00 a.m. NA-B was observed to assist R8 to the bathroom. R8's buttocks was observed intact with an approximate six inch, round, purple area.	F 314			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428		(X2) TYPE OF DEFICIENCY A. BUILDING _____ B. WING _____ C. CONSTRUCTION _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 314	Continued From page 42 On 11/6/13, at 10:50 a.m. NA-B confirmed R8 was last repositioned at 6:28 a.m. a total of three hours and 22 minutes earlier. NA-B stated R8 was to be assisted with repositioning every hour to every hour and a half. On 11/7/13, at 3:15 p.m. registered nurse (RN)-A verified R8's POC was not followed as directed. R12 did not receive timely assistance with repositioning on the evening of 11/5/13, or the R12's diagnoses included congestive heart failure and dementia. R12's significant change MDS dated 8/28/13, indicated R12 had severe cognitive impairment and required total assistance with all activities of daily living. The MDS also indicated R12 was at risk for the development of pressure related ulcers. R12's Pressure Ulcer Care Area Assessment (CM) dated 9/1/13, indicated R12 was at risk for the development of pressure ulcers and directed staff to reposition R12 according to R12's POC. R12's Tissue Tolerance Assessment dated 7/16/12, indicated R12 required staff assistance with repositioning every 2.5 hours while in bed or in a chair. R12's Braden Scale for Prediction of Pressure Sore Risk dated 8/28/13, indicated R12 was at moderate risk for the development of pressure ulcers. R12's POC dated 9/14/13, directed staff to assist R12 with repositioning every 2.5 hours.	F 314				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ ALF A BLDG B WING		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11510TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 314	Continued From page 43 On 11/5/13, at 4:21 p.m. R12 was observed in the activity room, seated in her wheelchair. At 5:22 p.m. NA-C was observed to wheel R12 into the dining room. At 6:15 p.m. R12 was observed to receive her supper meal. At 6:50 p.m. R12 was observed to be wheeled from the dining room into the living room area. At 7:00 p.m. NA-D was observed to wheel R12 to her room. At 7:17 p.m. NA-C and NA-D were observed to transfer R12 from the wheelchair into bed via a full body mechanical lift. R12's wheelchair was observed to be equipped with a pressure redistribution cushion. R12's skin was observed to be pink and free of pressure related ulcers. At 7:30 p.m. NA-C verified R12 was assisted out of bed at 3:45 p.m. a total of 3.5 hours earlier. She confirmed R12 was to be repositioned every 2.5 hours as the POC directed and was not. On 11/6/13, at 7:16 a.m. R12 was observed to be wheeled from her room into the dining room. At 8:20 a.m. R12 was observed to receive assistance with her breakfast meal. At 9:10 a.m. R12 was observed to be assisted into the living room. At 10:00 a.m. NA-B was observed to assist R12 into the bathroom via mechanical standing lift. R12's wheelchair was observed equipped with a gel pressure redistribution cushion and her skin was observed to be pink and free of pressure ulcers. At 10:05 am. NA-B confirmed R12 was to receive assistance with repositioning every 2.5 hours and was not. She confirmed R12 had not	F 314			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 44 received assistance since 7:15 a.m. a total of 2 hours and 45 minutes earlier.				
F 315 SS=D	On 11/6/13, at 12:10 p.m. RN-A confirmed R12 was to receive assistance with repositioning every 2:5 hours as the POC directed. 483.25(d) NO CATHETER, PREVENT UTI, Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R14, R12, R2) in the sample who required assistance with toileting received timely assistance with toileting based on their individual comprehensive assessment. Findings Include: R14 did not receive timely assistance with incontinence cares on the evening of 11/5/13, or the morning of 11/6/13. R14's diagnoses included schizophrenia and depression. R14's significant change Minimum		F 315 Residents R14, R12, and R2 have been reassessed for assistance with toileting and the care plan has been updated based on their individual needs as identified. The care sheet has been updated. Residents R14, R12, and R2 are toileted as indicated by the needs assessment and care plan. An audit of residents needing assistance with toileting has been conducted. Care plans and care sheets have been updated to reflect the current plan of care. Residents are toileted as determined by the need assessment and resident request. DON/designee will conduct audits to monitor the frequency of toileting. Audits will be conducted weekly times 4, monthly times 3 and then quarterly. Deviations will be reported to the Quality Committee on a quarterly basis.	12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	WING CONSTRUCTION A BLDG B WING		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 315	Continued From page 45. Data Set (MDS) dated 10/16/13, indicated R14 had severe cognitive impairment, was totally incontinent of bowel and bladder and required total staff assistance for all activities of daily living. R14's Urinary Incontinence Care Area Assessment (CAA) dated 10/18/13, indicated R14 was totally incontinent and directed staff to assist with incontinence cares every two hours. R14's plan of care (POC) dated 10/24/13, directed staff to assist with incontinence cares every two hours. On 11/5/13, at 4:40 p.m. nursing assistant (NA)-C was observed to wheel R14 from her room to the living room. R14 was observed to remain in the living room until 5:25 p.m. at which time she was wheeled into the dining room. At 6:40 p.m. R14 was assisted from the dining room back to the living room. At 7:45 p.m. R14 was wheeled to her room. At 7:55 p.m. NA-C and NA-D were observed to transfer R14 from her wheelchair into bed via a full body mechanical lift. R14's incontinent brief was observed wet. On 11/5/13, at 8:00 p.m. NA-C confirmed R14 had last been assisted with incontinence cares at 4:40 p.m. a total of 3 hours and 10 minutes earlier. On 11/6/13, at 7:45 a.m. R14 NA-B and NA-F were observed providing R14 morning cares which included incontinence cares. At 7:50 a.m. NA-B and NA-F were observed to transfer R14 from the bed to the wheelchair via a full body mechanical lift. R14 was then assisted from her room the dining room. At 9:20 a.m. R14 was wheeled from the dining				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11510th AVENUE NORTHEAST DEER RIVER, MN 56636			
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F 315	Continued From page 46 room into the living room area, R14 was observed to remain in the living room until 10:20 a.m. at which time she was assisted to the activity room for Bingo. At 10:38 a.m. NA-B was observed to assist R14 to her room. At 10:44 a.m. NA-B and NA-F were observed to transfer R14 into bed. R14's incontinent brief was observed wet. At 10:50 a.m. NA-B confirmed R14 had not been assisted with incontinence cares since being assisted out of bed at 7:50 a.m. a total of 3 hours and 5 minutes earlier. She confirmed R14 was to receive assistance with incontinence cares every two hours. On 11/6/13, at 12:00 p.m. registered nurse (RN)-A confirmed R14 was to receive assistance with incontinence cares every two hours according to her assessed need and as directed by R14's POC. R12 did not receive timely assistance with incontinence cares on the morning of 11/6/13. R12's diagnoses included congestive heart failure and dementia. The significant change MDS dated 8/28/13, indicated R12 had severe cognitive impairment, was totally incontinent of bowel and bladder and required total staff assistance with all activities of daily living. R12's Urinary Incontinence CAA dated 8/28/13, directed staff to assist R12 with incontinence cares every two hours.					

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 315	Continued From page 47 R12's POC dated 9/14/13, directed staff to assist R12 with incontinence cares every two hours. On 11/6/13, at 7:16 am. R12 was observed to be wheeled from her room to the dining room. At 8:20 a.m. R12 received assistance with her breakfast meal. At 9:10 a.m. R12 was wheeled into the living room. At 10:00 a.m. NA-B was observed to assist R12 into the bathroom using a mechanical standing lift. R12's incontinent brief was observed wet with urine. At 10:05 a.m. NA-B confirmed R12 was to receive assistance with incontinence cares every 2 hours. She also confirmed R12 had not received assistance since 7:15 a.m. a total of 2 hours and 45 minutes earlier. On 11/6/13, at 12:10 p.m. RN-A confirmed R12 was to receive assistance with incontinence cares every 2.5 hours as assessed and as directed by R12's POC. R2 did not have an individual comprehensive bowel and bladder assessment completed in order to determine a bowel and bladder pattern. R2's quarterly MDS dated 9/19/13, indicated R2 had diagnoses of cerebral palsy and traumatic brain injury. The MDS also indicated R2 had severe cognitive impairment, was totally dependent upon staff for toileting and was always incontinent of urine. R2's Urinary incontinence CAA dated 6/21/13, indicated R2 had urinary and bowel incontinence.					

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
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F 315	Continued From page 48 The Observation report dated 6/23/13, indicated R2 was severely impaired, always incontinent, was totally dependent on two staff physical assist for toileting needs. R2's medical record lacked a current individual bowel and bladder assessment. R2's FOC dated 9/13, indicated R2 had an alteration in elimination related to bowel and bladder incontinency. The POC directed two staff three hours and as needed. On 11/6/13, from 6:11 a.m. until 10:40 a.m. R2 was continually observed. During this time R2 was not observed to receive incontinence care. At 10:40 a.m. NA-F was observed to provide incontinence cares. R2's incontinent brief was observed wet. At this time, NA-F verified R2 last received incontinence cares at 6:00 a.m. (total of four hours and 29 minutes) earlier. NA-F stated R2 was usually incontinent when cares were provided. On 11/7/13, at 3:00 p.m. RN-A verified R2 did not have a comprehensive bowel and bladder assessment completed and should have. RN-A stated she would complete an assessment now in order to determine R2's toileting pattern and timing of care needs. A policy for bowel and bladder and toileting was requested, none were provided.						
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) FULLY A. BUILDING B. WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
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F 318	Continued From page 49 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. This REQUIREMENT is not met as evidenced: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services according to the assessed need to prevent further decrease in ROM abilities for 1 of 2 (R2) residents in the sample reviewed who had limitations in ROM. Findings include: R2's annual Minimum Data Set (MDS) dated 6/21/13, indicated R2's diagnoses included a traumatic brain injury (TBI) and anxiety. The MDS also indicated R2 had severe cognitive impairment and required extensive assist of two staff for mobility. The MDS also indicated R2 had right sided functional limitation in ROM ability of the upper and lower extremities. The Restorative Services Recommendation form dated 3/12/12, indicated R2 was to receive passive ROM to bilateral upper extremity exercises two to three times a week or more frequently if R2 declined to participate in order to reach this required frequency. The form also directed staff to provide the service in the evening as R2 was more acceptable to the exercises during that time of the day. R2's plan of care (POC) dated 6/23/13, indicated	F 318	HRLC does ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion, and to prevent further decrease in range of motion. Resident R2 was reassessed and the care plan updated accordingly. R2's ROM is being provided according to the care plan and need assessment. The documentation form for restorative cares was found while the survey team was present and cares are being provided as identified in the plan of care. Residents with limited ROM have been reassessed and the care plans updated. Clinical nursing staff have been educated and instructed to follow the plan of care. The policy has been reviewed and updated. Residents are reassessed at least annually, quarterly as indicated by rule and more frequently as needs are identified. The DON/designee will conduct audits to monitor the frequency of ROM. Audits will be conducted weekly times 4, monthly times 3, and then quarterly. Deviations will be addressed at the time they are discovered and will be reported to the Quality Committee on a quarterly basis.		12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 318	Continued From page 50 R2 had an alteration in mobility and directed staff to provide ROM restorative nursing services to decrease stiffness and prevent contractures. The POC directed staff to see R2's restorative program and data flow sheets for further direction. The Functional Status-Mobility, ROM and falls form dated 9/15/13, indicated R2 had one sided upper and lower extremity functional limitation impairment. The form also indicated R2 had a TBI which caused severe cognitive impairment, impaired ability to move voluntarily or with purpose and was dependent on all staff for activities of daily living. The Essentia Behavioral Conditions form dated 9/15/13, indicated R2 rarely was rarely understood or understood others. The form also indicated R2 currently received restorative nursing to maintain ROM ability and to prevent further decline of contractures. Review of the R2's monthly Restorative Services documentation form revealed the following: -September 2013, indicated R2 received restorative services twice weekly. -October 2013, indicated R2 was provided restorative services four times this month. -November 2013, documentation form was unable to be located. On 11/6/13, at 7:45 a.m. NA-B was observed to provide R2 morning cares. When assisted to dress R2 was observed to move all extremities and hands without pain or discomfort. On 11/6/13, at 9:10 a.m. nursing assistant (NA)-A	F 318			

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F 318	Continued From page 51 (rehab) verified she had not provided ROM exercises for R2. NA-A stated nursing was responsible to provide R2's restorative services. NA-A further stated physical or occupational therapy makes the residents restorative program recommendations and she was responsible to inform the residents nurse so that the resident could receive those services. On 11/6/13, at 9:31 a.m. NA-B stated the evening shift was responsible to provide R2's restorative ROM exercises. On 11/7/13, at 8:51 a.m. the director of nursing (DON) reviewed R2's restorative documentation forms and verified R2 had not received the ROM services as directed. The DON stated she was unaware R2 had not received the ROM services and did not know why the required documentation was not completed to indicate why the services were not provided. The DON again verified R2 had not received restorative ROM services as directed by the POC. A Restorative nursing and ROM policy and procedures were requested and not provided.					
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353	F 353 Care is provided in a timely manner to current residents. Everyone answers call lights, all nursing staff toilet, feed, and ambulate patients. The PPD for the month of November was 2.83. Teamwork is emphasized, staff asks for assistance from a coworker when help is needed.		12/17/13	

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F 353	Continued From page 52 care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff were available to meet resident needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 29 residents residing in the facility. Findings include: The facility failed to provide assistance in dining in a dignified manner for 3 of 3 totally dependent residents (R14, R12, R27). In addition, the facility failed to ensure residents received personal care assistance in a dignified manner for 1 of 1 resident (R26) had requested assistance. See F241. The facility failed to provide services in accordance with the resident's written plan of care for 2 of 3 residents (R8, R12) who required assistance with repositioning, for 2 of 2 residents	F 353	There has been one discharge since 11/7/13 and there have been no new admits since 11/7/13. The current census is 28. Admissions are scrutinized for level of care. The facility has continued to seek qualified applicants. Two new staff started on 11/11/13. Three new employees are scheduled for orientation on 12/23/13. Recruitment continues to look at new ways of drawing in staff. A plan exists for when staff call-in. The DON checks weekly with Human Resources to check for new applicants. The DON reports monthly to Administration on staffing status. The DON reports quarterly to the Quality Committee on the status of open staff positions.			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) ☒ ALLE A BLDG B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE DEER RIVER, MN 56636 NORTHEAST			
(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 353	Continued From page 53 (R14, R12) in the sample who required assistance with toileting; for 1 of 2 residents (R2) who require assistance with range of motion. See F282. The facility failed to provide the necessary treatment and services to improve and maintain the resident's abilities to ambulate for 1 of 2 residents (R25) in the sample who were on an ambulation program and for 2 of 2 residents (R22 and R3) who did not receive needed assistance with meals. See F311. The facility failed to ensure residents identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 2 of 3 residents (R8, R12) in the sample identified at risk for pressure ulcers. See F314. The facility failed to ensure 3 of 3 residents (R14, R12, R2) in the sample who required assistance with toileting received timely assistance with toileting based on their individual comprehensive assessment. See F315. The facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for 1 of 2 residents (R2) in the See F318. On 11/5/13, at 7:45 p.m. the director of nursing (DON) stated the facility's normal staffing pattern was as follows: The day shift consisted of three nursing assistants (NA) assigned to provide resident care					

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115117TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 353	Continued From page 54 from 6:00 a.m. to 2:30 p.m. One NA assigned to restorative nursing from 7:00 a.m. to 3:30 p.m., a licensed nurse working from 6:00 a.m. to 2:30 p.m. and one to two registered nurses (RN) working from 8:00 a.m. to 4:30 p.m. The afternoon consisted of two NAs working from 2:15 p.m. to 10:45 p.m., one NA working from 3:00 p.m. to 9:00 p.m. and one licensed nurse working from 2:15 p.m. to 10:45 p.m. The night shift consisted of two NA's with one working from 10:30 p.m. to 7:00 am, and the other NA working from 11:30 p.m. to 8:00 am, and one licensed nurse working from 10:00 p.m. to 6:30 a.m. In addition, the DON stated she had met with the nursing staff and due to the inability to find staff to hire, the day shift and the evening shifts were working with only two NA's each shift to provide patient care. The staffing report for August 2013, identified 31 days of which 23 days were without shortage and 8 days (8/9, 8/10, 8/17, 8/18, 8/23, 8/24, 8/25, and 8/30) nursing staff had shortages of one to two staff members. In September 2013, the facility had 18 days without shortages and 13 days (9/1, 9/4, 9/5, 9/9, 9/14, 9/15, 9/16, 9/17, 9/19, 9/20, 9/22, 9/25, and 9/29) in which the nursing staff was short one to two nursing assistants. In October 2013, the facility was fully staffed on 5 days (10/1, 10/3, 10/5, 10/19 and 10/20) and had experienced nursing shortages on the other 26 days of one to two NAs. The				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11510TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 353	Continued From page 55 November report indicated the facility had experienced nursing shortages 7 out of 7 days. On 11/4/13, at 4:33 p.m. R30, an alert and oriented resident, stated the facility was short of nursing staff. He indicated he occasionally had to wait greater than 15 minutes before the staff members were able to answer his call light. On 11/4/13, at 5:00 p.m. R26, an alert and oriented resident, stated it was difficult to get assistance an hour before or after meals. She explained the nursing staff were assisting with dining and they unable to assist with cares during this time. On 11/4/13, at 5:48 p.m. R8, an alert and oriented resident, stated she had experienced incontinence episodes because of having to wait for assistance to the rest room. On 11/4/13, at 7:40 p.m. NA-H stated the facility had been working with only 2 NAs in the evening for some time and she did not feel there was enough staff to ensure the residents were getting enough help. She explained that while the two NAs were assisting in the dining room, they did not have time to answer the lights and keep track of when the residents needed assistance with toileting or repositioning. On 11/5/13, at 7:30 p.m. NA-C and NA-D stated the facility had been working without a 3:00 p.m. to 9:00 p.m. NA for quite a while. They explained that the corporate office staff had been to the facility to evaluate the staffing issues and had promised assistance but at this time, they were to continue to work with only 2 NAs. They stated						

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 71510TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 353	Continued From page 56 the nurses assisted with cares, but they frequently did not have the time to assist with resident cares. On 11/5/13, at 8:06 p.m. licensed practical nurse (LPN)-D stated the facility did not have enough She stated the residents were not getting enough help in the dining room and the staff were getting t i r e d On 11/6/13, at 6:18 a.m. LPN-A stated the facility had been working short for the past few months. She stated the night staff assist the day shift by providing morning cares to the residents. She also stated the night staff start providing morning cares around 5:00 a.m. to ensure they would be able to leave the facility on time when their work shift ended. On 11/6/13, at 6:44 a.m. NA-K stated the night staff assisted all of the residents residing on the east wing before they left the facility. She also stated she was not aware of any of the residents be up and dressed before the night staff could leave in the morning. On 11/6/13, at 6:55 a.m. housekeeper-A stated that facility was usually short of nursing staff. She stated she was aware some of the resident call lights would be on "longer than they should." She explained she could answer lights and assist with basic needs, but was not able to provide care to the residents. She explained on many days, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428		(X2) LIFE CONSTRUCTION A BLDG: _____ B WING: _____		(X3) DATE SURVEY COMPLETED 11/07/2013	
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 353	Continued From page 57 staff would be mandated to work an additional shift. When this happened, the staff were crabby and the residents picked up on their moods. On 11/6/14, at 9:40 a.m. NA-B stated the staffing concern had been bad in the past but could not recall them being this short staffed. She explained the hiring process is now extended with the new corporate policies, but corporate employees had been to the facility in an attempt to assist with the hiring process. She stated staff attempted to keep up with resident cares and were doing the best they could possibly do. On 11/6/13, at 12:30 p.m. RN-A verified the facility had been working with 2 NAs for the past few months. She stated while at the facility, she attempted to assist with resident care, but that could have caused some of the RN duties to "slip" a bit. On 11/6/13, at 12:50 p.m. the DON stated corporate staff had been in the facility to assist with recruiting. She also stated the facility had completed a job fair, placed advertisements in the local papers and had offered assistance with completing the online application process. The DON confirmed she was aware the staff were working with one to two NAs short 24 hour period, however, she had not completed any type of audits to ensure the resident cares were being completed timely. She explained the facility had also implemented a screening process for new residents and planned to admit only residents she thought the facility would be able to care for. The DON stated the facility had turned away several						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246428	WING CONSTRUCTION A BUILDING B WING		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 353	Continued From page 58 residents but confirmed they had admitted a new resident on 11/8/13. On 11/7/13, at 8:35 a.m. the administrator confirmed he was aware of the nursing shortages. He explained the facility was doing all that they could with the current staff and would be implementing incentive bonuses for new hires and longevity bonuses. He had also been in contact with a local college in an attempt to have a nursing assistant class to offer training for future staff members. He was unaware the facility staff were having difficulty providing cares to the current residents.				
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F 431 HRLC has a licensed consulting pharmacist who establishes a system of record of receipt and disposition of controlled drugs. Drugs and biologicals are labeled in accordance with accepted principles. Fentanyl patches are being destroyed by two nurses according to Federal policy by being flushed down the toilet. Destruction is documented by licensed staff. Insulin pens are being stored appropriately in the medication cart. Medications are not left unattended.	12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) LIFELINE A BLDG _____ B WING _____		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 431	Continued From page 59 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches were disposed of in accordance with federal DEA (Drug Enforcement Agency) regulations for 2 of 2 residents (R14, R15) who were prescribed Fentanyl patches. In addition, the facility failed to ensure Insulin pens were stored in a safe manner for 1 of 1 resident (R6) currently utilizing Insulin pens. Findings include: During observation of the medication storage room with licensed practical nurse (LPN)-B on 11/7/13, at 2:53 p.m., the disposed Fentanyl (a narcotic pain medication) patches were noted to be in an approximately 1 gallon covered white plastic container. The container was easily opened, and several discarded Fentanyl patches were observed. LPN-A verified the facility disposed of the Fentanyl patches in this bucket (which she called the black box), which in turn	F 431	The white bucket has been replaced and the lid cannot be removed without damaging the bucket. The Policy for Fentanyl patches has been reviewed and revised. Nursing staff (LPNs and RNs) were educated on proper disposal of controlled substances and storage of medications. The DON/designee will observe/review documentation of medication destruction on a weekly basis times four, monthly times three, and quarterly times three. Deviations will be reported to the Quality Committee.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	(X2) TYPE OF DEFICIENCY A. BUILDING _____ B. WING _____ C. SUITE _____ D. ROOM _____ E. OTHER _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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F 431	Continued From page 60 was given to maintenance to dispose of when it was full. On 11/7/13, at 3:45 p.m. the director of nursing (DON) was interviewed and verified the facility was disposing of Fentanyl patches in the black box. The DON stated the consultant pharmacist had told her how to properly dispose of Fentanyl patches, but she had forgotten. The facility policy and procedure on disposal of Fentanyl patch, revised 2/13, directed the facility to fold the Fentanyl patch in half, or place a tissue paper on the adhesive side, and flush the patch down the toilet in the presence of a licensed nurse and a witness. The policy further directed the use of a medication waste hauler to be disposed of is not an option due to federal DEA regulations. The facility failed to ensure R6's Insulin was stored appropriately. On 11/4/13, at 4:15 p.m. an insulin pen was observed sitting on the nurses desk next to a computer with a prescription label on it for R6. No nursing staff were observed in the area. Survey staff continuously observed the pen. At 5:30 p.m. the director of nursing (DON) was observed to pick up the insulin pen move it about 3 inches away from the computer and proceeded to work on the computer. At no time was the DON observed to place the Insulin pen in a safe or secure area. At 6:48 p.m. (2.5 hours later) the survey staff picked up the insulin pen and brought it to registered nurse (RN)-B. RN-B confirmed the insulin pen was new and it was to be kept in a secure location. RN-B then brought the pen to				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 115 DEER RIVER, MN 56636
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F 431	Continued From page 61 licensed practical nurse (LPN)-B. LPN-B stated she had forgotten the pen at the desk. LPN-B confirmed the pen was to be stored in a safe secure area like the medication room or the secured medication cart. On 11/6/13, at 12:30 p.m. RN-A stated all medications were to be kept locked in either the medication room or the medication cart when not being used by the nursing staff. The Medication Storage policy dated 10/2012, directed staff to store medications safely, securely and properly following manufacture's recommendations. The policy also indicated only licensed nursing personnel, pharmacy personal and staff member lawfully authorized to administer medications was to have access to the medications.			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program-designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections,	F 441	HRLC has an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Residents identified as having infections or placed on antibiotics are reported to the DON. Residents identified as needing isolation are isolated according to CDC guidelines. A log is kept of all infections and to established trends. The facility has assessed its community risk for tuberculosis. The facility is not in an area of high incidence of tuberculosis per the Minnesota Tuberculosis Quarterly Surveillance Report.	12/17/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	QUALITY A BUILDING B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
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F 441	Continued From page 62 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: , Based on interview and document review, the facility's infection control program lacked a surveillance program which included information related to employee infections, tracking and trending analysis related to employee infections and failed to ensure a tubercle bacillus (TB) community risk assessment was completed. This had the potential to affect all 28 residents who resided in the facility. Findings include: On 11/07/13, at 9:45 a.m. the director of nursing (DON) was interviewed regarding the infection control program and on going surveillance for the	F 441	New residents have a two-step mantoux administered per standing order to screen for Tuberculosis. Employee Health interviews and immunizes new employees before they have contact with a resident. A policy and procedure was developed for employees and volunteers to report infections and illnesses. The DON will track and trend employee and visitor illnesses. Employees with infectious diseases are not allowed to have direct contact with residents or their food. Reportable diseases will be reported to the proper authorities. Hand washing stations are provided. The DON will track and analyze infectious disease in employees. The DON will consult with corporate Infection Control for procedures to be implemented when trends are identified. The Annual Risk Assessment of Mycobacterium Tuberculosis has been completed and the risk for the facility is low. The DON/designee will monitor and track infectious diseases. Disease reports will be shared with the Quality Committee on a quarterly basis.			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 DE 10TH AVENUE NORTHEAST ER RIVER, MN 56636		
(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)		(X6) COMPLETION DATE
F 441	Continued From page 63 facility's employee's and volunteers. When asked if they had policies or procedures to identify or track infections of employees or volunteers the DON stated the facility did not have a system to track staff or volunteers. The DON also stated up until last spring, the facility had a program to identify employee's infections as well as for tracking and trending them. The DON stated she had recently found out that this was her responsibility was not being done. In addition, the DON stated she plans to write a policy on tracking and identifying employee's infections. The facility failed to ensure a tubercle bacillus (TB) Community Risk Assessment was completed according to facility policy. The facility's policy titled Tuberculosis (TB) Prevention & Control Policy and Procedure, dated 9/2013, indicated the Infection Preventionist nurse was responsible to provide ongoing measures to prevent and control the transmission of Mycobacterium Tuberculosis. The Policy further indicated the Annual Risk Assessment would include facility specific surveillance and community data provided by the state/local public health department. On 11/21/13, at 10:15 a.m. the DON verified she had not completed the facility Annual Risk Assessment as directed by the facility policy. The DON also verified she was the facility Infection control nurse and stated she had never completed an annual risk assessment. The facility failed to ensure a tubercle bacillus (TB) Community Risk Assessment was completed according to facility policy. The facility's policy titled Tuberculosis (TB)				

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHE AS DEER RIVER, MN 56636 T		
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F 441	Continued From page 64 Prevention & Control Policy and Procedure, dated 9/2013, indicated the Infection Preventionist nurse was responsible to provide ongoing measures to prevent and control the transmission of Mycobacterium Tuberculosis. The Policy further indicated the Annual Risk Assessment would include facility specific surveillance and community data provided by the state/local public health department. On 11/21/13, at 10:15 a.m. the DON verified she had not completed the facility Annual Risk Assessment as directed by the facility policy. The DON also verified she was the facility infection control nurse and stated she had never completed an annual risk assessment.				
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was maintained in a safe and comfortable manner including the main kitchen walls and floors, refrigerator floors and resident rooms. This practice had the potential to affect all 29 residents residing in the facility. Findings Include: On 11/7/13, at 9:13 a.m. during the environmental tour of the kitchen with the dietary manager (DM)		F 465 No negative consequences were identified in the citation. The kitchen was assessed by corporate environmental staff and the architect on 12/10/13. Project plan is in development and proposed plans are enclosed with the POC. Kitchen correction is undetermined at the time of the POC being submitted. Project plans include this being completed by April 2014. The resident room concerns have been repaired.	12/17/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428	☒ MULTIPLE CONSTRUCTION A BLDG _____ B WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 465	Continued From page 65 the following concerns were identified: Kitchen: -By the food service serving window and prep table a 36 inch (in.) X 3.0 in. wide crack filled with black debris was observed in the floor tile. The tile flooring in the door way going into the dry food storage area was also observed to have numerous cracks. At the time of the observation, the DM verified the findings and stated the floors with cracks were not cleanable surfaces. - - The wall area behind the food prep sink was observed with peeling paint and paint chips. - - The wall area behind the toaster and food processor counter has chipped paint areas. -The wall behind the food steamer was observed chipped and with gray debris on it. The floor tile just under the steamer was observed missing approximately two feet wide by two and half feet deep exposing rough cement. At the time of the observation, the DM confirmed the dimensions. -Black debris was observed on the floor under and going to the drain the food steamer is connected to. The DM stated she had not noticed the black debris before and was not sure what it was. -The pipes from the food steamer were observed exposed and rusted with debris on them. -The wall molding behind the food steamer and under the sink counter to left of food steamer was observed pulled away from the wall. The DM verified the areas were not cleanable surfaces. Dishwashing room:- - A three by eight inch hole was observed in the dishwashing area wall, left of the sink.	F 465	Staff have been instructed to notify maintenance of environmental conditions needing repair. Environmental audits will be conducted in resident rooms monthly times four, then quarterly. Deviations will be reported to the Quality Committee.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245428		(X2) MULTIPLE A. BUILDING B. WING		CONSTRUCTION		(X3) DATE SURVEY COMPLETED 11/07/2013	
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11610TH AVENUE NORTHEAST DEER RIVER, MN 56636					
(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)			(X6) COMPLETION DATE	
F 465	Continued From page 66 -floor tiles were observed missing with exposed crumbling cement, pipes in the all area were also observed exposed. -The wall at the end of the dishwasher was observed with a three foot long and 2.0 in. inch wide scrape with a hole that measured 2.0 in: X 2.0 in. just below the light switch. -The wall behind the dishwasher was observed to have missing tiles. -The corner wall next to the dishwasher was observed to have missing tiles with crumbling cement exposed. -White scale / lime build up was observed on the back and outer edges of the dishwasher. The DM stated the facility had some one who cleaned the dishwasher. -The walls in the dishwashing area were observed with black scuff marks on them. The DM verified the areas was in need of repair and that the paint on the walls was not the correct paint for the area and was difficult to clean. Walk in cooler: -The metal floor in the walk in cooler was observed to have a five feet by five feet rusted, non smooth and uncleanable surface. The Deer River Healthcare policy and procedure titled: Maintenance Service, effective date June 2004, indicated the facility would be maintained in good repair and free from hazards. The policy titled Food Preparation areas dated December 2005, indicated all floors, walls and ceilings in the food preparation and storage areas were washable and floors had a non-slip finish. On 11/7/13, at 9:40 a.m. the DM verified the			F 465					

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
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F 465	Continued From page 67 findings and stated the lack of maintenance and cleaning could of had the potential to cause food borne illnesses. The DM stated she had previously reported these areas concerns to the administrator. On 11/7/13, at 9:30 a.m. during the environmental tour with the environmental services director (ED), the following was observed: R25's wall had an approximately 4 foot (ft) by 6 inch (in) paint scrape on the wall, and the entire radiator was full of scrape marks. R14's bathroom wall had an approximately 1 ft by 6 in paint scrape, and the entire radiator was full of scrape marks. R26's bathroom wall had two gouges, approximately 2 ft by 2 in. R7's wall had an approximately 4 ft by 6 in scrape. R2's bathroom wall had an approximately 1 ft by 6 in scrape. At the time of the tour, the ED verified the findings, and stated the facility did do preventative			F 465			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 DE 10TH AVENUE NORTHEAST ER RIVER, MN 56636			
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F 465	Continued From page 68 radiators and also caused the gouges on R26's bathroom walls.	F 465				



Addendum to Plan of Correction for Essentia Health Homestead

As per the telephone conversation on 1/13/14 the following changes will be made to the 2567:

F242 (page 13)

Resident preference interviews were conducted for all residents. Preferences were noted in the care plan. Care plans were updated as needed.

F280(page 25)

The ambulation program for Resident R25 has been assessed and the restorative program and care plan has been revised and needed. R25 is being ambulated per the program in place at this time. R25 was seen by the physician on 12/10/13 and he noted that decline in strength and coordination may be due to neuropathy. In addition to the current restorative program, R25 is currently receiving therapy services for strengthening. Therapy will modify the current ambulation program as needed after completion of their therapy.

The following statement will be removed from page 25 in the first paragraph "When R3 is choosing not to eat."

F314(page 41)

The opening sentence of the last paragraph will be revised to: The DON/designee will conduct observational audits to monitor the frequency of repositioning.

F315 (page 45)

The opening sentence of the last paragraph(page will be revised to: The DON/designee will conduct observational audits to monitor the frequency of toileting.

F318 (page 51)

The plan of correction is written on page 50. A pdf of Page 51 has been attached to this document due to formatting concerns with the page in the document previously submitted.

F353(page 53)

Add

The DON/designee conducts observational audits for answering call lights, positioning, and toileting. Audits will be conducted weekly times 4, monthly times 3 and then quarterly. Deviations will be reported to the Quality Committee on a quarterly basis.

F441(page 63)

Change the second sentence to read: Employee Health screens new employees before they have contact with a resident.

*Reviewed & approved 1/14/14
JB*

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
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K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Homestead Rehabilitation and Living Center 01 Main Building was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok 12-13-14 RECEIVED DEC 26 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Homestead Rehabilitation and Living Center is a 1-story building without a basement that is attached to a hospital. The building was constructed in 2 major stages. The original building was constructed in 1973, was determined to be of Type II(111) construction. In 1990 an addition to the north of the building was constructed and was determined to be of a Type II(111) construction. The hospital is separated from the nursing home building with two hour fire barriers and was not inspected at this time. The building is divided into 2 smoke zones. The building is completely sprinkler protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads, except as noted in K56. The facility has a fire alarm system with smoke detection throughout the corridor system, in spaces open to the corridors and in all sleeping	K 000			

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K 000	Continued From page 2 rooms that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition) The facility has a capacity of 32 beds and had a census of 29 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings the facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and test of the exit doors, it was determined that one exit access door is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.2.1.6. This deficient practice could negatively affect all 32 of the 32 residents , any staff and any visitors of the facility by slowing their egress if they need to exit form the north wing.	K 038	K 038 Facilities Staff replaced faulty delayed egress lock on exit access door. Quarterly door checks will begin December 2013. Replaced label on North wing exit door.		11/8/13

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K 038	Continued From page 3 Findings include: Observations during the facility tour on November 7, 2013 between 10:00 am and 11:30 am, by surveyor 03006, revealed that the North Wing cross corridor exit access doors are locked against egress. The Director of Maintenance indicated that the locking system was a 15 second delayed egress system. When tested, the locked did not go into alarm nor did it release after 15 seconds as required. The labeling of the door has also been altered and no longer indicates the door will release after 15 seconds. The Director of Maintenance verified these findings during the facility tour and at the exit conference.	K 038			