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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RCZ0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00413

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245502**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BRIDGES CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**

6. DATE OF SURVEY 02/04/2014 (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman. Unit Supervisor — 2/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 3/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 03/26/2014 CO. RCZ0

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/15/2014
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 27, 2014, the facility is certified for 49 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 10, 2014

Mr.. Tyler Hoemberg, Administrator
Bridges Care Community
201 9th Street West
Ada, MN 56510

RE: Project Number S5502024

Dear Mr.. Hoemberg:

On January 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2013, effective January 27, 2014 and therefore remedies outlined in our letter to you dated January 14, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman /lbz

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245502

March 18, 2014

Mr. Tyler Hoemberg, Administrator
Bridges Care Community
201 9th Street West
Ada, Minnesota 56510

Dear Mr.. Hoemberg:

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

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

Effective January 27, 2014, the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Kate Johnston

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245502	A. Building B. Wing	2/4/2014

Name of Facility	Street Address, City, State, Zip Code
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

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 F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/27/2014	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 01/27/2014	ID Prefix F0367 Reg. # 483.35(e) LSC	Correction Completed 01/27/2014
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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2/10/14	Signature of Surveyor: 10562	Date: 2-10-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/19/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RCZ0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00413

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245502**
2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BRIDGES CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**

6. DATE OF SURVEY **12/19/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Aandel, HFE NE II 12/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/05/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CNN-24-5502

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7906

January 13, 2014

Mr. Tyler Hoemberg, Administrator
Bridges Care Community
201 9th Street West
Ada, Minnesota 56510

RE: Project Number S5502024

Dear Mr. Hoemberg:

On December 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
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 January 28, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 19, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a nursing rehabilitation ambulation program was provided as directed by the care plan for 1 of 1 resident (R28) reviewed. Findings include: R28's medical record Face Sheet indicated R28's diagnoses included weakness, osteoarthrosis and debility.	F 282	F282 On 1/13/14 R28 was admitted to Hospice and her restorative nursing orders including ambulation orders were discontinued. All residents on an ambulation program will be reviewed by the DON/designee and adjusted to offer a walking program 6x week. Care plans and orders will be adjusted with changes on 1/17/14. A wellness/restorative meeting will be held monthly and will include a RN and wellness/restorative staff. Residents with declines will be reviewed and referrals and changes will be made to maintain/improve residents function. DON/designed will audit residents with decline in ADLs monthly to ensure restorative programs maintain/improve residents function. The DON/Designee will pull weekly restorative log through Matrix (EHR) for compliance and follow-up with staff if concerns arise. This will be brought to Quality Council quarterly. Staff was educated on the new walking program and the importance of reporting declines to the RNs on 1/15/14. Corrective action will be completed on 1/27/14.	

Approved
1/21/14
SB

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

Administrator/CEO 1/21/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 282	Continued From page 1 R28's current care plan dated 12/14/13, indicated R28 required one staff assistance, a gait belt and a wheeled walker for ambulation. The care plan also indicated R28 ambulated with nursing rehab up to three times a week. R28's nursing documentation for ambulation revealed the following: -10/1/13-10/31/13: R28 ambulated two out of 12 opportunities. -11/1/13-11/18/13: no ambulation was documented. -11/18/13-11/29/13: R28 ambulated three times. -12/1/13-12/18/13: R28 ambulated once. On 12/18/13, at 7:00 a.m. R28 was observed seated in her wheelchair at the dinner table across from the nursing desk. At 9:30 a.m. and 11:00 a.m. R28 was observed seated in her wheelchair, at the same table, sleeping. At 2:30 p.m. R28 was observed in her own bed, sleeping. On 12/18/13, at 9:15 a.m. nursing assistant (NA)-B stated R28 did not walk. On 12/18/13, at 12:45 p.m. licensed practical nurse (LPN)-A stated R28 was very weak and did not walk a lot. In addition, LPN-A stated R28 was on a walking program, however, R28 was always so tired and had really declined in the past couple of weeks. LPN-A verified R28's ambulation documentation revealed R28 lacked ambulation services and stated R28 could not walk as directed by the care plan or refused to walk. On 12/19/13, at 8:20 a.m. NA-A stated R28 had not walked as directed by the care plan.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 282	Continued From page 2 On 12/19/13, at 8:50 a.m. registered nurse (RN)-A verified R28's nursing rehab ambulation was not provided as directed by the care plan.	F 282		
F 311 SS=D	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 re-assess and implement a current ambulation program in order to improve or maintain each resident's ability to ambulate for 1 of 1 resident (R28) reviewed for ambulation with a restorative program. Findings include: R28's medical record Face Sheet indicated R28's diagnoses included weakness, osteoarthrosis and debility. R28's annual Minimum Data Set (MDS) dated 10/18/13, indicated R28 was cognitively impaired and required extensive assist with activities of daily living (ADL's), was non-ambulatory and utilized a wheelchair. R28's quarterly MDS dated 7/19/13, indicated R28 was non-ambulatory. R28's Cognitive Loss Dementia Care Area Assessment (CAA) dated 10/24/13, indicated R28 had memory problems and confusion related to dementia. R28's Fall CAA dated 10/24/13, indicated R28 utilized a wheelchair and a wheeled walker for ambulation with the nursing rehabilitation ambulation	F 311	F311 On 1/13/14 R28 was admitted to Hospice and her restorative nursing orders including ambulation orders were discontinued. All residents on an ambulation program will be reviewed by the DON/designee and adjusted to offer a walking program 6x week. Care plans and orders will be adjusted with changes on 1/17/14. A wellness/restorative meeting will be held monthly and will include a RN and wellness/restorative staff. Residents with declines will be reviewed and referrals and changes will be made to maintain/improve residents function. DON/designed will audit residents with decline in ADLs monthly to ensure restorative programs maintain/improve residents function. The DON/Designee will pull weekly restorative log through Matrix (EHR) for compliance and follow-up with staff if concerns arise. This will be brought to Quality Council quarterly. Staff was educated on the new walking program and the importance of reporting declines to the RNs on 1/15/14. Corrective action will be completed on 1/27/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 311	Continued From page 3 program. R28's Nurse Progress Note (PN) dated 11/23/13, indicated a nursing assistant (NA) transferred R28 from a recliner into her wheelchair. The note also indicated the transfer was very difficult with R28 unable to move her feet. R28's Physical Therapy (PT) evaluation note dated 8/21/13, indicated R28 was evaluated for necessary PT treatment and it was determined R28 would receive PT for lower extremity strengthening and transfer training three times a week. The note also indicated R28 had muscle weakness, abnormal gait and nursing reported increased difficulty with transferring and increased leaning to the right while sitting. R28's PT progress note dated 9/19/13, indicated R28 ambulated 45 feet with a front wheeled walker with a second staff member pushing a wheelchair behind R28. R28's PT note dated 9/23/13, indicated R28's PT was discontinued due to R28 meeting PT goals. The note also indicated R28 would start the wellness class and participate in a nursing ambulation program. R28's current care plan dated 12/14/13, indicated R28 required one staff assist, a gait belt and wheeled walker to ambulate with the nursing rehabilitation staff up to three times a week. R28's current nursing order dated 1/22/13, indicated R28 was to ambulate three times a week and as needed (PRN) per her request for a distance she could tolerate.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 311	Continued From page 4 R28's ambulation documentation revealed the following: -10/1/13-10/31/13: R28 ambulated two out of 12 opportunities. -11/1/13-11/18/13: no ambulation was noted. -11/18/13-11/29/13: R28 ambulated three times. -12/1/13-12/18/13: R28 ambulated once. On 12/18/13, at 7:00 a.m. R28 was observed seated in her wheelchair, at the dinner table across form the nursing desk. -At 9:30 a.m. and 11:00 a.m. R28 was observed seated in her wheelchair at the same table, sleeping. - At 2:30 p.m. R28 was observed in bed sleeping. On 12/18/13, at 9:15 a.m. nursing assistant (NA)-B stated R28 did not walk. - At 12:45 p.m. licensed practical nurse (LPN)-A stated R28 was very weak and did not walk a lot. LPN-A verified R28 was on a walking program and staff staff could be walking her, however, stated R28 was always so tired and weak. Additionally, LPN-A stated R28 had declined in the past couple of weeks and now required two staff assistance to transfer and previously had only needed one staff assistance. At this same time, LPN-A verified R28's ambulation documentation and confirmed R28 was not ambulated as directed. On 12/18/13, at 2:20 p.m. LPN-A stated R28 had declined since this summer. LPN-A stated up until two to three months ago, R28 was able to walk approximately 150 feet and now was not able to	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 311	Continued From page 5 walk due to being so tired and weak. At the same time the activity director, who was in charge of the wellness program, stated on this day, R28 had walked only 15 steps. -At 2:30 p.m. the physical therapist was interviewed via telephone. The therapist verified R28 received PT from 8/22/13, until 9/23/13, for positioning and transfers strengthening. The therapist stated R28 was to be placed on a nursing rehabilitation ambulation program following the discontinuation of PT services. On 12/18/13, at 2:45 p.m. the physical therapy assistant (PTA)-A verified R28 received PT for transfers and positioning. PTA-A confirmed R28's PT was discontinued on 9/23/13, due to met goals. On 12/19/13, at 8:20 a.m. NA-A stated R28 did not walk like she used to because she was always so sleepy. - At 8:30 a.m. NA-A was observed to attempt to ambulate R28. NA-A applied a gait belt around R28's waist and attempted to stand her up. R28 was observed to be able to partially stand up. NA-A assisted R28 back into a sitting position and stated she would get another staff member to assist her. Moments later LPN-B and NA-A were observed to assist R28 to stand up. R28 stated "I am weak." R28 was observed to slowly take 15 steps and was assisted to sit down. NA-A stated that was far enough and told R28 she did a good job. On 12/19/13, at 8:50 a.m. registered nurse (RN)-A verified R28 was to walk up to three times a week, depending on her status. RN-A also verified R28's current nursing rehab order	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 311	Continued From page 6 correctly indicated R28 was to walk three times a week. In addition, RN-A confirmed R28's care plan directed staff to ambulate R28 three times a week. RN-A stated R28's nursing rehab order needed to be changed. RN-A stated she thought it had been over 3 months since she wrote a nursing rehab note regarding R28's ambulation status, and 3 months ago R28 could walk well. RN-A verified R28's ambulation care plan should be re-evaluated.	F 311		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and serve a menu corresponding with the physician ordered therapeutic diet for 1 of 1 resident (R47) reviewed with a prescribed renal diet. Findings include: R47's current Physician Order's dated 12/19/13, indicated an order for a regular with thin liquid and renal diet with diabetic fluid restriction of 1500 cubic centimeters (cm.) R47's undated diet Kardex indicated a renal diet with diabetic features and directed staff to avoid	F 367	F367 R47 was discharged from dialysis 1/13/14 and admitted to Hospice 1/13/14. R47 passed away 1/15/14. R47 is the only resident with a renal diet ordered currently no other residents with a renal diet order in our facility. We have subscribed to Menus on Demand through USFoods which includes diet extensions for the renal diet. All planned menus will include a renal diet plan by February15th, 2014. Culinary Director and/or RD, LD will monitor and audit meal service weekly to ensure residents receive therapeutic diets as ordered and report findings quarterly to Quality Council. Staff will be educated at next monthly culinary staff meeting on both the renal diet requirements and how to read the new planned menu spreadsheets.	1/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 367	Continued From page 7 lunch meat, orange juice, pudding and tomatoes. On 12/18/13, at 12:05 p.m. R47 was observed to be offered raw tomato slices prior to being served the noon meal however, R47 declined. On 12/18/13, at 12:21 p.m. the posted planned noon menu indicated the following was to be served: 4 ounces (oz.) BBQ ribs, 1/2 baked potato, 3 oz. wax beans, buttered bread, pineapple tidbits and the soup was chicken dumpling. Cook (C)-A was observed to dish up and serve R47 mashed potatoes with butter, BBQ ribs, wax beans and 1/2 slice buttered bread. On 12/18/13, at 1:53 p.m. C-A stated she was unaware of any specific dietary exchanges for a renal diet but had been told R47 could not have ham, pudding or excess fluids. C-A also stated she avoided giving R47 ham or food high in potassium such as potatoes. However, C-A confirmed R47 had just been served mashed potatoes for the noon meal. On 12/18/13, at 1:55 p.m. C-B stated the facility had pureed, mechanical soft and regular diets. C-B also stated the facility no longer served low calorie diets rather they just serve smaller portions. In addition, C-B stated the facility did not have a specific renal diet other than providing less fluids. On 12/18/13, at 2:55 p.m. the consulting registered dietitian (RD) stated one of the RD duties was to review menus/diets for nutrients and variety, however, stated she had not completed a thorough in-depth review of the facility menus within the past three years and stated the dietary manager was completing this	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 367	Continued From page 8 task. The RD confirmed the facility menus were written by the previous RD and included regular, regular with diabetic features (regular meal with 1/2 desserts), mechanical soft, ground meat, special diets as recommended by speech pathologist (done on an individual basis), and pureed diets. The RD confirmed the facility did not have a documented, planned renal diet. The RD stated the requested restricted items should have been placed on the resident's kardex and if potato was on the menu it was expected that rice or a noodle be offered in its place. In addition, The RD confirmed R47 should not have been offered tomatoes. The undated Bridges Care Community Week 3 Wednesday menu provided regular, mechanical soft, and pureed diets. A planned menu for a renal diet was lacking. The undated policy entitled Menu Standards directed "Menus for all regular and therapeutic diets, including pureed and mechanical soft diets, are planned in advance, dated, and followed as written, per state and federal regulations."	F 367		

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

F5502023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Bridges Care Community 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. Bridges Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and 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	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The facility was surveyed as two buildings, 01 Main building as existing and 02 Chapel as new construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL/ ASSISTED LIVING** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 Chapel Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Bridges Care Community 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. Bridges Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and 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	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL/ ASSISTED LIVING** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The facility was surveyed as two buildings, 01 Main building as existing and 02 Chapel as new construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7906

January 13, 2014

Mr. Tyler Hoemberg, Administrator
Bridges Care Community
201 9th Street West
Ada, Minnesota 56510

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5502024

Dear Mr. Hoemberg:

The above facility was surveyed on December 16, 2013 through December 19, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health,

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 16, 17, 18, & 19 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 2 by: Based on observation, interview and document review, the facility failed to ensure a nursing rehabilitation ambulation program was provided as directed by the care plan for 1 of 1 resident (R28) reviewed. Findings include: R28's medical record Face Sheet indicated R28's diagnoses included weakness, osteoarthrosis and debility. R28's current care plan dated 12/14/13, indicated R28 required one staff assistance, a gait belt and a wheeled walker for ambulation. The care plan also indicated R28 ambulated with nursing rehab up to three times a week. R28's nursing documentation for ambulation revealed the following: -10/1/13-10/31/13: R28 ambulated two out of 12 opportunities. -11/1/13-11/18/13: no ambulation was documented. -11/18/13-11/29/13: R28 ambulated three times. -12/1/13-12/18/13: R28 ambulated once. On 12/18/13, at 7:00 a.m. R28 was observed seated in her wheelchair at the dinner table across from the nursing desk. At 9:30 a.m. and 11:00 a.m. R28 was observed seated in her wheelchair, at the same table, sleeping. At 2:30 p.m. R28 was observed in her own bed, sleeping. On 12/18/13, at 9:15 a.m. nursing assistant (NA)-B stated R28 did not walk. On 12/18/13, at 12:45 p.m. licensed practical	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 nurse (LPN)-A stated R28 was very weak and did not walk a lot. In addition, LPN-A stated R28 was on a walking program, however, R28 was always so tired and had really declined in the past couple of weeks. LPN-A verified R28's ambulation documentation revealed R28 lacked ambulation services and stated R28 could not walk as directed by the care plan or refused to walk. On 12/19/13, at 8:20 a.m. NA-A stated R28 had not walked as directed by the care plan. On 12/19/13, at 8:50 a.m. registered nurse (RN)-A verified R28's nursing rehab ambulation was not provided as directed by the care plan. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 4 resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to re-assess and implement a current ambulation program in order to improve or maintain each resident's ability to ambulate for 1 of 1 resident (R28) reviewed for ambulation with a restorative program. Findings include: R28's medical record Face Sheet indicated R28's diagnoses included weakness, osteoarthrosis and debility. R28's annual Minimum Data Set (MDS) dated 10/18/13, indicated R28 was cognitively impaired and required extensive assist with activities of daily living (ADL's), was non-ambulatory and utilized a wheelchair. R28's quarterly MDS dated 7/19/13, indicated R28 was non-ambulatory. R28's Cognitive Loss Dementia Care Area Assessment (CAA) dated 10/24/13, indicated R28 had memory problems and confusion related to dementia. R28's Fall CAA dated 10/24/13, indicated R28 utilized a wheelchair and a wheeled walker for ambulation with the nursing rehabilitation ambulation program.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 5	2 915		

R28's Nurse Progress Note (PN) dated 11/23/13, indicated a nursing assistant (NA) transferred R28 from a recliner into her wheelchair. The note also indicated the transfer was very difficult with R28 unable to move her feet.

R28's Physical Therapy (PT) evaluation note dated 8/21/13, indicated R28 was evaluated for necessary PT treatment and it was determined R28 would receive PT for lower extremity strengthening and transfer training three times a week. The note also indicated R28 had muscle weakness, abnormal gait and nursing reported increased difficulty with transferring and increased leaning to the right while sitting.

R28's PT progress note dated 9/19/13, indicated R28 ambulated 45 feet with a front wheeled walker with a second staff member pushing a wheelchair behind R28.

R28's PT note dated 9/23/13, indicated R28's PT was discontinued due to R28 meeting PT goals. The note also indicated R28 would start the wellness class and participate in a nursing ambulation program.

R28's current care plan dated 12/14/13, indicated R28 required one staff assist, a gait belt and wheeled walker to ambulate with the nursing rehabilitation staff up to three times a week.

R28's current nursing order dated 1/22/13, indicated R28 was to ambulate three times a week and as needed (PRN) per her request for a distance she could tolerate.

R28's ambulation documentation revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 6 following: -10/1/13-10/31/13: R28 ambulated two out of 12 opportunities. -11/1/13-11/18/13: no ambulation was noted. -11/18/13-11/29/13: R28 ambulated three times. -12/1/13-12/18/13: R28 ambulated once. On 12/18/13, at 7:00 a.m. R28 was observed seated in her wheelchair, at the dinner table across form the nursing desk. -At 9:30 a.m. and 11:00 a.m. R28 was observed seated in her wheelchair at the same table, sleeping. - At 2:30 p.m. R28 was observed in bed sleeping. On 12/18/13, at 9:15 a.m. nursing assistant (NA)-B stated R28 did not walk. - At 12:45 p.m. licensed practical nurse (LPN)-A stated R28 was very weak and did not walk a lot. LPN-A verified R28 was on a walking program and staff staff could be walking her, however, stated R28 was always so tired and weak. Additionally, LPN-A stated R28 had declined in the past couple of weeks and now required two staff assistance to transfer and previously had only needed one staff assistance. At this same time, LPN-A verified R28's ambulation documentation and confirmed R28 was not ambulated as directed. On 12/18/13, at 2:20 p.m. LPN-A stated R28 had declined since this summer. LPN-A stated up until two to three months ago, R28 was able to walk approximately 150 feet and now was not able to walk due to being so tired and weak. At the same time the activity director, who was in charge of the wellness program, stated on this day, R28 had	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 7 walked only 15 steps. -At 2:30 p.m. the physical therapist was interviewed via telephone. The therapist verified R28 received PT from 8/22/13, until 9/23/13, for positioning and transfers strengthening. The therapist stated R28 was to be placed on a nursing rehabilitation ambulation program following the discontinuation of PT services. On 12/18/13, at 2:45 p.m. the physical therapy assistant (PTA)-A verified R28 received PT for transfers and positioning. PTA-A confirmed R28's PT was discontinued on 9/23/13, due to met goals. On 12/19/13, at 8:20 a.m. NA-A stated R28 did not walk like she used to because she was always so sleepy. - At 8:30 a.m. NA-A was observed to attempt to ambulate R28. NA-A applied a gait belt around R28's waist and attempted to stand her up. R28 was observed to be able to partially stand up. NA-A assisted R28 back into a sitting position and stated she would get another staff member to assist her. Moments later LPN-B and NA-A were observed to assist R28 to stand up. R28 stated "I am weak." R28 was observed to slowly take 15 steps and was assisted to sit down. NA-A stated that was far enough and told R28 she did a good job. On 12/19/13, at 8:50 a.m. registered nurse (RN)-A verified R28 was to walk up to three times a week, depending on her status. RN-A also verified R28's current nursing rehab order correctly indicated R28 was to walk three times a week. In addition, RN-A confirmed R28's care plan directed staff to ambulate R28 three times a week. RN-A stated R28's nursing rehab order	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 8 needed to be changed. RN-A stated she thought it had been over 3 months since she wrote a nursing rehab note regarding R28's ambulation status, and 3 months ago R28 could walk well. RN-A verified R28's ambulation care plan should be re-evaluated. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		