DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			ND TRANSMITTAL E SURVEY AGENCY	ID: SSSG				
MEDICARE/MEDICAID PROVIDER NO (L1) 245125 STATE VENDOR OR MEDICAID NO. (L2) 112847700 S. EFFECTIVE DATE CHANGE OF OWN).	 NAME AND ADI (L3) FITZGERAL (L4) 227 MCKINI (L5) EVELETH, N 7. PROVIDER/SUF 	DRESS OF FACILIT L D NH AND REH L EY AVENUE MN PPLIER CATEGORY	ГҮ IAB Y	(L6) 55734	Facility ID: 00588 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		
(L9) 02/26/ 6. DATE OF SURVEY 02/26/ 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 24 	24 (L18)24 (L17)19 SNF	B. Not in Com	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director		
24 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS See Attached Remarks	(L39) S (IF APPLICABLE S	(L42) HOW LTC CANCELL	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE <u>Teri Ament, HFE NE</u>	II	Date :	03/04/2014	(L19)	18. STATE SURVEY AGENCY APPROVAL Date: (L20)			
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partial 2. Facility is not Eligible		20. COM	D BY HCFA RE PLIANCE WITH C ITS ACT:			ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE OF PARTICIPATION 05/15/1967 (L24)	23. LTC AGREEMI BEGINNING I (L41)	DATE	4. LTC AGREEME ENDING DATH (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>O(</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	nt 06-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVI A. Suspension of B. Rescind Susp 	of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (02/25/2014	OF APPROVAL DAT	ГЕ (L33)	DETERMINATION APPRO	VAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SSSG

	PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00588
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

CCN: 24-5125

On February 21, 2014, this Department notified the facility of a change in Scope and Severity (S/S) of health deficiency cited at F465, which was reduced from a S/S level of F to a S/S level of E.

On February 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify correction of deficiencies reissued at the time of the December 27, 2013 PCR where three deficiencies were reissued and one new deficiency was cited. The February 26, 2014 PCR determined correction of the deficiencies as of February 7, 2014. As a result of the change in S/S level of deciency cited at F465 and the February 26, 2014 PCR, this Department discontinued the category 1 remedy of State monitoring, effective February 7, 2014. In addition, we recommended the following to the CMS RO for imposition:

Per day civil money penalty, effective October 30, 2013, be rescinded due to the reduction in S/S for deficiency cited at F465. (42 CFR 488.430 through 488.444)
 Mandatory denial of payment for new Medicare and Medicaid admissions effective January30, 2014 be discontinued effective February 7, 2014. (42 CFR 488.417 (b))

Since Mandatory denial of payment for new Medicare and Medicaid admissions went into effect, the facility would be subject to a loss of NATCEP for a two year period, effective January 30, 2014. Refer to the CMS 2567b for health only.

Effective February 7, 2014; the facility is certified for 24 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5125

March 4, 2014

Ms. Patricia Banks, Administrator Fitzgerald Nursing Home and Rehabilitation 227 McKinley Avenue Eveleth, Minnesota 55734

Dear Ms. Banks:

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 7, 2014 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 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.

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

Sincerely,

Mark Meeth

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

cc: Licensing and Certification File General Information: (651) 201-5000 * TDD/TTY: (651) 201-5797 * Minnesota Relay Service: (800) 627-3529 * www.health.state.mn.us For directions to any of the MDH locations, call (651) 201-5000 * An Equal Opportunity Employer



Protecting, Maintaining and Improving the Health of Minnesotans

March 4, 2014

Ms. Patricia Banks, Administrator Fitzgerald Nursing and Rehabilitation 227 McKinley Avenue Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement actions, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On January 20, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 23, 2013. (42 CFR 488.422)

On January 20, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

• Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective February 8, 2014. (42 CFR 488.417 (b))

Also, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 8, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on October 30, 2013 and lack of substantial compliance at the Post Certification Revisit (PCR) completed on December 27, 2013. The most serious deficiencies were found 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 21, 2014, this Department notified you of the change in Scope and Severity (S/S) level of deficiency cited at F465 from S/S level F (widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy) to the reduced S/S level of E (a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was

Fitzgerald Nursing and Rehabilitation March 4, 2014 Page 2 not immediate jeopardy).

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 December 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 27, 2013, effective February 7, 2014. As a result of the revisit findings and the reduction in S/S of deficiency cited at F465, this department discontinued the Category 1 remedy of State monitoring, effective February 7, 2014.

In addition, this Department recommended the following to the CMS Region V Office, CMS has concurred and authorized this Department to notify you of the recommendations:

• Per day civil money penalty, effective October 30, 2013, be rescinded due to the reduction in S/S for deficiency cited at F465. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective February 8, 2014 be rescinded, effective February 7, 2014. (42 CFR 488.417 (b))

As we notified you in our letter of November 18, 2013, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 8, 2014. Since the primary trigger of denial of payment did not go into effect, the NATCEP prohibition is also 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 Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

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 245125	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/26/2014		
Name	of Facility		Street Address, City, State, Zip Code			
FITZGERALD NH AND REHAB			227 MCKINLEY AVENUE			
			EVELETH, MN 55734			

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	ſ	Y5) [Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0282	02/07/2014	ID Prefix	F0311	02/07/2014	ID Prefix	F0318		02/07/2014
Reg. #	483.20(k)(3)(ii)		Reg. #	483.25(a)(2)		Reg. #	483.25(e)(2)		
LSC			LSC			LSC			-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0441	02/07/2014	ID Prefix		-	ID Prefix			_
-	483.65		Reg. #			Reg. #			_
LSC			LSC			LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
					-				_
Reg. # LSC			Reg. #			Reg. #			_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		•	ID Prefix			ID Prefix			
Reg. #			Reg. #						
LSC						LSC			-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			_
LSC			LSC			LSC			_
	1								
Reviewed By	Reviewe	ed By	Date:	Signature of Surve	yor:			Date:	
State Agency	, MN	I/PH	03/04/201	4 29	9433			02/2	26/2014
Reviewed By	Reviewe	ed By	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to Survey Completed on:				Check for any Uncorrected Deficiencies. Was a Summary of					
	10/30/2013					(CMS-2567) Sent	-	YES	NO
			1						-

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			ND TRANSMITTAL E SURVEY AGENCY	ID: SSSG Facility ID: 00588			
MEDICARE/MEDICAID PROVIDER NO (L1) 245125 STATE VENDOR OR MEDICAID NO. (L2) 112847700 S. EFFECTIVE DATE CHANGE OF OWN	 NAME AND ADI (L3) FITZGERALI (L4) 227 MCKINI (L5) EVELETH, N PROVIDER/SUF 	DRESS OF FACILIT L D NH AND REH L EY AVENUE MN PPLIER CATEGORY	TY IAB	(L6) 55734	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		
(L9) 6. DATE OF SURVEY 12/27/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2013 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
 IILTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	24 (L18)24 (L17)	X B. Not in Com	ce With equirements		And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 24 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
 16. STATE SURVEY AGENCY REMARK See Attached Remarks 17. SURVEYOR SIGNATURE 	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY AF	PPROVAL Date:	
Teresa Ament, HFE N			02/03/2014 D BY HCFA RE	(L19)	OFFICE OR SINGLE STAT	(L20) TE AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partition 2. Facility is not Eligible 	cipate (L21)		IPLIANCE WITH CI ITS ACT:	IVIL		cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 05/15/1967 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVIA. Suspension ofB. Rescind Susp	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE:	(L28)	INTERMEDIARY/C 03001	(L45) ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (02/25/2014	OF APPROVAL DAT	TE (L33)	DETERMINATION APPRC		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SSSG

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS		PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00588
	C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

CCN: 24-5125

On December 27, 2013 the Department of Health complete a Post Certification Revisit (PCR) and on December 9, 2013 the Department of Public Safety completed a PCR to determine correction of deficience issued at the time of the standard survey completed on October 30, 2013. Based on our PCR we have determined the life safety code deficiencies were corrected, but three health deficiencies were reissued and one new health deficiency was citeded. The most serious deficiencies were found 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.

As a result of the PCR findings, the Category 1 remedy of State monitoring, effective November 23, 2013 will remain in effect. In addition, we recommended the following to the CMS RO for imposition:

-CMP per day, effective October 30, 2013

-Mandatory Denial of Payment for New Admissions (DOPNA), effective January 30, 2014

If Mandatory DOPNA goes into effect, the facility would be subject to a two year loss of NATCEP, effective January 30, 2014.

Refer to the CMS 2567 along with the facilities plan of correction and CMS 2567b. Post Certification Revisit to follow..



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7002 0860 0006 5192 3919

January 20, 2014

Ms. Patricia Banks, Administrator Fitzgerald Nursing Home and Rehabilitation 227 McKinley Avenue Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement actions, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On November 18, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 23, 2013. (42 CFR 488.422)

On November 18, 2013 this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office that the following enforcement remedy be imposed:

• Per day civil money penalty effective Ocotber 30, 2013 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 30, 2013. The most serious deficiencies were found 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 December 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 9, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on October 30, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the health deficiencies issued pursuant to our standard survey completed on, October 30, 2013 and PCR completed December 27, 2013. The health deficiencies not corrected are as follows:

> F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency:

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

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of January 20, 2013:

• Per day civil money penalty effective October 30, 2013 would remain in effect. (42 CFR 488.430 through 488.444)

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, This Department is recommending to the CMS Region V Office following additional remedy for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions, effective 15 days after receipt of this notice. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor Minnesota Department of Health 11 East Superior Street, Suite #290 Duluth, Minnesota 55802

Phone: (218) 302-6151 Fax: (218) 723-2359

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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. 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 and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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

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 April 30, 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,

Mart meath

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

5125r1_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 245125	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/27/2013
Name of Facility		Street Address, City, State, Zip Code	
FITZGERALD NH AND REHAB		227 MCKINLEY AVENUE EVELETH, MN 55734	

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	()	(5) Da	te	(Y4)	Item		(Y5)	Date	(Y4)	ltem	(Y5)	Date
		Correc	tion					Correction					Correction
		Compl						Completed					Completed
ID Prefix	F0157	12/13/2	2013		ID Prefix	F0274		12/13/2013		ID Prefix	F0279		12/13/2013
•	483.10(b)(11)					483.20(b)(2)(ii)				-	483.20(d), 483.2	0(k)(1)	
LSC					LSC					LSC			
		Correc	tion					Correction					Correction
ID Prefix	E0309	Compl 12/13/2			ID Prefix	E0329		Completed 12/13/2013		ID Prefix	E0/65		Completed 12/13/2013
								12/13/2013					12/13/2013
Reg. # LSC	483.25				Reg. # LSC	483.25(I)				Reg. # LSC	483.70(h)		
					L3C					L30			
		Correc	tion					Correction					Correction
		Compl						Completed					Completed
ID Prefix		Comp	cicu		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC					LSC								
		Correc	tion					Correction					Correction
		Compl	eted					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC		_			LSC					LSC			
		Correc						Correction					Correction
ID Prefix		Compl	eted		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
		_											
Reviewed By	Reviewe	d By		Da	te:	Signature of	Surve	yor:	1			Date:	
State Agency	и ММ	/PH		01	/16/20	14	20	9433				12	/27/2013
Reviewed By				Da		Signature of						Date:	
CMS RO													
Followup to Survey Completed on:					Check for any Uncorrected Deficiencies. Was a Summary of				I				
	10/30/2013						-				to the Facility?	YES	NO

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 245125	(Y2) Multiple Constru A. Building B. Wing	(Y3) Date of Revisit 12/9/2013		
Name	of Facility		Street Address, City, State, Zip Code		
FIT	ZGERALD NH AND REHAB		227 MCKINLEY AVENUE		
			EVELETH, MN 55734		

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) Iten	า	(Y5)	Date	(Y4)	ltem	(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction				Correction					Correction
	fiv		Completed 11/05/2013		ID Brofiv		Completed		ID Brofiv			Completed
	fix		11/05/2013				-					
•	.# NFPA 101 SC К0052				Reg. #		-		Reg. #			
	<u>10052</u>						-					
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Pre	fix		-		ID Prefix		-					
Reg					Reg. #		-		Reg. #			
LS	SC				LSC		-		LSC			
			Correction				Correction					Correction
			Correction Completed				Correction Completed					Correction Completed
ID Pre	fix				ID Prefix		_		ID Prefix			
Reg	. #				Reg. #				Reg. #			
LS	SC				LSC		-		LSC			
			Correction				Correction					Correction
ID Pre	fix		Completed		ID Prefix		Completed		ID Prefix			Completed
Reg	ш											
•	SC						-		LSC			
				1								
			Correction				Correction					Correction
ID Pre	fix		Completed		ID Prefix		Completed		ID Prefix			Completed
	#				D "							
Reg LS	· · · · · · · · · · · · · · · · · · ·				Reg. # LSC				Reg. # LSC			
							-					
Reviewed	Ву	Reviewed E	Зу	Dat	te:	Signature of Surve	eyor:				Date:	
State Age	ncy	MM/P	S	0	1/16/2014			()3005		12	/09/2013
Reviewed	Ву	Reviewed E	Зу	Dat	te:	Signature of Surve	eyor:				Date:	
CMS RO												
Followup	Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of					-			
	10/2	9/2013				Uncorrecte	d Deficiencie	s (CMS	6-2567) Sent to	o the Facility?	YES	NO

		AND HUMAN SERVICES				FORM	01/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC			(X3) DATE	
		245125	B. WING		FEB 0 3 2014	F 12/2	2.7/2013
NAME OF P	ROVIDER OR SUPPLIER			~	MN Dept of Health TREET ADDRESS, CIT OUSTATE, ZIP CODE	,	
FITZGER	ALD NH AND REHAE	3			27 MCKINLEY AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	rs	{F 0	000}			
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will tion of compliance.			01C 2-3-14 BLN		
	Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.						
	Census 21						
{F 282} SS=D	483.20(k)(3)(ii) SE	acility is a Special Focus Facility (SFF) 0(k)(3)(ii) SERVICES BY QUALIFIED ONS/PER CARE PLAN ervices provided or arranged by the facility be provided by qualified persons in dance with each resident's written plan of			· ·		
	must be provided						
	by:	NT is not met as evidenced					
	Based on observation, interview and document review, the facility failed to provide range of motion services as directed by the plan of care for 3 of 3 residents (R20, R31, R25) reviewed for range of motion services.						
	Findings include:						
	R20 was not prov	ided range of motion services					
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SI	SNATURE		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.

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

F282

- 1. It is the intent of this facility to provide care to our Residents by qualified persons in accordance to the care plan. Resident R20, R31 and R25 care plans have been re-evaluated.
- 2. All care plans have been reviewed and updated when necessary.
- 3. Practices for assessment and communication of assessment results have been revised when appropriate.
- 4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will be completed once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: February 7, 2014.

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

PRINTED: 01/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		R
	j	245125	B. WING		12/27/2013
	PROVIDER OR SUPPLIER	1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MCKINLEY AVENUE EVELETH, MN 55734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
{F 282}	Continued From p as directed in the		{F 282}		
	osteoarthritis of th change Minimum 12/29/13, indicate memory problems cognitive skills for (rarely/never mad indicated R20 had elbow, wrist, hand lower extremity (h impairment to bot The care plan dat at risk for pain rel extremities, and c applying a right w The restorative m directed staff to p on upper extremit Place your hand the elbow toward x10 (repetitions) high as tolerated holding wrist and both wrists in a c While in bed sup knee towards che straighten leg by x10 (repetitions). both ankles x10	naintenance record and	r y g		
	x10 (repetitions) both ankles x10 The restorative nursing	Rotate ankle in circular motion (repetitions).	~		

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

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 2 of 17

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

PRINTED: 01/17/2014 FORM APPROVED OMB NO. 0938-0391

			1				E SUBVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COV	
							R
		245125	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE		27/2013
NAME OF F	PROVIDER OR SUPPLIER				27 MCKINLEY AVENUE		
FITZGER	ALD NH AND REHAI	3			VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 282}	12/24/13, 12/25/13 On 12/27/13, at 9:4 (NA)-A was intervition R20 that mornin cares. NA-A stated to R20's hands an minutes, "I didn't g	-	{F 2	82}			
	documents it as be unable to complete	eing completed, even if she is e the ROM as ordered. ded range of motion services			·	-	
	Alzheimer's disea disuse. The admis indicated R31 had	dicated diagnoses that included se and muscular atrophy ssion MDS dated 10/25/13, I short and long term memory d moderately impaired cognitive ision making.				•	
	directed staff to p on upper extremit Place your hand of the elbow towards x10 (repetitions) I high as tolerated holding wrist and both wrists in a c While in bed sup knee towards che straighten leg by x10 (repetitions).	aintenance record for 12/13 erform ROM as follows: ROM by and and lower extremity daily on elbow and bend his arm at s body and then away from bod both arms. Raise both arms as over head as he tolerates by elbow x10 (repetitions). Rotate incular motion x10 (repetitions). porting ankle and knee and brin est as high as tolerated lowering it back down to the be Rotate ankle in circular motion (repetitions). Ambulate with 2	y g d			、	

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

Event ID: SSSG12

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Facility ID: 00588

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If continuation sheet Page 3 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES					PRINTED: 0 FORMA OMB NO. 0	PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DATE SURVEY COMPLETED R	
		245125	B. WING				1	7/2013
	ROVIDER OR SUPPLIER	3		227	EET ADDRESS, CITY, ST MCKINLEY AVENUE ELETH, MN 55734	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PL (EACH CORRECTI CROSS-REFERENC	AN OF CORREC IVE ACTION SHO ED TO THE APPR FICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 282}	•	age 3 walker in hallway 15 feet in the	{F 28	2}				
	restorative nursing	intenance record and in the computer indicated ided on 12/15/13, 12/19/13, 5/13.						
	and stated he did when he was getti he only did his arn times, then proces	15 a.m. NA-B was interviewed ROM on R31 that morning ng him dressed. NA-B stated ns, did them both about 10 eded to demonstrate by lifting stated he did not complete any			- • •			
	and stated she ha couple of times. N the restorative ma and if she has tim ordered. At 1:52 p stated she looks a book at the start of	49 p.m. NA-C was interviewed s done ROM on evening shift a IA-C further stated she checks intenance record every shift, e she will complete ROM as p.m. NA-D was interviewed and at the restorative maintenance of the evening shift, and will try if days shift did not get it done.			-			
	interviewed and s services be comp ordered on the re The DON said sh if they were unab	0:24 a.m. the DON was tated she would expect ROM leted for R20 and R31 as storative maintenance record. e would expect staff inform her le to complete ROM as ordered e reason it was not completed.						

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 4 of 17

		AND HUMAN SERVICES				FORM	: 01/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COI	TE SURVEY MPLETED R
		245125	B. WING			1	/27/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CC	DDE	
FITZGER	ALD NH AND REHAE	3			7 MCKINLEY AVENUE /ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 282}	Continued From pa The facility was un procedure on follov	able to provide a policy and	{F 2	282}			
	R25 was not provid services as directe	led Range of Motion (ROM) d in the care plan.				•	-
	including Alzheime and arthritis. The 11/25/13, indicated	ated 10/17/13, noted diagnoses r's disease, difficulty walking, significant change MDS dated I R25 had severe cognitive quired extensive assistance f daily living.				2	
	the maintenance p provide upper and day. Staff were ins UE (upper extremi extremities) daily. bend his arm at the away from body x1 as high as tolerate holding wrist and e a circular motion x While in bed support chest as high as to lowering it back do	lan, dated 10/17/13, included in rogram binder, directed staff to lower extremity ROM every tructed to, "Perform ROM on ties) and LE (lower Place your hand on elbow and e elbow towards body and then 10 both arms. Raise both arms d over head as he tolerates by elbow x10. Rotate both wrists in 10. orting ankle and knee towards blerated straighten leg by own to the bed x10. Rotate otion both ankles x10."					
	12/13/13 establish sessions of ROM						
FORM CMS-2		2/27/13 at 10:07 a.m. she did "a ons) with R25's upper ns Obsolete Event ID: SSSC		Fa	cility ID: 00588	f continuation sh	eet Page 5 of 17

	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED R	
		245125	B. WING _		12	27/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 227 MCKINLEY AVENUE	ODE	
FITZGER	ALD NH AND REHAE	3		EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 282} F 311 SS=D	dressed. She said her shoulders elbo demonstrated elbo away from body to fingers apart. She wrists and nothing extremities. She a be completing the The Director of Nu 12/27/13, at appro- expected staff to p and to communica been completed. 483.25(a)(2) TRE IMPROVE/MAINT A resident is given services to mainta specified in parage This REQUIREM by: Based on observice, the facility range of motion (orming while getting her she did about five reps with ws and fingers. She then we extension, shoulders - arm above head, and spread said she did nothing with R25's with the resident's lower dided the afternoon shift would lower extremity ROM for R25. arsing (DON) stated on oximately 10:45 a.m., she provide ROM services for R25 ate to the other staff if it had not ATMENT/SERVICES TO AIN ADLS in the appropriate treatment and ain or improve his or her abilities praph (a)(1) of this section. ENT is not met as evidenced vation, interview and document y failed to provide maintenance ROM) services for 1 of 3 aco) reviewed for ROM services	F 3	2}		
	R25 was not pro	vided ROM services as directed	d.			

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Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 6 of 17

F311

- 1. Resident R25 care plan for range of motion have been revised to include appropriate and attainable goals to meet their needs for range of motion. She is no longer receiving hospice support services.
- 2. All Residents range of motion care plan goals have reviewed with revisions made when appropriate.
- 3. Facility practices for the implementation of restorative nursing have been reviewed.
- 4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.

5. The Director of Nursing or her designee will be responsible for completion.

6. Correction date: February 7, 2014

		AND HUMAN SERVICES			(APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245125	B. WING			1	२ 2 7/2013
NAME OF F	PROVIDER OR SUPPLIER	L			REET ADDRESS, CITY, STATE, ZIP CODE		
FITZGER	ALD NH AND REHAI	3			7 MCKINLEY AVENUE /ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	R25's care plan, da	ated 10/17/13, noted her d Alzheimer's disease, difficulty	F	311		•	
	indicated R25 had	ange MDS dated 11/25/13, severe cognitive impairment nsive assistance with all ving.				;	
	the maintenance p provide upper and day. Staff were ins UE (upper extrem extremities) daily. bend his arm at th away from body x as high as tolerate holding wrist and a circular motion x While in bed supp chest as high as t lowering it back d	plan, dated 10/17/13, included in program binder, directed staff to lower extremity ROM every structed to, "Perform ROM on ities) and LE (lower Place your hand on elbow and e elbow towards body and then 10 both arms. Raise both arms ed over head as he tolerates by elbow x10. Rotate both wrists in x10. worting ankle and knee towards olerated straighten leg by own to the bed x10. Rotate notion both ankles x10."					
	Review of the Nu 12/13/13 establish sessions of ROM	rsing Rehab Time Log since hed R25 was provided six in 14 days.					
	few reps" (repetit extremities that n dressed. She sa her shoulders, ell demonstrated ell	2/27/13, at 10:07 a.m. she did " ions) with R25's upper norning while getting her id she did about five reps with bows and fingers. She then bow extension, shoulders - arm to above head, and spread	a				

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 7 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				F	ORM AP	1/17/2014 PROVED 38-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X:	3) DATE SI COMPLE	
		245125	B. WING				12/27	2013
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CO	DE		
FITZGER	ALD NH AND REHA	3			MCKINLEY AVENUE ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) OMPLETION DATE
F 311	wrists and nothing extremities. She a	age 7 said she did nothing with R25's with the resident's lower dded the afternoon shift would lower extremity ROM for R25.	F	311				
{F 318} SS=D	10:45 a.m., she ex services for R25 a staff if it had not b 483.25(e)(2) INCF	REASE/PREVENT DECREASE		318}	• • •			
	resident, the facili with a limited rang appropriate treatm	prehensive assessment of a ty must ensure that a resident ge of motion receives nent and services to increase nd/or to prevent further e of motion.						
	by: Based on observice review, the facility	ENT is not met as evidenced vation, interview and document v failed to provide range of rvices for 2 of 3 residents (R20, r ROM services.					ĩ	
	Findings include R20 was not pro by the plan of ca	vided ROM services as directed						
	R20's diagnoses osteoarthritis of l	list included dementia, and he right wrist. The significant			-	•	-	
FORM CMS	-2567(02-99) Previous Vers	ions Obsolete Event ID: SSS	SG12	Fa	acility ID: 00588	If continua	ation shee	Page 8 of 1

F318

- 1. Resident R20 and R31 care plans for range of motion have been revised to include appropriate and attainable goals to meet their needs for range of motion.
- 2. All Residents range of motion care plan goals have reviewed with revisions made when appropriate.
- 3. Facility practices for the implementation of restorative nursing have been reviewed.
- 4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: February 7, 2014

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 9 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	01/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245125	B. WING			12	27/2013
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE MCKINLEY AVENUE		·
FITZGER	ALD NH AND REHA	3.			ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 318}	On 12/27/13, at 9:- (NA)-A was intervit completed ROM for completing mornin about five repetitio took just a few mir NA-A demonstrate circular motion an- stated she did not ROM. At 12:28 p. always able to con the charge nurse, the administrator of complete it. NA-A ROM on a resider	48 a.m. nursing assistant ewed and stated she or R20 that morning when g cares. NA-A stated she did ns to R20's hands and arms, it nutes,"I didn't go crazy with it." ed by moving her wrist in a d lifting up her arm. NA-A attempt to do lower extremity m. NA-A stated she was not mplete ROM, and would inform director of nursing (DON) or when she was unable to further stated if she does any nt, she documents it as being if she is unable to complete the		318}	•		
	R31 was not prov	ided ROM services.					
	Alzheimer's disea disuse. The admi indicated R31 ha problems with mo skills for daily de	ndicated diagnoses that include ase and muscular atrophy ission MDS dated 10/25/13, d short and long term memory oderately impaired cognitive cision making. The MDS furthe d no impairment to upper or					
	directed staff to on upper extrem Place your hand the elbow toward x10 (repetitions) high as tolerated	naintenance record for 12/13 berform ROM as follows: ROM ity and and lower extremity dail on elbow and bend his arm at ds body and then away from bo both arms. Raise both arms as d over head as he tolerates by d elbow x10 (repetitions). Rotat	y. dy s				

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Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 10 of 17

		AND HUMAN SERVICES				FORMA	01/17/2014 PPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMP	LETED
		245125	B. WING				7/2013
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FITZGER	ALD NH AND REHA	3			227 MCKINLEY AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 318}	Continued From pa	-	{F 3	18]	}		
	While in bed suppo	cular motion x10 (repetitions). orting ankle and knee and bring t as high as tolerated					
	straighten leg by lo x10 (repetitions). F	wering it back down to the bed totate ankle in circular motion epetitions). Ambulate with 2					
• •		walker in hallway 15 feet in the					:
							:
	restorative nursing computer indicated R31 on 12/15/13, 12/25/13. A physic indicated R31 had	intenance record and documentation in the ROM was not provided for 12/19/13, 12/24/13, and al therapy note dated 12/19/13, reached maximum functional continue with ROM with nursing					
		s for lower extremities.					
	and stated he did when he was getti he only did his arr	15 a.m. NA-B was interviewed ROM on R31 that morning ng him dressed. NA-B stated ns, did them both about 10					
	up his arm. NA-B further ROM. At 1	eded to demonstrate by lifting stated he did not complete any 2:41 p.m. NA-B stated if he is e ROM he documents it as not					× ×
	On 12/27/13, at 1 and stated she ha shift a couple of ti checks the restord shift, and if she ha as ordered. At 1:5 and stated she loo	49 p.m. NA-C was interviewed is done ROM on the evening mes. NA-C further stated she ative maintenance record every as time she will complete ROM 2 p.m. NA-D was interviewed oks at the restorative k at the start of the evening	,				

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 11 of 17

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245125	B. WING			12/:	< 27/2013
NAME OF I	PROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	:	
FITZGER	ALD NH AND REHAD	3		227 MCKINLEY AV EVELETH, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRE RRECTIVE ACTION SHU ERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 318}		age 11 complete ROM if day shift did	{F 3	18}	:		
	interviewed and sta services be comple- ordered on the res The DON stated sl with registered nur start residents with to upper and lower to start somewhere had provided staff supplying paper in ROM was to be per DON verified she education. The DO completed audits of do them at the end things were going, expect staff to info	24 a.m. the DON was ated she would expect ROM eted for R20 and R31 as torative maintenance record, he started the ROM program se (RN)-B, and they decided to h daily ROM with 10 repetitions r extremities because they had e. The DON further stated she education on ROM by structions that indicated how erformed on each resident. The did not do any hands on staff DN stated she had not on range of motion; she would d of the month to see how . The DON said she would orm her if they were unable to ordered, and document the completed.			•		
	the DON were into NAs were having to complete ROM do it. The adminis being completed of a.m. cares. The d the care plan follo provided?" and ha facility audits were care audits, all we all of the required appropriately. The	2:55 p.m. the administrator and erviewed. The DON stated if the problems or questions on how , she would show them how to trator stated the audits were during the direct care audits on irect care audits included. "Was wed for the cares being ad a check box for yes or no. All e provided, and of the four direc ere answered, "Yes," indicating care was provided e DON verified ROM as being completed in the	;				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION (X3) DA		
		245125	B. WING		12	R /27/2013
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, Z	IP CODE	
FITZGER	ALD NH AND REHA	3		MCKINLEY AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
{F 318}		nance record and in the d not been consistent in where	{F 318}			
{F 441} SS=D	nursing rehabilitati rehabilitation provi residents to impro- through exercises program is overse RN nurse and ass appropriateness. documentation of repetitions as indi staff will be compl upon completion (483.65 INFECTIO	N CONTROL, PREVENT				
	Infection Control safe, sanitary and to help prevent th of disease and in (a) Infection Cont The facility must Program under w (1) Investigates, in the facility;	rol Program establish an Infection Control hich it - controls, and prevents infection			·	
	 (2) Decides what should be applied (3) Maintains a re actions related to (b) Preventing Space 		9			

F441

- 1. It is the policy of this facility to follow infection control protocols. R31 and R25 have been monitored for any potential infections with no negative outcomes.
- 2. All Residents are monitored for potential infections.
- 3. Procedure related to care delivery and hand washing have been reviewed. NA-A and NA-B have demonstrated proper procedure related to gloving and changing of a soiled brief.
- 4. All nursing staff members have demonstrated knowledge of proper procedure related to gloving and hand washing. Random hand washing audits will be completed three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: February 7, 2014

		AND HUMAN SERVICES					PROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R	
245125		B. WING			12/27/2013		
NAME OF F	ROVIDER OR SUPPLIER	L.,	·		REET ADDRESS, CITY, STATE, ZIP CODE		
FITZGER	ALD NH AND REHA	a .					
THEOLIN				EVELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE ((X5) COMPLETION DATE
{F 441}	•		{F 4	41}	· · · ·		
	 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 practi	ice.			· · ·		
	transport linens so	andle, store, process and as to prevent the spread of		,			
	infection.	•					
	by:	ENT is not met as evidenced					
	review, the facility hand hygiene was	ation, interview and document failed to ensure appropriate s completed for 2 of 3 residents			5		
	(R31, R25) obser	ved to receive personal cares.		•			
	Findings include:						
	Staff did not chan while providing in	ige gloves and wash their hands continence care for R31.	S				
	Alzheimer's disea disuse. The admi indicated R31 ha problems, and ha	ndicated diagnoses that include ase and muscular atrophy ission MDS dated 10/25/13, d short and long term memory ad moderately impaired cognitive					
	skills for daily dec	cision making. The MDS also		•••••	1		

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		AND HUMAN SERVICES				FORM	01/16/2014 APPROVED 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R			
245125			B. WING	;		12/27/2013			
NAME OF PROVIDER OR SUPPLIER FITZGERALD NH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 227 MCKINLEY AVENUE EVELETH, MN 55734						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
{F 441}	Continued From pa for toileting and for	-	{F 4	141	}				
	being toileted with NA-B. Both NAs w gloves, and used a the toilet. NA-A rer brief, took a clean drawer and hande wipes to cleanse F NA-B fastened R3 clothing and transf NA-B was question have changed glov after providing per	15 a.m. R31 was observed nursing assistant (NA)-A and ashed their hands, applied a lift stand to transfer R31 onto noved R31's soiled incontinent incontinent brief out of the d it to NA-B. NA-A then used R31's perineal area. NA-A and 1's clean brief, adjusted his ferred him to the wheelchair. ned, and stated she should ves and washed her hands sonal hygiene, and before brief and adjusting R31's			· · ·				
	(DON) was intervi expect staff would after removing a s incontinence care R25 was provided	24 a.m. the director of nursing ewed, and stated she would change gloves, wash hands oiled brief and providing personal cares without washing on 12/27/13.							
	including Alzheime and arthritis. The 11/25/13, indicate impairment and re with all activities of	lated 10/17/13 noted diagnoses er's disease, difficulty walking, significant change MDS dated d R25 had severe cognitive equired extensive assistance of daily living, including ileting and personal hygiene.	3						

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 15 of 17

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	FORM OMB NO. (X3) DATE COM	01/16/2014 APPROVED 0938-0391 E SURVEY PLETED
245125		B. WING _			R 12/27/2013		
		3		227	EET ADDRESS, CITY, STATE, ZIP CODE MCKINLEY AVENUE ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 441}	R25's care plan da was unable to care daily living such as and transferring. T	age 15 ted 10/17/13, indicated R25 for herself with activities of bathing, grooming, dressing he POC directed the staff to perineal care when toileting	{F 44	1}			
	the large bathroom provide toileting. A hands with soap a with paper towel a applied a transfer close to the reside walker and pivoted R25's pants and a Once R25 indicate her to stand from area, pulled up he her shirt down nea her to sit again in	34 a.m. NA-A brought R25 to a near the dining room to At 9:34 a.m., NA-A washed her nd water at the sink, dried them nd donned clean gloves. NA-A belt to R25, moved the walker nt and stood the resident at her t to the toilet. NA-A removed ssisted her to sit on the toilet. ed she was done, NA-A assisted the toilet, wiped R25's peri r underwear and pants, pulled atly around her waist, assisted the wheel chair, and flushed the moved her gloves and washed ink.	4				•
n	She acknowledge soiled gloves afte	wed on 12/27/13, at 9:42 a.m d she should have removed the r cleansing R25's peri area and her pants back up.	9				
	approximately 10 expected that sta from dirty to clear should have was	erviewed on 12/27/13, at 45 a.m. and stated it is ff wash their hands when going and in this instance, NA-A hed her hands after providing ore she assisted R25 in getting to place.				/	

Event ID: SSSG12

Facility ID: 00588

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

PRINTED: 01/16	3/2014
FORMAPPR	OVED
OND NO 0000	0004

CENTERS FOR MEDICARE & MEDICAID SERVICES OM							0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245125		B. WING			1	R 27/2013	
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FITZGERALD NH AND REHAB					27 MCKINLEY AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 441}	Continued From pa	age 16	{F 4	41}			
	directed staff to chain continence care	policy revised on 1/26/04, ange gloves, "after offering . After handling items nated with any resident					
		· .					
		·					
		:					
			·				
		-					
		1					
						-	

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

Event ID: SSSG12

Facility ID: 00588

If continuation sheet Page 17 of 17

DEPARTMENT OF	HEALTH AND HUM	AN SERVICES		CENTERS FOR MED	ICARE & MEDICAID SERVICES
		ARE/MEDICAID CERTIFICA			ID: SSSG
	PART I -	TO BE COMPLETED BY TH	E STAT	FE SURVEY AGENCY	Facility ID: 00588
 MEDICARE/MEDICAID (L1) 245125 STATE VENDOR OR MI (L2) 112847700 		3. NAME AND ADDRESS OF FACIL (L3) FITZGERALD NH AND RE (L4) 227 MCKINLEY AVENUE (L5) EVELETH, MN		(L6) 55734	 TYPE OF ACTION: <u>2</u>(L8) Initial Recertification Termination CHOW Validation Complaint
5. EFFECTIVE DATE CHA (L9)	ANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGOR 01 Hospital 05 HHA	RY)9 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY ACCREDITATION STA 0 Unaccredited 2 AOA 	10/30/2013 (L34) TUS:(L10) 1 TJC 3 Other	03 SNF/NF/Distinct 07 X-Ray 1	10 NF 11 ICF/IID 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERT	IFICATION	10.THE FACILITY IS CERTIFIED AS	S:		
From (a):		A. In Compliance With		And/Or Approved Waivers Of	
To (b):		Program Requirements Compliance Based On:		2. Technical Personnel 3. 24 Hour RN	 6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	24 (L18)	1. Acceptable POC		4. 7-Day RN (Rural SN	
13.Total Certified Beds	24 (L17)	X B. Not in Compliance with Program Requirements and/or Applied		5. Life Safety Code * Code: B *	9. Beds/Room (L12)
14. LTC CERTIFIED BED 1	BREAKDOWN			15. FACILITY MEETS	
	8/19 SNF 19 SNF	ICF IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	24 (L38) (L39)	(L42) (L43)		1861 (c) (1) 61 1861 (j) (1).	(2)
16. STATE SURVEY AGE See Attached Remarks	NCY REMARKS (IF APPLIC	CABLE SHOW LTC CANCELLATION D	ATE):		
17. SURVEYOR SIGNATU	JRE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Chris Elmgren,</u>	HFE NEII	12/09/2013	(L19)		(L20)
	PART II - TO BE	COMPLETED BY HCFA REG	IONAI	C OFFICE OR SINGLE S	TATE AGENCY
	Eligible to Participate	20. COMPLIANCE WITH C RIGHTS ACT:	CIVIL		icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
2. Facility is	(L21)				
22. ORIGINAL DATE	23. LTC AGREE	EMENT 24. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 05/15/1967	BEGINNIN	G DATE ENDING DATE		<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24)	(L41)	(L25)		02-Dissatisfaction W/ Reimburse	•
25. LTC EXTENSION DA		TVE SANCTIONS		03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspensio	on of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
	(L27) B. Rescind S	(L44) Suspension Date:			00-Active
		(L45)			
28. TERMINATION DATE	3: 2	9. INTERMEDIARY/CARRIER NO.		30. REMARKS	
		03001			
	(L28)		(L31)		
31. RO RECEIPT OF CMS-	1539 3	2. DETERMINATION OF APPROVAL D	DATE		
	(L32)		(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: SSSG PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00588

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5125

This facility is designated as a Special Focus Facility (SFF), Previously their name was Eveleth Health Services. A standard survey was completed at this facility on October 30, 2013. The most serious deficiency was cited at a S/S level of F which constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy.

As a result of the facility's designation as a SFF, a facility of this designation is subjec to increasingly stringent enforcement action. Since this nursing home meets the this criteria, this Department imposed the Category 1 remedy of State monitoring, effective November 23, 2013. In addition, this Department recommended teh following enforcement remedy listed below to the CMS Region V Office:

¿ Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5143 6695

November 18, 2013

Ms. Patricia Banks, Administrator Eveleth Health Services Park 227 McKinley Avenue Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On October 30, 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 significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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:

Patricia Halvorson, Unit Supervisor Minnesota Department of Health 11 East Superior Street, Suite #290 Duluth, Minnesota 55802

Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective November 23, 2013. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Eveleth Health Services Park November 18, 2013 Page 4 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 plan of correction.

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

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 January 30, 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 April 30, 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 Eveleth Health Services Park November 18, 2013 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program 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

5125s14SFF.rtf

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				'E SURVEY IPLETED
		245125		DEC 0 2 2013	10	
AME OF F	BOVIDER OR SUPPLIER				10/	30/2013
	HEALTH SERVICES	Fitzgerald NH & Rehab		227 MCKINLEY AVENUE		
(24) 10	SUMMARY STA	TEMENT OF DEFICIENCIES		EVELETH, MN 55734 PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	
F 000	INITIAL COMMEN	rs .	F 000	OK		
		AN OF CORRECTION (POC)		0K 12-9-13 BLH		
		OUR ALLEGATION OF ON THE DEPARTMENT'S				
	ACCEPTANCE. YO	OUR SIGNATURE AT THE		BLH		
	CMS-2567 FORM	FIRST PAGE OF THE WILL BE USED AS				
	VERIFICATION OF	COMPLIANCE.				
	ONSITE REVISIT	OF YOUR FACILITY MAY BE				
		MPLIANCE WITH THE				
	1	AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	CENSUS = 23					
		pecial Focus Facility (SFF)		-		
F 157 SS = D	483.10(b)(11) NOT (INJURY/DECLINE		F 157			
	A facility must imm	ediately inform the resident;				
	consult with the res	sident's physician; and if				
	or an interested fai	esident's legal representative nily member when there is an				
		the resident which results in potential for requiring physician				
	intervention; a sign	ificant change in the resident's				
		r psychosocial status (i.e., a alth, mental, or psychosocial				
		threatening conditions or ns); a need to alter treatment				
	significantly (i.e., a	need to discontinue an				
	consequences, or	atment due to adverse to commence a new form of				
		cision to transfer or discharge he facility as specified in				
	§483.12(a).					-
		DER/SUPPLIER REPRESEN TATIVE'S SIG	NATURE			(X6) DATE
Norarda V	Han Bank	DERISOPPLIER REPRESENTATIVES SIG	Nilty	ats 12/2/2	512	
deficien	cy statement ending with	an asterisk (*) denotes a deficiency where the patients (See instruction	nich lhe instit	ution may be excused from correcting provider for nursing homes, the findings stated above	ding it is det	ermined that
owing the	date of survey whether	or not a plan of correction is provided.	For nursing h	omes, the above findings and plans of correction is s are cited, an approved plan of correction is	ection are di	isclosable 14

- 1. It is the policy of this facility to notify others of changes in Resident condition. Resident R2's family has been notified that he had developed a reddened area on his left buttock. This area is currently healed.
- 2. All Residents' records have been reviewed. All family members have been notified when necessary.
- 3. The facility practice for communication of Resident changes has been reviewed and revised.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue one time per month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

12	2-02-113 14:23 F	ROM-fitz care	218-	-744-	-7573	T-721	P0004/003	
		AND HUMAN SERVICES					FORM	11/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT	E SURVEY
		245125	B. WING			-	10	/30/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STA	TE, ZIP COD		
EVELETI	H HEALTH SERVICES	PARK			MCKINLEY AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLA (EACH CORRECTIVI CROSS-REFERENCEL DEFIC	EACTION SI	HOULD BE	(X5) . COMPLETION DATE
F 157	and, if known, the r or interested family change in room or r specified in §483.1 resident rights under regulations as speci- this section. The facility must re the address and ph legal representative This REQUIREMEN by: Based on interview facility failed to prov- regarding a new pro-	age 1 so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update tone number of the resident's e or interested family member. NT is not met as evidenced wand document review, the vide timely family notification essure ulcer for 1 of 1 ewed for pressure ulcers.	F					
	delusions, diabetes cerebrovascular ins review indicated R2 notified when the le developed an open The quarterly Minir 8/1/13, indicated R required extensive repositioning, was	sufficiency. Medical record 2's responsible person was not oft buttock reddened area a area. num Data Set (MDS) dated 2 was cognitively intact, assistance with transfers and assessed to be at risk for the						
FORM CMS-2	had 1 stage 2 pres		11	Facil	Ity ID: 00588	lfo	ontinuation she	et Page 2 of 23

12	2-02-113 14:24 F	ROM-fitz care	218-	-744	1-7573	T-721	P0005/00	38 F-710
		AND HUMAN SERVICES					FORM): 11/18/2013 1 APPROVED): 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION			TE SURVEY MPLETED
	- 713	245125	B. WING			_	10	/30/2013
NAME OF F	PROVIDER OR SUPPLIER		T	\$T	REET ADDRESS, CITY, STA	TE, ZIP CO	14. Alter and a second	
EVELET	H HEALTH SERVICES	PARK			7 MCKINLEY AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLA (EACH CORRECTIVI) CROSS-REFERENCEE DEFIC	EACTION S	HOULD BE	. (X5) COMPLETION DATE
F 157	Continued From pa	ge 2	F 1	57				
F 274 SS=D	R2 was observed to unblanchable dark measuring 5 cm in the right buttock an width on the left but A resident progress R2 had an area of in measuring 10.0 cm in the middle of the cm by 3.0 cm. that pressure relief and On 10/30/13, at 10: (DON) the respons notified when the left constituted a chang 483.20(b)(2)(ii) CO AFTER SIGNIFICA A facility must cond assessment of a re facility determines, that there has been resident's physical	red areas on both buttocks, length by 4.2 cm in width on d 8.1 cm in length by 6.2 cm in ttock. a note dated 5/17/13, indicated redness on (L) [left] buttocks by 9.5 cm with an open area reddened area measuring 3.0 was treated with off loading a duoderm dressing. 00 a.m. the director of nursing ible person should have been at buttock opened up as that ge in R2's condition. MPREHENSIVE ASSESS	. F 2	274			•	
FORM CMS 2	resident's status th itself without furthe implementing stand interventions, that I one area of the res	cline or improvement in the at will not normally resolve r intervention by staff or by dard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the	11	Fac	cility ID: 00588		Continuation sha	et Page 3 of 23

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- 1. R26 no longer resides in facility. The Minnesota Department of Health-Case Mix Review department was contacted regarding submission of a modification/correction MDS.
- 2. The care plans of all current Residents have been reviewed to assess for the potential need for the completion of a significant change MDS.
- 3. The policy and procedure for changes in Resident condition has been revised.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 245125 NAME OF PROVIDER OR SUPPLIER	(X2) MUI A. BUILE B. WING			PRINITED: FORM A OMB NO. ((X3) DATE COMP 10/3	PPROVED 9938-0391 SURVEY LETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245125	(X2) MUI A. BUILE B. WING	DING		(X3) DATE COMPI	SURVEY LETED
· · · · · · · · · · · · · · · · · · ·	· · ·	STREET ADDRESS,	CITY, STATE, ZIP CODE	10/3	0040
NAME OF PROVIDER OR SUPPLIER			CITY, STATE, ZIP CODE		JIZU13
	·	227 MCKINLEY AV			
EVELETH HEALTH SERVICES PARK	1 10	EVELETH, MN 5	5734		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		IX (EACH CO	ER'S PLAN OF CORRECT RRECTIVE ACTION SHOU ERENCED TO THE APPR DEFICIENCY)	ILD BE	(X6) COMPLETION DATE
F 274 Continued From page 3 care plan, or both.)	F	274			
This REQUIREMENT is not met as evidence by: Based on interview and document review, th facility failed to complete a significant change condition assessment for 1 of 1 residents (R2 who had a decline in activities of daily living (ADLs), was placed on comfort care and developed pressure ulcers.	e e in				
Findings include:					
R26's diagnoses included cirrhosis of the live hepatitis C, chronic airway obstruction, epiler and ascites. The admission Minimum Data S (MDS) dated 5/29/13, indicated R26 was cognitively intact and required stand by assistance of one staff for bed mobility. The directed R26 required limited assistance of o staff for transfers, ambulation, locomotion on off the unit, dressing, toileting and eating. Th MDS further indicated R26 did not have a terminal diagnoses and was not at risk for th development of pressure ulcers.	osy Set MDS Inne I and e				
Physician's orders on 7/30/13, included com cares (care at the end of life). The order dire to discontinue all medications (with the exce of pain medications, antianxiety medications antinausea medications, and medication to o secretions), insert a Foley catheter for urinar drainage, administer oxygen as needed, and follow a diet as tolerated.	cted ption , lry up y			inuation sheet	

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1	2-02-′13 14:24 F	ROM-fitz care	218-7	744-7573	T-721 P0008/0	
		AND HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D	ATE SURVEY
		245125	B. WING _		1	0/30/2013
NAME OF F	PROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, S		
EVELETI	HEALTH SERVICES	PARK		227 MCKINLEY AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 274	Continued From pa	age 4	F 27	4		
	required increased following areas: ex for bed mobility, dr dependence for toi off the unit. The MI	dated 8/19/13, indicated R26 staff assistance in the tensive assistance of one staff essing, bathing, and total staff leting and locomotion on and DS further indicated R26 did I diagnoses was not at risk for f pressure ulcers.				·
	indicated R26 had	conference summary a decline in ADLs and disease assistance of two staff, and re.		•		
	developed a press 9/22/13. The press measured 1 centin pressure ulcer on 1 by 3 cm. Both area transparent dressi were not staged (s underlying tissue o ulcer). The pressu eventually measur buttock, and 6.5 cm	cord review indicated R26 ure ulcer on each buttock on sure ulcer on the right buttock neter (cm) by 1 cm. The the left buttock measured 2 cm as were open, bleeding, and a ng was applied. The areas staging is a description of the lamage caused by a pressure re ulcers increased in size, ing 4 cm by 3.2 cm on the right m by 4.9 cm on the left buttock wpired on 10/12/13.				
FORM CMS-2	(DON) was intervie team considers po condition assessm DON stated a cha to complete a sign	0:07 a.m. the director of nursing ewed and stated the facility intential resident change of ments at morning meetings. The nge in ADLs would be a reason ificant change assessment, as f the care plan when comfort so Obsolete Event ID: SSSG		Facility ID: 00588	If continuation s	heet Page 5 of 23

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	S FOR MEDICARE	& MEDICAID SERVICES). <u>0938-039</u> TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			co	MPLETED
		245125	B. WING		10	/30/2013
NAME OF F	ROVIDER OR SUPPLIER	· ·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
EVELETH		PARK		227 MCKINLEY AVENUE EVELETH, MN 55734	••••	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE É APPROPRIATE	(X5) COMPLETIC DATE
F 274	significant change should have been o The facility was una	d. The DON confirmed a in condition assessment	F 274			
F 279 \$\$=E	483.20(d), 483.20(COMPREHENSIVI	E CARE PLANS	F 279	9		
		the results of the assessment and revise the resident's In of care.				
	plan for each resid objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive				
	to be furnished to a highest practicable psychosocial well- §483.25; and any a be required under due to the residen	at describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment 4).				
	by: Based on observa review, the facility address psychoac residents (R15, R ²	NT is not met as evidenced ation, interview and document failed to develop a care plan to tive medications for 2 of 6 11) reviewed for unnecessary for 1 of 3 residents (R16)				

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- 1. The care plans for R11, R15 and R16 have been reviewed and revised.
- 2. The care plans of all current Residents have been reviewed and revised when needed.
- 3. Inter-disciplinary practices for assessment and communication of Resident changes have been revised.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			E SURVEY PLETED
		245125	B. WING				10/:	30/2013
	ROVIDER OR SUPPLIER	PARK		227	EET ADDRESS, CITY, STATE MCKINLEY AVENUE ELETH, MN 55734	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	K	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOU	LD BE	(X5) COMPLETIO DATE
F 279	log indicated R15 r (mg) (antidepressa 12/7/12. R15's diagnoses in stage renal disease and dementia. The care plan lack and approaches re monitoring of the a On 10/30/13, at 10 (DON) verified the	ronic medication order history eceived Zoloft 75 milligrams nt medication) since on cluded mental disorder, end e, impulsive emotional state ed a problem statement, goals lated to the use, risks and ntidepressant medication. :45 a.m. the director of nursing antidepressant was not on the	F 2	79				
	use of an antidepro R11's diagnoses in R11's quarterly mir 8/19/13, indicated	I not address the indications for essant (Celexa). noluded depressive disorder. nimum data set (MDS) dated R11 was cognitively intact, had a, and occasionally exhibited						
	Physician orders d	ated and signed 10/13/13, ceive citalopram [Celexa] 10						
		ted 8/5/13, did not address use of the antidepressant						

CENTER		AND HUMAN SERVICES				APPROVE
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COI	TE SURVEY MPLETED
		245125	B. WING		10	/30/2013
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE,		
EVELETI	H HEALTH SERVICES	S PARK		227 MCKINLEY AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROS\$-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 279	Continued From pa medicaiton.	age 7	F 279	9	•	
	registered nurse (F did not address the	proximately 10:00 a.m. RN)-B stated R11's plan of care use of an antidepressant with individualized approaches or target behaviors.				
	R16 did not have a interventions relate easily.	a care plan to address ad to a history of bruising				
	disease, diabetes	ncluded end stage renal and pain. The significant data set (MDS) dated 8/9/13 cognitively intact.				
• .	be laying on his be was bruised, and t bruises noted on h elbow. R16 stated bruises on the left	17 p.m. R16 was observed to ed. R16's entire left forearm here were several smaller is left upper arm near the he bruised easily, and the arm were from the dialysis nd subsequent surgery to				
	during a blood dra used a tourniquet in finding a vein. R tighten the tourniq bruises easily. RN sample on the firs tourniquet, and we	28 a.m. R16 was observed w. The registered nurse (RN)-A on R16's right upper arm to aid N-A stated she did not like to uet too tight because R16 -A was unable to draw a blood t try. She released the ent to get more supplies. RN-A urniquet, and was able to obtain				

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Received Time Dec. 2. 2013 1:18PM No. 4955

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		E SURVEY PLETED
		245125	B. WING			10/:	30/2013
NAME OF I	PROVIDER OR SUPPLIER		L		REET ADDRESS, CITY, STATE, ZIP CODE		
EVELET	H HEALTH SERVICES	PARK			MCKINLEY AVENUE ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 279	a blood sample. W tourniquet, R16 wa	age 8 hen RN-A released the s noted to have a bruise on the it had not been there prior to	F 2	279	• • • • • • • • • • • • • • • • • • •		
	stated R16 is able the bruising. The D did not address bru	:14 a.m. the director of nursing to tell the facility the origin of OON verified R16's care plan uising, and she stated it would it be on the care plan.					
F 282 SS=D	procedure on care 483.20(k)(3)(ii) SE	RVICES BY QUALIFIED	F	282			
	must be provided l	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	by: Based on observa review, the facility	NT is not met as evidenced ation, interview, and document failed to follow the care plan for 19) reviewed for dialysis.					
	Finding include:						
	R19's diagnoses ii hemodialysis.	ncluded renal failure with					

Received Time Dec. 2. 2013 1:18PM No.4955 .

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- 1. It is the intent of this facility to provide care to our Residents by qualified persons in accordance to the care plan. Resident R19 dialysis access site has been re-assessed. Assessment indicates no adverse results to R19.
- 2. All Residents have been re-assessed for any potential changes in condition.
- 3. Practices for assessment and communication of assessment results have been revised when appropriate. RN-A and RN-B have been re-educated to policy and procedures regarding dialysis plans of care and communication of resident assessment results.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will be completed once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DA), 0938-0391 TE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED
		245125	B. WING _			/30/2013
	PROVIDER OR SUPPLIER	PARK		STREET ADDRESS, CITY, STA 227 MCKINLEY AVENUE	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 282	R19's care plan edi receiving dialysis th plan further directer catheter in the right symptoms of infect	age 9 ited 9/5/13, indicated R19 was aree times weekly. R19's care d monitoring of R19's split ash t upper chest for signs and ion and to notify dialysis unit if of infection were noted.	F 28	.2		
	dialysis. RN-A was observe R19's cath	0 p.m. R19 was back from in the room but did not not heter or the right chest dressing RN- A stated R19 has a s treatments.				
F 309 SS=D	stated there were r dialysis was the da p.m. RN-B stated r and dressing was r plan of care. 483.25 PROVIDE 0	proximately 10:30 a.m. RN- B to cares required for R19 since y before. On 10/30/13, at 1:30 nonitoring of R19's catheter not provided as directed by the CARE/SERVICES FOR SEING	F 30	09		
	provide the necess or maintain the hig mental, and psycho	t receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in le comprehensive assessment				
	by: Based on observa review, the facility	NT is not met as evidenced ition, interview, and document failed to monitor the dialysis f 1 residents (R19) reviewed for				

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- It is the intent of this facility to provide the necessary care and services so our Residents attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with a comprehensive assessment and plan of care. Resident R19 dialysis access site has been re-assessed. Assessment indicates no adverse results to R19.
- 2. All Residents with dialysis access sites present have been re-assessed. Assessments indicate no adverse effects.
- 3. Practices for assessment and care planning have revised when appropriate. RN-A and RN-B have been re-educated to policy and procedures regarding dialysis plans of care.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident care and Resident interviews will be conducted three times a week for four weeks, then one time a week for four weeks. Direct care audits and interviews will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

		& MEDICAID SERVICES				BNO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	´ _ (X	3) DATE SURVEY COMPLETED
		245125	B. WING		·	10/30/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY		
EVELET	H HEALTH SERVICES	PARK		227 MCKINLEY AVENU EVELETH, MN 5573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	E COMPLETIC TE DATE
	Continued From pa dialysis.	age 10	F 30	9	•	
	Finding include:					
	R19 was admitted that included includ dialysis.					
· .		m data set (MDS) dated 19 was cognitively intact and				
· .	receiving dialysis the plan further directed catheter in the right symptoms of infection	ited 9/5/13, indicated R19 was hree times weekly, R19's care ed monitoring of R19's split ash t upper chest for signs and tion and to notify dialysis unit if s of infection were noted.				
	be absent from the (RN)-A stated R19 approximately 11:3	00 a.m. R19 was observed to a facility. Registered nurse was the dialysis unit. At 30 a.m. R19 was observed in returned from dialysis				
	room, per R19's re when meal intake R19 but did not ob dressing site on th	30 p.m. RN-A entered R19's equest, with supplement for was low. RN-A stayed with serve R19's catheter or e right chest. At 2:45 p.m. RN- a catheter for dialysis mes per week.				

1	.2-02-′13 14:26 B	FROM-fitz care	218-7	44-7573	T-721	P0018/003	38 F-710
		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E \$URVEY PLETED
		245125	B. WING	·····	·	10/3	30/2013
	PROVIDER OR SUPPLIER	S PARK	2	STREEY ADDRESS, CITY, ST 227 MCKINLEY AVENUE EVELETH, MN 55734	ATE, ZIP CODI	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTI CROSS-REFERENCE	VE ACTION SH	OULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 11	F 309				
F 318 SS=D	monitoring of R19's R19's care plan, bu had been back and shunt and catheter was not on the elec record. 483.25(e)(2) INCR IN RANGE OF MC Based on the com resident, the facility with a limited range appropriate treatm	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase nd/or to prevent further	F 318				
	by: Based on observa review, the facility	ENT is not met as evidenced ation, interview, and document failed to provide restorative ROM) for 2 of 3 residents (R14, sical limitations.					
	Findings include:						
	cognitive impairme Registered Nurse at 4:46 p.m. R14 t neck and both low	ncluded depression and ent. -A (RN-A) stated, on 10/27/13, nad contractures of the hands, rer extremities. R14 was 8/13, at 8:26 a.m., in the wheel					
FORM CMS-2	2567(02-99) Previous Version	······		Facility ID: 00588,	, If co	ntinuation shee	Page 12 of 23

Received Time Dec. 2. 2013 1:18PM No. 4955

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- 1. R19 no longer resides at this facility; however, prior to discharge, range of motion exercise was added to the plan of care. R14 continues to reside at this facility; this plan of care has been assessed to include the elimination of a wheel chair seat belt and the addition of rolled wash cloth used in the palm of each hand.
- 2. All Residents with restorative nursing services in their care plan have been reassessed for appropriateness of care.
- 3. Facility policy and procedure for restorative nursing have been reviewed and revised. Facility practices for the implementation of restorative nursing have been reviewed.
- 4. All nursing staff members have been educated to the change of practice. Audits of Resident care and records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

1	12-02-'13 14:26 FROM-fitz care			218-7	44-7573	T-721	P0020/003	8 F-710
DEPART	MENT OF HEALTH		ERVICES					APPROVED
	RS FOR MEDICARE					,		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SU IDENTIFICATIO					(X3) DATE COMP	SURVEY PLETED
		245	125	B. WING			10/3	0/2013
NAME OF F	PROVIDER OR SUPPLIER			·····	STREET ADDRESS, CITY	, STATE, ZIP COE)E	
EVELET	H HEALTH SERVICES	B PARK			227 MCKINLEY AVENU EVELETH, MN 5573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI Y MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	id Prefix Tag	(EACH CORRE CROSS-REFERE	S PLAN OF CORRI CTIVE ACTION SI NCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMFLETION DATE
F 318	Continued From parchair with hands cleasplints or padding of the 4/8/13, quarter impairment in both extremities. The quarter impairment in both extremities and one the annual Minimu 10/2/13, identified in ROM on both sides and lower extremite and lower extremite and lower extremite a signed by the Direct as indicated of signed by the Direct as indicated of signed by the Direct approved by the pl 5/17/13, OT completermined R14 we appropriate ROM protect skin integrit with self care. A set "achieve optimal p with appropriate or OT - Therapist Pro Summary, dated 5 goals, was dischar appropriate U/E (uto include hand wr integrity, and main care a signed with appropriate U/E (uto include hand wr integrity, and main care).	enched on the la observed in the r rly MDS noted bi- her upper and la pairment in her lo e side in her upp am Data set (MD R14 with functions (bilaterally) of t ies. vsician, dated 5/ d] ROM in bilater pational therapy) orders." The required the set up of program for bilat ty and maintain econd goal noted ositioning of bilat ty and ty and ty and ty	room. ilateral ower ited 7/7/13, ower ber extremities. DS) dated nal limitation in the body, upper 15/13, stated, ral hands - evaluate and uest was DON) and /13. On sessment and on an teral hands to ROM for ease d R14 would iteral hands otector" The harge d R14 met nd, "Set up on ROM program o protect skin	F 31	· · · ·			
	The Discharge Su at the facility was completing ROM a protectors for R14 Plan was for R14 t	mmary also note educated on the and on the use o to use at night. to remain in the	ed nursing staff importance of if palm The Discharge nursing home					
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete	Event ID: \$\$\$G1	1	Facility ID: 00588	lf co	ntinuation sheet	Page 13 of 23

1	2-02-′13 14:26 B	ROM-fitz care	218-	744-7573	T-721 P0021/00	
		AND HUMAN SERVICES			FORM	7. 11/18/2013 1APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245125	B. WING _			/30/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 227 MCKINLEY AVENUE	TATE, ZIP CODE	
EVELETI	H HEALTH SERVICES	S PARK		EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(XS) COMPLETION DATE
F 318	· · .	age 13 Iaintenance Program.	F3 ²	18		
	for the required RC in the restorative b	ated 9/29/13, lacked direction DM and the OT orders were not inder where the orders are cument treatment provided.				
	stated that OT disc from 5/21/13, shou the functional main DON said nothing or palm protectors 9:45 a.m., the DOI	wed on 10/30/13, at 9:11 a.m., charge orders, including R14's ald have been used to develop ntenance program for R14. The was done and no hand splints were provided for R14. At N stated there was no facility itiation of OT recommended ervices.			· · · · · · · · · · · · · · · · · · ·	
	nursing services, incomplete quadri spinal cord) and co myopathy (charact	ded consistent restorative R22's diagnoses included plegia (partial damage to the ervical spondylosis with terized by neck stiffness, arm the hands, and weakness of s).				
1	the wheelchair wit the lap. RN-A state R22 did not have o	d on 10/27/13, at 4:12 p.m. in h the right arm laying limp on ed, on 10/27/13 at 4:46 p.m., contractures, but had significant pper and lower extremities.				
	established R22 h limitations on both	MDS, dated 9/27/13, ad upper and lower extremity a sides of the body.				
FORM CMS-2	The care plan date 2567(02-99) Previous Version	ed 9/19/13, indicated R22 had	 311	Facility ID: 00588	If continuation she	et Page 14 of 23

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245125	B. WING		10	/30/2013
	PROVIDER OR SUPPLIER		227	REET ADDRESS, CITY, STATE, ZIP (7 MCKINLEY AVENUE 7 ELETH, MN 55734	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 318	no ability to ambula coordination of his to incomplete quad directed staff to en complete independ RN-A interviewed of	ate related to poor muscle lower extremities, secondary friplegia. The Care plan courage and educate R22 to	F 318			
	ROM to both upper 483.25(I) DRUG R UNNECESSARY I Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of th Based on a compr resident, the facilit who have not used given these drugs therapy is necessar as diagnosed and record; and reside drugs receive grad behavioral interver	r and lower extremities. EGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose I or discontinued; or any	F 329			

- 1. R27 no longer resides at this facility; however, the physician was scheduled to visit with R27 to review medications prior to discharge.
- 2. All Residents have been assessed for side effects with gradual dose reductions implemented when necessary.
- 3. Policies and procedures regarding negative side effects of psychotropic medication and Resident responsible party refusal of care have been reviewed with revisions made when needed.
- 4. All nursing staff members have been educated. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

12	2-02-′13 14:27 F	ROM-fitz care	218-	744-	-7573	T-721 PØ		
		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(XS) DAT	E SURVEY PLETED
		245125	B. WING _		~	_	10/	30/2013
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STA	TE, ZIP CODE		
EVELETI	H HEALTH SERVICES	S PARK			MCKINLEY AVENUE ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITÉMÉNT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLA (EACH CORRECTIVI CROSS-REFERENCED DEFJO	É ACTION SHOUL TO THE APPRO	D BE	(X5) COMPLETION DATE
F 329	This REQUIREMEN by: Based on interview facility failed to ider ongoing use of med (R27) whose medic Findings include: R27 was admitted diagnoses that incl obstruction, hypert Admission physicia (antipsychotic med schizophrenia and (mg) twice a day. T address symptoms monitored. The temporary car R27 had behaviors pulling on medical care plan directed calmly explain the	age 15 NT is not met as evidenced v and document review, the ntify, assess and monitor dications for 1 of 6 residents cations were reviewed. from a hospital on 7/9/13, with uded chronic airway ension and atrial fibrillation. on's orders included risperdal ication used to treat bipolar disorders) 1 milligram The risperdal order did not a or side effects to be e plan, dated 7/9/13, indicated tubing such as catheter. The staff to monitor behaviors, harm that could be caused by and to administer risperdal	F 32	29				
	R27 was too weak chair. On 7/11/13, i indicated R27 requi- bed mobility and tr On 7/11/13 at 11:3 R27 required assis mobility, ate only a	7/10/13, at 10:45 p.m. indicated to get out of bed to sit in a at 11:01 a.m., nursing notes ired assistance of 2 staff for ansfers with a mechanical lift. 0 p.m., nursing notes indicated stance of 2 staff for bed few bites of supper and fell 8, at 1:43 p.m., nursing notes						

Facility ID: 00588

If continuation sheet Page 16 of 23

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245125	B. WING		10/	30/2013
		S PARK	227	EET ADDRESS, CITY, STATE, ZIP C MCKINLEY AVENUE ELETH, MN 55734	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE	(X5) COMPLETIC DATE
F 329 F 441 SS=D	sedation and confu Nursing notes on 7 R27 had expired. The director of nur 10/28/13, at 1:52 p symptom identifica monitoring for the if anyone question orders, the DON si DON verified the fa- risperdal, but they report R27's confu 483.65 INFECTION SPREAD, LINENS The facility must e Infection Control P safe, sanitary and to help prevent the of disease and infe- (a) Infection Control The facility must e Program under wh	nily was concerned about usion possibly from risperdal. 7/14/13, at 1:22 p.m. indicated ses (DON), interviewed on o.m., verified the lack of ation and/or side effect use of risperdal. When asked ed the admission physician's hook her head, "No". The amily concern with the use of did not contact the physician to sion and sedation. N CONTROL, PREVENT stablish and maintain an Program designed to provide a comfortable environment and a development and transmission ection.	F 329 F 441			
	should be applied	procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.				
	determines that a	read of Infection ction Control Program resident needs isolation to d of infection, the facility must		· .		

•

- 1. It is the policy of this facility to follow infection control protocols. R2 has been monitored for any potential infections with no negative outcomes.
- 2. All Residents are monitored for potential infections.
- 3. Procedure related to care delivery and hand washing have been reviewed. NA-A has been re-educated to this procedure and the risk to the Residents of not following procedure.
- 4. All nursing staff members have been educated. Random direct care audits will be completed three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
- 5. The Director of Nursing or her designee will be responsible for completion.
- 6. Correction date: December 13, 2013

12	12-02-'13 14:28 FROM-fitz care			-744	-7573	T-721	P0027/003	
	•	AND HUMAN SERVICES			, · · ·		FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	_	(X3) DATI COM	E SURVEY PLETED
		245125	B. WING			~~	10/	30/2013
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CO	DE	
EVELET	H HEALTH SERVICES	PARK			7 MCKINLEY AVENUE /ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PL/ (EACH CORRECTIN CROSS-REFERENCE DEFI	/EACTION S	HQULD BE	(X5) COMPLETION DATE
F 441	communicable dise from direct contact direct contact will to (3) The facility must hands after each do hand washing is in professional practic (c) Linens Personnel must hat transport linens so infection. This REQUIREME by: Based on observa- review, the facility precautions were to (R2) during observa- Findings include: R2's diagnoses in delusions and ure The quarterly min 8/1/13, indicated fi- required extensive repositioning, and	the store, process and as to prevent the spread of ENT is not met as evidenced ation, interview, and document did not ensure infection control followed for 1 of 4 residents vation of personal care.	F	441				
FORM CMS-	2567(02-99) Previous Versio	ns Obsolete Event ID: \$\$\$0	311	Fa	acility ID: 00588	lf c	continuation shee	t Page 18 of 23

1:	12-02-'13 14:28 FROM-fitz care		218-	-744-7	7573	T-721 H	P0028/003	38 F-710 : 11/18/2013
	· · ·					FORM	APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			A.R		<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			—	(X3) DAT CON	E SURVEY IPLETED
		245125	B. WING				10/	30/2013
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, ST	ATE, ZIP CODE		
EVELET	H HEALTH SERVICES	S PARK			ICKINLEY AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PL (EACH CORRECTI CROSS-REFERENCE DEF	VEACTION SHO	DULD BE	(X5) COMPLETION DATE
F 441	Continued From pa		F 4	141				
1 441				141				
		ed 4/29/13, directed catheter						
		rovided every shift and extension tubing were to be						
	changed every wee	ek and as needed.						
,								
		7 a.m. nursing assistant (NA)-A						
		viding catheter cares for R2						
	gloves, disconnect	ed the urinary drainage bag						
	from R2's indwellin	ng suprapubic catheter, and ainage bag. NA-A wiped the						
	catheter end with a	an alcohol wipe, attached a new	,					
		b the catheter end, and then bag to the other end of the						
		NA-A secured the extension						
		thigh using a pre-applied velcro						
	to the shower room	gloves, and opened the door n with her unwashed hands						
		r room. NA-A returned at 7:41						
		r room with straps for the leg R2's lower leg. NA-A applied						
	the straps to the le	g bag and then to R2's lower						
		a transfer belt around R2's E2-stand to assist R2 to stand			·			
	up from the showe	er chair. NA-A used a large						
		R2's bottom, pulled up R2's nd assisted R2 to sit in the						
	wheelchair. NA-A	pushed R2 in the wheelchair,						
		shower room door with her out to R2's room, stating she						
		2's morning cares in the	s					
	NA-A stated she u	on 10/29/13, at 10:20 a.m., isually washes her hands after neter cares and removal of						
EORM CMS /	2567(02-99) Previous Version		 311	Facility	/ ID: 00588	If conf	tinuation shee	t Page 19 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM ARCOVED SOUND NO. 0538 0539 CENTERS FOR MEDICARE &	12	12-02-'13 14:28 FROM-fitz care			-744	1-7573	T-721	P0029/00	
STATEMENT OF DEPENDENCIES (X) PROVIDERSUPPLIEUCLA (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND PLANG 248125 3 WN3 10/30/2013 INAME OF PROVIDER OR SUPPLIER 211/2012 3 WN3 10/30/2013 EVELETH HEALTH SERVICES PARK 211/2012 212/2012 212/2012 Market of PROVIDER OR SUPPLIER 211/2012 211/2012 211/2012 Code Dr. Provider Structure on periodencies 211/2012 211/2012 211/2012 Provide Reservices 211/2012 211/2012 000000000000000000000000000000000000								FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 20 CODE EVELETH HEALTH SERVICES PARK 227 MOKINLEY AVENUE CMD SUMMARY STATEMENT OF DEFICIENCIES FAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES FAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES FAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES GOUDENT OR SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES GOUDENT OR SUMMARY STATEMENT OF DEFICIENCIES GOUDENT SUMMARY STATEMENT OF DEFICIENCI	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA						
EVELETH HEALTH SERVICES PARK 227 MCRINEY AVENUE Image: Constraint of the service of			245125	B. WING			_	_10	/30/2013
EVELETH HEALTH SERVICES PARK EVELETH, KM 55734 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EXPONDER'S FLAN OF CORRECTION RESULATORY OR USE DENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S FLAN OF CORRECTION (CONSENSITIES FLAN OF CORRECTION (CONSENSING CONSENSITIES FLAN OF CORRECTION (CONSENSING	NAME OF F	ROVIDER OR SUPPLIER					TE, ZIP COI	DE	
Prefix TAG IEAD IDERIGINATION WEST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG IEAD IDERIGINATION OF LSC IDENTIFYING INFORMATION) PREFIX TAG F 441 Continued From page 19 gloves. NA-A stated she forgot to wash her hands after removing the gloves and leaving the shower room. F 441 F 441 On 10/30/13, at approximately 2:00 p.m. the director of nursing (DON) stated the NA's should be washing their hands after glove removal with catheter care and Foley [catheter] care and before and after gloving. F 465 F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABL. ENVIRON F 465 The facility must provide a safe, functional, santary, and comfortable environment for residents, staff and the public. F 465 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of wales and furning area, the dining room and all resident rooms. This had the public. F 465 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of wales and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical ills observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility.	EVELETH	HEALTH SERVICES	S PARK						
gloves. NA-A stated she forgot to wash her hands after removing the gloves and leaving the shower room. On 10/30/13, at approximately 2:00 p.m. the director of nursing (DON) stated the NA's should be washing the inhands after glove removal with catheter cares. A Hand Washing policy revised 1/26/04, indicated handwashing was to be performed after offering incontinence care and Foley [catheter] care and before and after gloving. F 466 \$83=F SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility. Findings include:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVI CROSS-REFERENCEL	EACTION \$ TO THE A	HOULD BE	COMPLETION
director of nursing (DON) stated the NA's should be washing their hands after glove removal with catheter cares. A Hand Washing policy revised 1/26/04, indicated handwashing was to be performed after offering incontinence care and Foley [catheter] care and before and after gloving. F 465 SS=F SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of walls and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility.	F 441	gloves. NA-A state hands after removi	ed she forgot to wash her	F	441				
handwashing was to be performed after offering incontinence care and Foley [catheter] care and before and after gloving. F 465 F 465 483.70(h) F 465 SS=F SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON F 465 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. F 465 This REQUIREMENT is not met as evidenced by; Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of walls and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all residents residing in the facility. Findings include:		director of nursing be washing their h	(DON) stated the NA's should						
sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of walls and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility. Findings include:	1	handwashing was incontinence care before and after gl 483.70(h) SAFE/FUNCTION	to be performed after offering and Foley [catheter] care and oving.		465				
by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of walls and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility. Findings include:		sanitary, and com	fortable environment for						
		by: Based on observa review, the facility good repair of wal resident rooms (R of 4 mechanical lif corridor utilized by main entrance to 6 and all resident ro	ation, interview and document did not ensure cleanliness and Is and furniture in 3 of 12 20, R14, R11); cleanliness of 2 fts observed, and in the main all persons passing from the the living area, the dining room toms. This had the potential to						
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SSSG11 Facility ID: 00588 If continuation sheet Page 20 of a		Findings include:							
	FORM CMS-	1 (567 (02-99) Previous Versio	ns Obsolete Event ID: \$\$\$0	 311	Fa	cility ID: 00588	lfc	ontinuation she	et Page 20 of

- 1. This facility works to provide a safe, functional, clean and comfortable environment for residents, staff and the public and is currently in a position to work on improving this. R20's bedside stand was fixed and the walls in his room were patched. R14's bedroom walls were patched. The toilet pipe in R11's room was repaired. The floor mat in R11's room was replaced. The corridor was cleaned of scuff marks. The wood trim and handrails were sanded and re-finished. The tile trim has been cleaned and re-grouted. The mechanical lifts have been cleaned.
- 2. All residents, staff and visitors could be affected.
- 3. The facility's practices addressing preventative maintenance and cleaning routines have been reviewed with revision when needed. This facility now has the ability to address physical plant needs ongoing. A painting company has been contracted with a plan in place to assure completion of necessary work.
- 4. All staff members have been educated on these practice changes. Audits of progress and prevention will be completed three times a week for four weeks and then one time a month; ongoing, with the results brought to QA meetings for review and recommendation.
- 5. The Administrator or her designee will be responsible for completion.
- 6. Correction date: 12/13/13

12	2-02-′13 14:28 F	ROM-fitz care	218-	744-757	73	T-721	P0031/003	8 F-710
		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DATE	E SURVEY
		245125	B. WING				10/3	30/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, S	TATE, ZIP COD		
EVELETH	H HÉALTH SERVICES	PARK			KINLEY AVENUE TH, MN 55734		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	(EACH CORRECT ROSS-REFERENC	LAN OF CORRE IVE ACTION SH ED TO THE AP FICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465	Continued From pa	age 20	F 46	65				
	maintenance staff the following was o	mental tour with the (MS) on 10/30/13, at 9:00 a.m., bserved: imerous nail holes in the wall						
	next to the bed. Th were two pieces of approximately 5 by	e paint was cracked and there missing plaster measuring 3 inches and 2 by 1 inches. bedside stand was loose and						
	next to the bed. The color paint, approx the wall and an are approximately 2 by the over bed light.	umerous nail holes in the wall here was square of different timately 6 by 6 inch square, on ea of missing plaster, / 4 inches, on the wall under There was chipped and osing the plaster around the the bed.				·		
	pipe coming from behind the toilet ne on the right of the had different color fall mat standing in a long tear on the gray duct tape, an	ad rust colored stains around a the wall to the toilet as well as ear the floor. The bedroom wall entry door was discolored and ed paint on wall. There was a in the bathroom with torn edges, center that was covered with d had several areas of exposed nyl covering was absent.						
	rooms along one s three feet of wall of	le long corridor with 12 resident side of the corridor. The lower on both sides of the corridor en with many scrapes and soiled	1	Facility ID	00586	If co	ontinuation shee	Dane 21 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDE: Services CENTERS FOR MEDICARD & MEDICARD SERVICES OMB NO.0383-0331 STATEMAR TO PERCENCISS (I) PROVIDE:NOPPERCIAL MAR PLAN OF CORRECTION (I) PROVIDE:NOPPERCIAL Name of PROVIDER OF SUPPERSI STREET ADDRESS, CITY, STATE, ZIP CODE EVELETH HEALTH SERVICES PARK STREET ADDRESS, CITY, STATE, ZIP CODE OULD SUMMAY STATEMENT OF DEPICANCES OULD SUMMAY STATEMENT OF DEPICANCES DAY FILL PREMAR RESOLUTION ON SUMMAY STATEMENT OF DEPICANCES EVELETH HEALTH SERVICES DAY FILL OULD SUMMAY STATEMENT OF DEPICANCES DEPY FILL EVELETH, MI B973 PREMAR RESOLUTION ON SUMMAY STATEMENT OF DEPICANCES EVELETH, MI B973 OULD STATEMENT OF DEPICANCES EVELETH, MI B973 STREER ADDRESS, CITY, STATE, ZIP CODE Construction Strong State ON STATEMENT OF THE ADDRESS, CITY, STATE, ZIP CODE STREER ADDRESS, CITY, STATE, ZIP CODE Construction Strong State ON STATEMENT OF THE ADDRESS, CITY, STATE, ZIP CODE STREER ADDRESS, CITY, STATE, ZIP CODE Construction Strong State ON STATEMENT OF THE ADDRESS, CITY, STATE, ZIP CODE STREER ADDRESS, CONTINUED STATEMENT OF DEPOCHANCE EVELETH, MI B973 OULD STATEMENT OF THE STATEMENT OF DEPOCHANCE EVELETH, MI B973 STREER ADDRESS, CITY, STATEMENT OF DEPOCHANCE EVELETH, MI B974 STREER ADDRESS, CONTINUED STATEMENT OF DEPOCHANCES <th>1</th> <th>2-02-′13 14:28 H</th> <th>FROM-fitz care</th> <th>218-</th> <th>-744-7573</th> <th>T-721</th> <th>P0032/00</th> <th>38 F-710</th>	1	2-02-′13 14:28 H	FROM-fitz care	218-	-744-7573	T-721	P0032/00	38 F-710
STATEMENT OF DEFICIENCES (X1) PROVIDERSUPPLIERVILL (CAUNTELE CONSTRUCTION A BUILDING COMPLETED							FORM	APPROVED
MAKE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE EVELETH HEALTH SERVICES PARK 227 MCORLEY AVENUE PALIN SUMMARY STREMENT OF DEFICIENCIES PALIN SUMMARY STREMENT OF DEFICIENCIES PALIN REQULATORY OR USE OF PROCEDO BY FULL TAG REQULATORY OR USE OF PROCEDO BY FULL PALIN REQULATORY OR USE OF PROCEDO BY FULL TAG RECOMPTION PALIN RECOMPTION PALIN RECOMPTION PALIN RECOMPTION RECOMPTION RECOMPTION <	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DAT COM	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLER EVELETH HEALTH SERVICES PARK THEET ADDRESS CITY, STATE, 2P CODE [AVAID] SUMMARY STATEMENT OF DEFICIENCIES (CAD) EVELETH, MN S0734 EVELETH, MN S0734 [AVAID] SUMMARY STATEMENT OF DEFICIENCIES (CAD) PREFX PREFX EVELETH, MN S0734 [F465] Continued From page 21 areas along the entire length. There was a strip of vanished wood trim, approximately four inches wide, and approximately four inches wide, and approximately four inches wide, and approximately not foot above the floor along both sides of the corridor. The grout was black with sol. The correr of the wall at the utility room entry near the runsing station was marred and the wall paper was torn. All of the doors, door jams and wall corners throughout the entire corridor were scraped and scratched. In the walls were scraped and scratched, the walls were scratched, solied and had black marks. Two of four mechanical lifts were observed to be solied the floor and the dought of the ador the corry or 10/27/13 to 10/07/07/13. The floor floor mathen paper, or verbally when repairs were needed. During the tour, the MS verified the observations and had been focusing on the boilers and the equipment on the off. The MS stated staff notified him was mare needed.			245125	B. WING _			10/	30/2013
EVELETH HEALTH BERVICES PARK EVELETH, MN 56734 (X4) ID PREFIX TAG SUMARY STATEMENT OF DEFICIENCIES (EXC) DEFICIENCY ON USE BERVIEW IN INFORMATION) ID PREFIX REGULATIONY ON LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLANOF CORRECTION (EXC) DEFICIENCY TAG D PROVIDERS PLANOF CORRECTION (EXC) DEFICIENCY TAG	NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, (CITY, STATE, ZIP COD		
PREFX TAG LEACH CORRECTIVE ACTION SHOULD BE ECULATORY OR USCIDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLETION DEFICIENCY F 465 Continued From page 21 areas along the entire length. There was a strip of along both sides of the corridor. The wood tim was scraped with exposed rough wood. Below the wood tim mere were 6 inch square caramic tibles along the file for and curving up the well on both sides of the corridor. The wood with were scraped and scratched. The wall at the ultiprom entry near the nursing station was mared and the wallpaper was torner of the wall at the ultiprom ere scraped and scratched. The walls were scraped and scratched. The baseboards were scraped and scratched. The walls were scraped and scratched. The walls were scraped and scratched. The walls were scraped and scratched in the entryways to all 12 of the resident's rooms. The baseboards were scraped and scratched with black marks on them. The the metal kick plates on the bottom of all the room doors were scraped and black gray color. The Hoyer lift foot plate was solied a black gray color. During the tour, the MS verified the observations and stated he does a weekly walk through of the facility. The MS was the only maintenance person and had been focusing on the Stated staff notified thin via email, paper, or verbally when repairs were needed. On 10/30/13, at 10:22 a.m. the housekeeping On the stated staff	EVELET	H HEALTH SERVICES	PARK					
areas along the entire length. There was a strip of varnished wood trim, approximately four inches wide, and approximately not not be floor along both sides of the corridor. The wood trim was scraped with exposed rough wood. Below the wood trim there were 6 inch square caramic tiles along the floor and curving up the wall on both sides of the corridor. The grout was black with soil. The corridor The grout was black with soil. The corridor The grout was black waitpaper was torn. All of the doors, door jams and wall corners throughout the entire corridor were scraped and scratched. The walls were scraped and scratched. The walls were scraped and scratched. The walls were scratched with black marks on them. The the metal kick plates on the bottom of all the room doors were scratched, soiled and had black marks. Two of four mechanical lifts were observed to be soiled on all days of the survey, from 10/27/13 to 10/30/13. The foot plate on the easy move lift was covered with lock lifts to ware solled a black gray color. During the tour, the MS verified the observations and stated he does a weekly walk through of the facility. The MS was the only maintenance person and had been focung on the botten so and the equipment on the root. The MS stated staff notified him via email, paper, or verbally when repairs were needed. On 10/30/13, at 10:22 a.m. the housekeeping	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH COI	RRECTIVE ACTION SH ERENCED TO THE AP	IOULD BE	COMPLETION
soiled on all days of the survey, from 10/27/13 to 10/30/13. The foot plate on the easy move lift was covered with loose light brown colored substance. The Hoyer lift foot plate was soiled a black gray color. During the tour, the MS verified the observations and stated he does a weekly walk through of the facility. The MS was the only maintenance person and had been focusing on the boilers and the equipment on the roof. The MS stated staff notified him via email, paper, or verbally when repairs were needed. On 10/30/13, at 10:22 a.m. the housekeeping	F 465	areas along the ent varnished wood trin wide, and approxim along both sides of was scraped with en- the wood trim there tiles along the floor both sides of the co- with soil. The cornel entry near the nurs wallpaper was torn and wall corners the were scraped and scraped and scrate of the resident's ro scratched with blace metal kick plates of doors were scratch	tire length. There was a strip of m, approximately four inches nately one foot above the floor i the corridor. The wood trim exposed rough wood. Below were 6 inch square ceramic and curving up the wall on orridor. The grout was black er of the wall at the utility room sing station was marred and the a All of the doors, door jams broughout the entire corridor scratched. The walls were ched in the entryways to all 12 oms. The baseboards were ck marks on them. The the on the bottom of all the room		65			
On 10/30/13, at 10:22 a.m. the housekeeping		soiled on all days of 10/30/13. The foot covered with loose The Hoyer lift foot color. During the tour, the and stated he doe facility. The MS wa and had been focu equipment on the notified him via em	of the survey, from 10/27/13 to plate on the easy move lift was e light brown colored substance. plate was soiled a black gray e MS verified the observations s a weekly walk through of the as the only maintenance person using on the boilers and the roof. The MS stated staff mail, paper, or verbally when					
		On 10/30/13, at 10	0:22 a.m. the housekeeping				_ AT AT A	

12	2-02-113 14:29 Fi	ROM-fitz care	218-	-744	-7573 T-	721 PØ	033/0038	8 F-710
DEPART	MENT OF HEALTH	AND HUMAN SERVICES				I		ויטציעדיויז APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				(0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245125	B. WING				10/:	30/2013
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	ST	REET ADDRESS, CITY, STATE, 2	IP CODE		
EVELETI	H HEALTH, SERVICES	S PARK			7 MCKINLEY AVENUE /ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOUL THE APPRO	D BE	(X5) COMPLETION DATE
F 465	manager (HM) stat done on Saturdays checklists to follow were not provided.	age 22 ed that deep cleaning was and Sundays. There were for cleaning. The checklists sing (DON), interviewed on	F 4	465				
	10/30/13, at 10:45 aware of the condit room. The DON ind schedule for the m	a.m., stated she was not tion of the fall mat in R11's dicated there was no cleaning echanical lifts but expected its weekly and whenever the			Υ			
	administrator was i identified during the conversation, a wh vent around the en hanging away from	proximately 11:30 a.m., the notified of the concerns e tour. During the ite cone shaped device with a d of it was observed to be the ceiling. The administrator when the device was pointed						
	procedure (not dat preventive mainter for each piece of e maintenance progr schedule. The doo	aintenance policy and ed) indicated there would be a hance procedure established equipment. The preventive ram was set up according to a rs and door jams were to be and the lifts were checked					×	
	.567(02-99) Previous Version	s Obsolete Event ID: SSSG	11	Far	5ility ID: 00588	lf continu	nation share	Page 23 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245125				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		
		B. WING				
AME OF F Fitzgei	PROVIDER OR SUPPLIER Cald NH And Reha HEALTH SERVICES	b PARK Name Change		STREET ADDRESS, CITY, STATE, ZI 227 MCKINLEY AVENUE EVELETH, MN 55734	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE COMP HE APPROPRIATE D	
K 000	INITIAL COMMENT	ſS	K 00	00		
12-9-13	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	FETY OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		PICH 8 12-3-13		
VC;	ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATION HAS	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE BEEN ATTAINED IN ITH YOUR VERIFICATION.	-	1000 W.	÷	
	PLEASE RETURN CORRECTION FOR DEFICIENCIES TO	R THE FIRE SAFETY				
b)	Health Care Fire Ins State Fire Marshal 444 CEDAR STREI ST. PAUL, MN 5510	Division ET, SUITE 145			5) 	
5,00,01 :11	By E-Mail to: Marian.whitney@st: Barbata.lundbery@			RECEIV	ED	
EXIT:	DEFICIENCY MUS FOLLOWING INFO	vhat has been, or will be, done	~	DEC 2 20 MIN DEPT. OF PUBLIC STATE FIRE MARSHAL		
RATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	INATURE	TITLE	(X6) DA	

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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	•	AND HUMAN SERVICES			2		FORM	: 11/18/2013 APPROVEI . 0938-039	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DAT COM	(X3) DATE SURVEY COMPLETED 10/29/2013	
	245125			B. WING					
NAME OF PROVIDER OR SUPPLIER EVELETH HEALTH SERVICES PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 227 MCKINLEY AVENUE EVELETH, MN 55734						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTI CROSS-REFERENCE		LD BE	(X5) COMPLETION DATE	
K 000	Continued From pa	ige 1	K OC	00					
	2. The actual, or pr	oposed, completion date.							
		r title of the person rection and monitoring to ence of the deficiency.							
E		,,	•	š		×			
-	Minnesota Departm time of this survey was found not in survey requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),	3	i d					
	with a partial basen constructed in 1959 The original building I(111) therefore, the one building. The b health unit operated portion of this buildi and was inspected properly 2 hour fire is fully fire sprinkler complete fire alarm in spaces open to the for automatic fire do facility has a license	vices Park is a 1-story building nent. The building was 9, with one addition in 1996. g and the addition are Type e building was inspected as uilding also contains a mental d by others. The mental health ing is not properly separated on this date. The ESRD is rated separated. The building protected. The facility has a system with smoke detection he corridor, that is monitored epartment notification. The ed capacity of 24 beds and at the time of the survey.				а С		-	

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

Facility ID: 00588

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES				PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE COMF	PLETED
		245125	B. WING		10/2	9/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVELET	EVELETH HEALTH SERVICES PARK			227 MCKINLEY AVENUE EVELETH, MN 55734		
			L	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	COMPLETION DATE
K 000	Continued From pa	ge 2	K 0	00		
	The requirement at not met.	42 CFR Subpart 483.70(a) is				
K 052 SS=D		FETY CODE STANDARD	K 0	52		
	installed, tested, an with NFPA 70 Natio 72. The system has	required for life safety is ad maintained in accordance anal Electrical Code and NFPA s an approved maintenance		*		
	and testing program requirements of NF	n complying with applicable PA 70 and 72. 9.6.1.4	12			
1				<		
					-	а 11 м
	Based on observat fire alarm system is conformance with N	s not met as evidenced by: tion and interview, the facility's s not maintained in NFPA 72. This deficient ct all building occupants in the				
	Findings include:			3		
5	10-29-13 between that doors are being	ion during the facility tour on 8:00-9:00 AM, it was observed g held open with electric				5
	alarm connected sr the door opening. T Managers Office, S Administrators Office	and they do not have a fire moke detector within 5 feet of These doors are the Business social Services Office, and the ce. One fire alarm system at is centrally located would		•		ik≦ ≊
	567(02-99) Previous Versions	2 N/	21	Facility ID: 00588 If contin	uation shee	t Page 3 of 4

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PRINTED: 11/18/2013

K052

- 1. On November 5, 2013, a new smoke detector was installed. A wire to this smoke detector was run to connect the smoke detector to zone two. A test was performed. The smoke detector is installed correctly by ESC Systems.
- 2. November 5, 2013
- 3. The Maintenance Director is responsible for monitoring this.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CATION NUMBER: IDENTIFICATION NUMBER: 245125 (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 NAME OF PROVIDER OR SUPPLIER 245125 STREET ADDRESS, CITY, STATE, ZIP CODE 277 MCKINLEY AVENUE EVELETH HEALTH SERVICES PARK C(A) UPPLIER SUMMARY STATEMENT OF DEFICIENCIES PREFX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 227 MCKINLEY AVENUE EVELETH, MN 55734 (A) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFX REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PREFX TAG PROVIDER'S PLAN OF CORRECTIC (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PREFX TAG PREFX TAG PREFX TAG K 052 Continued From page 3 meet the requirement. K 052 K 052 These deficient practices were verified by the Director of Facility Maintenance and the Administrator at the time of exit. K 052			AND HUMAN SERVICES				FOR	D: 11/18/2013 MAPPROVED D. 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EVELETH HEALTH SERVICES PARK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID K 052 Continued From page 3 meet the requirement. K 052 These deficient practices were verified by the Director of Facility Maintenance and the Administrator at the time of exit. K 052	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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meet the requirement. These deficient practices were verified by the Director of Facility Maintenance and the Administrator at the time of exit.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EA	CH CORRECTIVE ACTI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
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