DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL FE SURVEY AGENCY		ID: TXE1 Facility ID: 00353
1. MEDICARE/MEDICAID PROVID (L1) 245238 2.STATE VENDOR OR MEDICAID (L2) 739745302	3. NAME AND AL (L3) MAHNOME (L4) 414 WEST J (L5) MAHNOME	EFFERSON AV	NTER	PO BOX 396 (L6) 56557	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation		
5. EFFECTIVE DATE CHANGE OF (L9)		01 Hospital		09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	
6. DATE OF SURVEY 02/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	07 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	32 (L18) 32 (L17)	X A. In Complia Program Re Compliance1. A B. Not in Comp	Y IS CERTIFIED AS ince With equirements e Based On: cceptable POC liance with Program and/or Applied Wai		And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: A 15. FACILITY MEETS	el 6. Scope of 7. Medical	f Services Limit Director Coom Size
18 SNF 18/19 SNF 32 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM See Attached Remarks	IARKS (IF APPLICA		ANCELLATION DA	ATE):			
17. SURVEYOR SIGNATURE Sherri Softing, HFE NEII		Date : 0	03/30/2017	(L19)	18. STATE SURVEY AGENCY Mark Meeth		Date: Decialist 06/19/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA REG	IONAI	OFFICE OR SINGLE S	STATE AGENCY	(****)
19. DETERMINATION OF ELIGIBI _X 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITH C HTS ACT:	CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Abov	rol Interest Disclosure St	
22. ORIGINAL DATE OF PARTICIPATION 08/04/1981	23. LTC AGREEI BEGINNINC		4. LTC AGREEME ENDING DATE		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	<u>INVOL</u>	(L30) <u>UNTARY</u> to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	ion <u>OTHE</u> F	vider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE			

(L33)

DETERMINATION APPROVAL

03/03/2017

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5238

On February 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 24, 2017, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 6, 2017. Based on our revisits, we have determined the facility has corrected deficiencies issued pursuant to the extended survey, effective February 9, 2017. As a result that the facility achieved compliance, the Department discontinued the Category 1 remedy of State monitoring as of February 9, 2017.

However, the Department recommended to the CMS Region V office the following actions related to the remedies recommended in our letter of March 30, 2107, for imposition:

- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, 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), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2017, as a result of the extended survey that identified Substandard Quality of Care (SQC).

Effective February 9, 2017 the facility is certified for 32 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245238

June 18, 2017

Mr. Dale Kruger, Administrator Mahnomen Health Center 414 West Jefferson Avenue, PO Box 396 Mahnomen, MN 56557

Dear Mr. Kruger:

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 9, 2017 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 30, 2017

Mr. Dale Kruger, Administrator Mahnomen Health Center 414 West Jefferson Avenue, PO Box 396 Mahnomen, Minnesota 56557

RE: Project Number S5238027

Dear Mr. Kruger:

On January 24, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective January 29, 2017. (42 CFR 488.422)

In addition, on January 24, 2017, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies being imposed:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Furthermore, this Department recommended to the CMS that the following additional enforcement remedy be imposed. CMS concurred and had authorized us to notify you of the imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective April 6, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on January 6, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On February 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 24, 2017, 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 an extended survey, completed on January 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 6, 2017, as of February 9, 2017.

Mahnomen Health Center March 30, 2017 Page 2

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 9, 2017.

However, as we notified you in our letter of January 24, 2017, 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 January 6, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of January 24, 2017:

- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 6, 2017, be rescinded. (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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 30, 2017

Mr. Dale Kruger, Administrator Mahnomen Health Center 414 West Jefferson Avenue, PO Box 396 Mahnomen, Minnesota 56557

Re: Reinspection Results - Project Number S5238027

Dear Mr. Kruger:

On February 24, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 6, 2017, with orders reviewed electronically on January 25, 2017. At this time these correction orders were found corrected.

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.

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDIC PART I

ARE/MEDICAID CERTIFICATION AND TRANSMITTA	AL ID: TXE1
- TO BE COMPLETED BY THE STATE SURVEY AGEN	CY Facility ID: 00353
3. NAME AND ADDRESS OF FACILITY	4. TYPE OF ACTION: 2 (L8)

2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): A. In Compliance With And/Or Approved Waivers Of The Following Requirements:	
From (a): A. In Compliance With And/Or Approved Waivers Of The Following Requirements:	
To (b): Program Requirements Compliance Based On: 2. Technical Personnel 6. Scope of Services Limit Compliance Based On: 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room	
Requirements and/or Applied Waivers: * Code: B * (L12)	
14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)	
(L37) (L38) (L39) (L42) (L43)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):	
See Attached Remarks	
17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:	
Beth Nowling, HFE NEII 02/13/2017 (L19) Mark Neeth, Enforcement Specialist 03/03/20	017 (L20)
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY	
19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21. 1. Statement of Financial Solvency (HCFA-2572) 22. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 33. Both of the Above:	
22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)	
OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY 08/04/1981 ENDING DATE VOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety	y
(L24) (L25) 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
(L27) B. Rescind Suspension Date: (L45)	
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS	
03001	
(L28) (L31)	
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	
(L32) DETERMINATION APPROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5238

On January 6, 2017 an extended survey was completed. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to residents health and safety. CMS policy requires that facilities will not be given an opportunity to correct before remedies would be imposed when immediate jeopardy has been identified. The facility meets this criterion. Therefore, this Department imposed the following Category 1 remedy:

- State Monitoring effective January 29, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Furthermore, 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 a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 6, 2017. 42 CFR488.417 (b))

The facility would be subject to a two year loss of NATCEP, beginning January 6, 2017, as a result of the extended survey, that identified SQC. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 24, 2017

Mr. Dale Kruger, Administrator Mahnomen Health Center 414 West Jefferson Avenue, PO Box 396 Mahnomen, Minnesota 56557

RE: Project Number S5238027

Dear Mr. Kruger:

On January 6, 2017 an extended 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.

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

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 6, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

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

• State Monitoring effective January 29, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

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

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 6, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 6, 2017. (42 CFR 488.417 (b)). The will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2017. (42 CFR 488.417 (b)). You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mahnomen Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective January 6, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to: Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

APPEAL RIGHTS

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

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

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

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-64
Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have 1 been affected by the deficient practice;
- address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by April 6, 2017 (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 July 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

245238

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 02/13/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245238	B. WING		01/06/2017
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MAHNON	MEN HEALTH CENTE	3		414 WEST JEFFERSON AVENUE, PO BOX 3	96
	MENTILALITY GENTLE	•		MAHNOMEN, MN 56557	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	-s	F 0	00	
	Department of Hea January 6, 2017. The Immediate Jeopard facility's failure to confectively implement alarm which resulte harm or death. The	ucted by the Minnesota th on January 3, 2017 through he survey resulted in an y (IJ) at F323 related to the emprehensively assess and nt fall interventions of an d in the high potential for IJ began on September 20, oved on January 6, 2017.			
	extended survey wa	fication of the IJ at F323, an as conducted by the ent of Health on January 5			
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 241 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the an attained in accordance with	F 2	41	2/9/17
	resident in a manne	t treat and care for each er and in an environment that nce or enhancement of his or			
BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE
Flectron	ically Signed				02/01/201

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

B. WING

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

program participation.

Event ID:TXE111

Facility ID: 00353

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY
		245238	B. WING	·····	01/0	06/2017
	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	her quality of life reindividuality. The fapromote the rights This REQUIREMEI by: Based on observareview the facility fadressed in a dignific (R22) reviewed for Findings include: R22's annual Minim 11/16/16, indicated and Alzheimer's dis R22 had severely in incontinent of urine assistance for dressistance for d	cognizing each resident's acility must protect and of the resident. NT is not met as evidenced tion, interview, and document ailed to ensure residents were ed manner for 1 of 2 residents dignity concerns. The mum Data Set (MDS) dated R22 had Parkinson's disease sease. The MDS identified mpaired cognition, was and required extensive sing and ambulation. Teed 12/12/16, indicated R22 ance of one to two staff, a gait ambulation, and assistance of the man and an ambulation area. R22 was a pair of gray sweat pants that	F 24	" On 01/06/2017 the hole in Resi 22 s grey sweat pants, below the I front pocket was repaired. " 01/25/2017 Nursing staff and L staff were provided education by th Director of Nursing or Designee. education included direction to inspresident clothing at the time of laun and when assisting residents with dressing. If clothing is found to be i of repair the clothing will be set asid the seamstress to fix or if needed, family/representative will be notified purchase new clothing. " By 02/03/2017 the same educa will be discussed during one-on-on nursing home staff meeting. Staff in present during these meetings will educated on their first shift worked 02/03/2017. " By 02/03/2017 staff will receive education by the Director of Nursing Designee on treating and caring for residents in a manner and in an environment that promotes mainter or enhancement of his or her qualit recognizing each resident s individ Staff not present during these meet will be educated on their first shift wafter 02/03/2017. " The Director of Nursing (DON) designee, will monitor the residents appearance and condition of clothing the set of the present during the present during the presen	aundry e The ect all dering n need de for d to ation e not be after g or all nance y of life duality. tings vorked , or her	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245238	B. WING		01/0	06/2017
	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R		STREET ADDRESS, CITY, STATE, ZIP COD 114 WEST JEFFERSON AVENUE, PO E MAHNOMEN, MN 56557	Ē	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	stationary chair in the serving door with head room filled with responts gaped open a outer left thigh and Throughout the dinfrom 4:58 p.m. to 5 past R22 on the water was attempts or offers the control of the control	co.m. R22 was seated in a he dining room outside of the is left side facing the dining idents. The hole in R22's and exposed R22's upper, white incontinence brief. ing observation on 1/3/17, :49 p.m. multiple staff walked by to the serving door, with no onchange R22's pants. a.m. nursing assistant (NA)-Eard extensive assistance with on and incontinence cares. and many pairs of sweat pants, we had the sweat pants that showed p.m. licensed practical nurse are pants that showed p.m. licensed practical nurse are pants that showed c.m. the dietary manager she observed the hole in R22's M-A confirmed she could see and white material hanging out the sweat pants as R22 was the dining room. DM-A are ware that R22's clothes that R22's clothes that R22's clothes that R22's had a	F 241	1month until found to be comp monitoring data will be brough the Quality Assurance Perform Improvement by Nursing Home Improvement designee (QAPI) determined compliant. As of 02/09/2017 all residents were inspected by director of r MDS coordinator for defects. found to be defective were pul to laundry for repair. After this clothing will be inspected during laundering and examined by stime of dressing.	t through lance e Quality until clothing lursing and Clothing led and sent date,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245238	B. WING _		01/	06/2017	
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BO MAHNOMEN, MN 56557	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 241 F 282 SS=D	dressed in them. On 1/5/17, at 3:27 pconfirmed the hole dignified, and would change R22's pants The facility's Quality 3/2016, indicated efor in a manner that quality of life, dignit 483.21(b)(3)(ii) SEPPERSONS/PER CA	o.m. clinical manager (CM)-A in R22's pants was not dhave expected staff to s. y of Life-Dignity policy dated ach resident would be cared the promotes and enhances y, respect and individuality. RVICES BY QUALIFIED ARE PLAN	F 24			2/3/17	
	care. This REQUIREMENT by: Based on observative, the facility full planned non-pharm ongoing monitoring severe pain for 1 of for pain. Findings include: Review of R18's carevealed R18 had or related to a history	qualified persons in such resident's written plan of NT is not met as evidenced stion, interview and document ailed to implement care accological interventions and of frequent moderate to 3 residents (R18) reviewed re plan dated 11/15/16, complaints of chronic pain of alcohol abuse and falls with racture. R18's care plan		" On 01/04/2017 a review of I medication regime was conduct consulting pharmacist. The findifor no recommendations at that " 01/06/2017 R18 was sent to was found to have an upper resinfection and was given an antib steroid. " 01/06/2017 BIMS s and Pherformed on R18. He scored a indicates some mild depression " 01/10/2017 Primary care princreased R 18 s gabapentin from	ed by the ngs were time. o clinic and piratory iotic and IQ-9 were a 6 which covider		

PRINTED: 02/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING (COMPLETE	JRVEY
245238 B. WING 01/06/20	2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MAHNOMEN HEALTH CENTER 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETION DATE
revealed R18 had complained of pain with therapy, he had been educated to continue therapy despite the pain as he had not been using his arm due to pain. R18's care plan directed staff to provide R18 with pain medications, BioFreeze (an over the counter topical pain relieving medication) and non-pharmacological pain interventions of warm/cold packs. R18's care plan revealed PT has been ordered for shoulder pain and R18's MD had declined further pain medications or diagnostic testing of an MR1 as of 11/8/16. The care plan further revealed R18 had enjoyed activities of trivia, reminiscing, and western movies shortly after he was admitted and R18's shoulder pain prevented him from attending activities. The care plan also revealed R18 preferred to lay in bed for comfort and had declined further activities due to pain. An identified care plan goal was for R18 to develop coping strategies to help adapt to pain. R18's admission Minimum Data Set (MDS) dated 11/2/16, R18 had frequent pain of a moderate level and had received as needed (prn) pain medications. The MDS identified R18 did not receive scheduled pain medications or non-medicinal interventions for pain within the seven day look back period. Son 1/6/17, at 8:20 a.m. Registered Nurse Manager (NM) stated R18's cognition had improved since his admission assessment and no longer had moderate cognitive impairment. NM stated R18 would be a reliable source of information regarding his pain level. Review of R18's Pain Care Area Assessment	

(CAA) dated 11/2/16, identified R18 had many

can move his arm a lot better so it seems

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01//	06/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		J0/2017	
IVAIVIL OI	THO VIDEN ON SOLT EIE	ı		414 WEST JEFFERSON AVENUE, PO			
MAHNOI	MEN HEALTH CENT	ER		MAHNOMEN, MN 56557	DOX 390		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	complaints about The CAA identified collar bone. Review of R18's production of R18's	shoulder, neck and back pain. d R18 had a history of a broken assessment dated d R18 had stated upon staff requent pain of the right icle (collar bone) with onset with ssessment revealed R18 had as an ache and was of a y. The assessment revealed in place of Tylenol 650 y mouth (po) every four hours and a referral for physical occupational therapy (OT). To p.m. R18 had his right arm est and a furrowed brow, squinted eyes, with facial To p.m. R18 was observed with tightly guarded to his chest. As grimaced with a furrowed brow, reses offered him ibuprofen and n which was frequently tated the staff had offered ice he was admitted and that was medication administration record r, November and December 18 was having inconsistant relief tions were requested and 8 reported ineffective, somewhat otive relief after receiving the	F 2	that the increase in gabapen effective. Staff will discuss I control and ability to perform weekly IDT meetings. Nursin PT/OT will notify the DON if the indication by R18 that the resis not controlled. " 01/26/2017 Follow up ap was made with orthopedics of 02/01/2017 for a follow up to proper healing of clavicle for management. " 01/26/2017 Family was replan to treat R18 is pain. Fainformed of the orthopedic along and the increase in the gabat that the Ibuprofen is now schill monitor facial expression behaviors of R 18 and documexpressions that would be in 18 experiencing pain for exafurrowed brow, taut jaw and pursed lips. Non-pharmacologinterventions will be offered in experiencing pain break throadministering additional PRN medication per R18 is reques interventions could include be limited to heat, cold pack, bid repositioning etc. " On 01/27/2017 a depresion regarding depression screen on the proposition of the proposition	R 18 s pain ADLs at the ng staff and here is any sident s pain pointment or ensure pain notified of the mily was popointment pentin and eduled ursing staff s and nent facial dicative of R mple cheeks, and gical f R 18 is ugh, prior to I pain st. These ut are not perfereze, sion d on R18 with minimal rovider was lan: R18 D1/31/2017 ing results.		

Facility ID: 00353

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/0	06/2017	
NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP	•		
				414 WEST JEFFERSON AVENUE,	PO BOX 396		
MAHNO	MEN HEALTH CENT	ER		MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 282	moderate to sever Tylenol 650 mg 3 R18 had somewhat revealed R18 receitimes and out of the had somewhat efficities and out of the ibuprofen was Review of Therapt form dated 10/28/to the facility funct (FMP) three times Review of a Therapt form dated 11/9/16 pain from a fracturand pain. The assattempted seven 12/1/16 and R18 his three of the seven The assessment for have pain in his Review of facility pto 1/4/17, revealed which was moderareceived prn medi inconsistent result R18's medical recof non-pharmacole having been offered management. On 1/5/17, from 7 observed to have attempting to utiliz possible, R18 utilizensible, R18 util	tre pain and had received times and out of the three times at effective pain relief. The MAR elived ibuprofen 400 mg eight ne eight times two times R18 ective pain relief and six times effective. YASSESSMENT, OT evaluation 16, revealed R18 was referred ional maintenance program a week for ROM. The py Assessment, PT evaluation 6, revealed R18 had shoulder re and had decreased ROM essment revealed PT had visits with R18 from 11/11/16 to had participated in therapy on visits and had refused the rest. For urther revealed R18 continued a shoulders. The pain and had refused the rest. For a consistently reported pain ate to severe in intensity. R18 cations upon request with	F 2	R18 s pain was conducted does not affect his ADL secheduled medications with non-pharmaceutical intervers. PRN Tylenol for breakthrous provided. The care plan wand revised. By 02/03/2017 all Nurre provided education on R15 Those that are not working educated on their first shift 02/03/2017. O1/10/2017 maintenary clips to all recliners for the fastened too. On 01/10/2017 the Memet with the Administratory discuss the issue of pain rethe nursing home. Discussidentifying the barriers to opain issues. The results of discussion are: Residents/patients with abuse and recent sobriety treated conservatively. There are those reside with brain injuries from the abuse or have dementiany them being poor historians it difficult to determine what is. Providers should atternon-pharmaceutical intervisimple analgesics to be triangle analgesics to be triangle analgesics will continue more timely and aggressive m	s or his sleep. ill be given with rentions and rentions are viewed sing staff was 8 s care plan. g will be it worked after ance fastened e alarms to be redical Director and DON to management in resion included deal with chronic rentions included the substance rention and lead to s and can make at the pain level rentions and rentions and rentions making attively. rentions making		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245238	B. WING		01/0	06/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9, _ 9 11
			4	114 WEST JEFFERSON AVENUE, PO BOX 3	396	
MAHNON	MEN HEALTH CENTE	ER .		MAHNOMEN, MN 56557		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	taut jaw and cheek he was not doing was tated he could not oarm pain. R18 s Tylenol and it had to have severe paid. On 1/6/17, at 9:16 independently toward forehead creased, was in a lot of pain that morning, and reducing his pain. On 1/5/17, at 12:43 refused to participaright shoulder. On 1/5/17, at 1:55 (LPN)-A stated R1 pain frequently. LF to her both the Tyleineffective in reliev not offered R18 ar On 1/5/17, at 2:39 stated she had see station and compla NA-A stated R18 her he had pain. On 1/5/17, at 3:18 reported to her he	ved to have a furrowed brow, ks, and pursed lips. R18 stated very well due to arm pain. R18 t sleep the previous night due tated the nurse had given him not worked, and he continued	F 282	,	mine est or ure timely, nent all ns. 5 days erbal ably. aged at the pain will be 60 ans r 5 re not viewed. I that B, RD, ain (1-5	
	completed residen	a.m. NA-D stated she t restorative therapy daily and d to have upper and lower		at 100mg and continue with hydrod for breakthrough pain " RG-Plan: Ask resident in the she would like a Tylenol for leg pai	AM if	

Facility ID: 00353

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245238	B. WING		01/	06/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0 0, = 0	
MALINOMEN HEALTH OFNITER			414 WEST JEFFERSON AVENUE, P	O BOX 396		
MAHNOMEN HEALTH CENTER			MAHNOMEN, MN 56557			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
complete range of m R18's right arm three in November. NA-D sto work with R18 the complaints of pain. Nowhen he attempted to shoulder away from had not seen an important management or ROI On 1/6/17, at 8:30 a. frequently complaints shoulder. On 1/6/17, at 2:23 p. interview the NM state not receiving routine mediations of Tyleno stated she felt R18 cand that his pain was	NA-D stated she was to notion (ROM) exercises with etimes a week which started stated she had been unable week of survey due to R18's NA-D stated R18 had pain to lift his right arm, moving his his body. NA-D stated she provement in R18's pain M since he was admitted.	F 2	re-evaluate 02/06/2017 to se should be scheduled. "RH-Plan: Declines furth intervention. States his Tyle effective. "RI-Plan: Increase sched from BID to TID "RJ-Plan: Declines any treat pain. Performs his ow but would like a hot pack off entered to offer hot pack be re-evaluate in 2 weeks (02/2 see if this is effective. "RM-Plan: Resident state anxiety related. Will plan to Tylenol daily and continue whydrocodone for breakthrou. "RN-Plan: Declines furth intervention. States current Tylenol and Tramadol is effe. "RO-Plan: Tylenol was so 01/24/2017 BID. Will continue for effectiveness. "RP-Plan: Continue gab 400mg TID and Hydrocodor Will plan to schedule Tyleno. "RQ-Plan: Declines furth intervention. State current rare effective. ¿1 complained of severe 10). RC-Plan: Has Doctor of 01/31/2017 will request for 1 scheduled and continue hydrocodor will plan to scheduled the policy by 02/03/2017 by Nursing or designee. Those	medicine to n exercises fered. Order fore bed, will 13/2017) to tes it is more schedule vith gh pain. The treatment of ective. Scheduled nue to monitor the BID PRN. In the AM. Ther medications pain (7 out of appointment Tylenol to be drocodone of the Director of the Director of the process of the Director of the Directo		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE COMF	SURVEY
		245238	B. WING			01/0	06/2017
	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R	,	STREET ADDRESS, CITY, STATE, ZI 414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD THE APPROPR	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 9	F 2	working before 02/03/201 educated on their next shall be educated Director and put into effer All staff will be educated 02/03/2017 by the Director designee. Those staff no 02/03/2017 will be educated shift worked. By 02/03/2017 mill be educated worked after 02/03/2017 or This education regarding pain residents. Staff not presoneeting will be educated worked after 02/03/2017 or This education included. How to recognize a resperiencing pain by more expressions, ability to peinability to sleep, present behaviors, lack of appetite 2. Monitoring and document of the education effective of pain control in 3. Communication with regarding medication effective of pain control. Non pharmaceutical the importance of utilization administration of PRN passing the importance of utilization administration of PRN passing the pain control in the education effective resident pain control. By 02/03/17 Mahnom Center Providers will evant the nursing home with coon a routine basis. Weekly at the IDT miresident who receives passing concerns, the IDT miresident who receives passing concerns where	nift worked. nagement p by Medical cet immedia on the polic or of Nursir of working I ated on thei ag staff rece a managem ent during of l on their fire. ded: resident is nitoring factoring with te. mentation of medication. providers ectiveness intervention ion prior to ain medicat brainstorm rol and how men Health aluate resid omplaints of eeting, each ain medicat	colicy I tely. cy by ng or before r next eived ent for this est shift ial s, of the and ion ling of v to ents in f pain ch ion or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/	06/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
MALINO	AENLUE ALTU OFNITE	·n		414 WEST JEFFERSON AVENUE, F	O BOX 396		
MAHNOI	MEN HEALTH CENTE	:K		MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	age 10	F2	effectiveness of the medical interventions that are being concerns are determined, the follow up with the physician "At the time of the Quarned Assessment, the Minimum (MDS) coordinator, will interventions or if the resident if the assessming pain concerns or if the residencering pain medication. Coordinator will follow up with physician regarding the indication coordinator will follow up with physician regarding the indication. The MDS coordinator review and revise the care needed. By 02/03/2017 all licented ducated on the process to pain intensity rating pre/postadministration for PRN medicated and intensity resident care plans for residutilize pain medication were the care plans are accurated interventions and resident significant the documentation of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medications were sure the effectiveness is monitored and communication of PRN pain medication were sure the effectiveness is monitored and communication of PRN pain medication were sure the effectiveness is monitored and communication of PRN pain medication.	utilized. If the DON will in terly Data Set erview staff and ent leads to dent is The MDS ith the ividual resident inator will plan as sed staff will be a document st dication in the nee will monitor dents who kly to ensure e as to status change. In the effective weekly to being ted to the nee, will entation of we symptoms concerns, is ated the pain.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245238	B. WING _		01/0	06/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO B MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH ACTION SHOUTH APPOSES FREE FRENCED TO THE APPOSES FREE FRENCED TO THE APPOSES FREE FREE FREE FREE FREE FREE FREE F	OULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 11	F 28	Performance Improvement (QA determined compliant. The nemeting is scheduled for Febru 2017.	xt QAPI	
F 309 SS=G	483.24, 483.25(k)(l) FOR HIGHEST WE	PROVIDE CARE/SERVICES ELL BEING	F 30	9		2/3/17
	applies to all care a residents. Each residents. Each residential facility must provide services to attain or practicable physica well-being, consiste	e and amental principle that and services provided to facility sident must receive and the extension that the highest and maintain the highest and psychosocial ent with the resident's sessment and plan of care.				
	provided to residen consistent with prof the comprehensive	ent. Issure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences.				
	residents who requiservices, consistent of practice, the compared the care plan, and the repreferences. This REQUIREMENT by:	cility must ensure that ire dialysis receive such twith professional standards aprehensive person-centered esidents' goals and				
	review, the facility fainterventions, monit the pain management	cion, interview and document ailed to implement tor for efficacy and reassess ent program to relieve frequent pain following a fracture of		" On 01/04/2017 a review of medication regime was conduct consulting pharmacist. The find for no recommendations at that " 01/06/2017 R18 was sent to	ted by the lings were t time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245238	B. WING		01/0	06/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (9, 2, 3, 3
				414 WEST JEFFERSON AVENUE, F	O BOX 396	
MAHNOI	MEN HEALTH CENTE	ER .		MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	the right clavicle for reviewed for pain. actual harm to R18 Findings Include: R18's admission M11/2/16, identified impairment and hapain of upper extre (CHF) and seizure R18 had frequent had received as not The MDS identified scheduled pain mainterventions for paback period. On 1/6/17, at 8:20 (NM) stated R18's his admission assemoderate cognitive survey R18 had im R18 had minimal cable to verbalize hidifficulty. NM state source of information Review of R18's P (CAA) dated 11/2/complaints about some The CAA identified collar bone. The C	or 1 of 3 residents (R18) This deficient practice caused	F3		antibiotic and and PHQ-9 were pred a 6 which ssion. The provider of the properties of the properties of the program of the pro	
	home rounds. Alth significant pain, the pain after this CAA the pain and pain r	ough R18 reported consistent, ere were no re-assessments of a. The facility failed to re-assessmanagement program in order acy of interventions and the		was ordered to be administ TID scheduled instead of F Tylenol will be PRN for brea Nursing staff will monitor th of the Ibuprofen increase a	tered 400mg PRN and akthrough pain. he effectiveness	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		245238	B. WING		01/0	06/2017
NAME OF F	PROVIDER OR SUPPLIER	J		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/1	70/2011
			4	114 WEST JEFFERSON AVENUE, PO BOX	396	
MAHNON	MEN HEALTH CENTE	ER .		MAHNOMEN, MN 56557		
(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 SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From page	age 13	F 309			
F 309	need to modify any interventions. Review of R18's paragraph 10/27/16, revealed interview he had from shoulder and clavismovement. The assectibed the pain moderate intensity interventions were milligrams (mg) by as needed (PRN) at the rapy (PT) and constructed R18's carevealed R18 had related to a history recent collar bone revealed R18 had the rapy despite the using his arm due directed staff to produce interventions.	age 13 y existing or implement new ain assessment dated R18 had stated upon staff equent pain of the right cle (collar bone) with onset of sessment revealed R18 had as an ache and was of a . The assessment revealed in place of Tylenol 650 mouth (po) every four hours and a referral for physical occupational therapy (OT). are plan dated 11/15/16, complaints of chronic pain of alcohol abuse and falls with fracture. R18's care plan complained of pain with en educated to continue e pain as he had not been to pain. R18's care plan ovide R18 with pain eeze (an over the counter	F 309	effectiveness to the Provider on D Rounds or sooner if pain is not coro or maintained at a tolerable level. " 01/17/2017 The IDT met to dis 18 s response to the increase in medications. R18 has reported to rehab that his pain is getting bette can move his arm a lot better so it that the increase in gabapentin ha effective. Staff will discuss R 18 control and ability to perform ADLs weekly IDT meetings. Nursing sta PT/OT will notify the DON if there indication by R18 that the resident is not controlled. " 01/26/2017 Follow up appoint was made with orthopedics for 02/01/2017 for a follow up to ensu proper healing of clavicle for pain management. " 01/26/2017 Family was notifie plan to treat R18 s pain. Family winformed of the orthopedic appoint and the increase in the gabapentir that the Ibuprofen is now schedule.	scuss R the OT and r and he seems s been s pain s at the ff and is any s pain ment re d of the was ment n and	
	topical pain relievir non-pharmacologic warm/cold packs. I had been ordered	ng medication) and cal pain interventions of R18's care plan revealed PT for shoulder pain and R18's		" Beginning 01/26/2017 nursing will monitor facial expressions and behaviors of R 18 and document f expressions that would be indicating	staff I acial	
	diagnostic testing of care plan further reactivities of trivia, removies shortly after shoulder pain prevactivities. The care preferred to lay in I declined further activities.	arther pain medications or of an MRI as of 11/8/16. The evealed R18 had enjoyed eminiscing, and western or he was admitted and R18's ented him from attending e plan also revealed R18 ped for comfort and had tivities due to pain. An a goal was for R18 to develop		18 experiencing pain for example furrowed brow, taut jaw and cheek pursed lips. Non-pharmacological interventions will be offered if R 18 experiencing pain break through, padministering additional PRN pain medication per R18 s request. The interventions could include but are limited to heat, cold pack, bio-free repositioning etc.	is prior to nese not	

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			4	414 WEST JEFFERSON AVENUE, PO BOX 3	96	
MAHNON	MEN HEALTH CENTE	ER .		MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pacoping strategies to the coping strategies to the copi	age 14 o help adapt to pain. O p.m. R18 was lying on his left the TV with his eyes open. arm guarded to his chest and a nched jaw and squinted eyes, ng. p.m. R18 was seated on the sfeet on the floor. His right arded to his chest. As he naced with a furrowed brow. been experiencing pain or to admission to the facility in R18 continued to guard his nace. R18 stated he had sharp at his collar bone and radiated R18 stated at times the pain at least an "8" on a pain scale being the worst imaginable e was right handed, so being his cares and eating had been enced pain whenever he moved stated at times it was hard for hit and coughing significantly level. R18 stated he told the in everyday. R18 stated the equently ineffective. R18 stated	F 309	" On 01/27/2017 a depression reassessment was performed on F a score of 3 which indicates minimal depression. Primary Care Provide consulted for advisement. Plan: Folinic appointment made for 01/31/regarding depression screening results. "On 01/27/2017 a reassessment R18 s pain was conducted. His does not affect his ADL s or his slands so on the service of the ser	R18 with al r was 18 2017 sults. at of pain eep. en with and wed was plan. after ned to be ector N to nent in uded	DATE
	therapy for the pai with therapy due to stated his physicia the medication, ga treat nerve pain fro had been taking th and had not had re he felt he had a hig	by the nurses to work with an and stated he could not work to it causing too much pain. R18 on had recently started him on bapentin (a medication used to to me neuropathy). R18 stated he are gabapentin since December belief from the pain. R18 stated gh pain tolerance as he was n", and the nurses and doctor		discussion are: 1. Residents/patients with substa abuse and recent sobriety need to treated conservatively. 2. There are those residents/patie with brain injuries from the substan abuse or have dementia which can them being poor historians and car it difficult to determine what the pai is.	ents ice lead to i make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/	06/2017	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BO MAHNOMEN, MN 56557	-		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	were not relieving had offered ice padand that was also i exhibit a furrowed ligrimacing. R18 state affected his well be he did was smoke but couldn't do it. Fpain kept him isolate himself. Review of R18's cut 12/13/16, revealed management: Tyle every four hours for ibuprofen 400 mg tright arm pain (star order dated 12/16/gabapentin 300 mg. Review of R18's m (MAR) for October 2016, revealed the PRN pain medication of the	n when he said the medications his pain. R18 stated the staff cks right after he was admitted neffective. R18 continued to brow, squinted eyes, and ted he felt the pain had sing, he felt depressed and all and try to sleep the pain away a18 stated he felt his continued ted and he did not feel like arrent physician orders signed the following orders for pain nol 325 mg, take two tablets por pain (start date 10/27/16), three times a day (TID) po for a date 12/7/16). A hand written 16, revealed an order for gs by mouth TID for pain. Redication administration record and December following administration of ons and the effectiveness: Realed R18 had reported epain and had received PRN times and one out of 10 times relief from the Tylenol. R18 had the effective relief the other nine revealed R18 reported	F 309	3. Providers should attempt the non-pharmaceutical intervention simple analgesics to be tried fir. 4. Residents often refuse non-pharmaceutical intervention it difficult to treat conservatively. 5. Providers will continue to the more timely and aggressive. 6. Staff will communicate with provider more frequently about will discuss pain of residents at Inter-disciplinary meetings to de what interventions seem to wor what to try different. Staff will emedication administration is do accurately and appropriately. By 01/30/2017 a pain assessith interviews were completed residents receiving pain medication. Those residents, who were not interviewable, will be observed and will be determined from non cues if their pain is managed to Residents, whose pain is not material to the residents of their pain is managed to Residents, whose pain is not material to the real treatment and their treatment adjusted accordingly. A pain reassessment will be performed days or sooner if needed. Carefully of a residents will be observed days for non-verbal cues as the interviewable.	ns and st. ns making . eat pain the pain and etermine k best or nsure ne timely, ssment on all tions. for 5 days n-verbal lerably, anaged at to the pain nts will be d in 60 e plans d for 5 y are not		
	Tylenol 650 mg 44 26 out of the 44 tim Tylenol it had been	e pain and had received PRN times. The MAR revealed on nes R18 had received the somewhat effective and three has ineffective in relieving R18's		o 1 Resident refused to be in Will continue to try and interview o 16 Residents were interview ¿ Of the 16 interviewed 5 state they didn thave any pain. (RA)	v. ved ed that		

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F 309	pain. R18 had report times. -December 2016, remoderate to severe Tylenol 650 mg 32 the times R18 had resomewhat effective had received ibuprothe month, out of the ibuprofen was semi effective and 18 times. -January 2017, revemoderate to severe Tylenol 650 mg 3 times and out of the had somewhat revealed R18 receive times and out of the had somewhat effective ibuprofen was effective of an x-ray identified R18 had a distal third of the clahealing subacute from Review of R18's ph 11/8/16, revealed R18 had a distal third of the clahealing subacute from Review of R18's ph 11/8/16, revealed R18 had a collarbone on 10/14 constant, sharp pai collarbone down his	evealed R18 had reported pain and had received PRN times and out of the 32 times, eported the medication was and 3 times ineffective and 11. The MAR also revealed R18 of the 400 mg 31 times during e 31 times 10 times the effective, three times not es was effective. The MAR also revealed R18 of the active pain relief. The MAR also received mes and out of the three times effective pain relief. The MAR are dibuprofen 400 mg eight the eight times two times R18 of the pain relief and six times of the active pain relief and six times of the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active which appeared to be a series of the pain relief and the active pain relief and the act	F3	609	RE, RK) ¿ 10 complained of moderate pare on a 1-10 scale). " RF-Plan increase gabapentin of at 100mg and continue with hydroc for breakthrough pain " RG-Plan: Ask resident in the Ashe would like a Tylenol for leg pair re-evaluate 02/06/2017 to see if Tyshould be scheduled. " RH-Plan: Declines further intervention. States his Tylenol BID effective. " RI-Plan: Increase schedule Tylefrom BID to TID " RJ-Plan: Declines any medicing treat pain. Performs his own exerce but would like a hot pack offered. Centered to offer hot pack before be re-evaluate in 2 weeks (02/13/2017) see if this is effective. " RM-Plan: Resident states it is anxiety related. Will plan to schedute Tylenol daily and continue with hydrocodone for breakthrough pain." RN-Plan: Declines further intervention. States current treatmed Tylenol and Tramadol is effective. " RO-Plan: Tylenol was scheduled 1/24/2017 BID. Will continue to more feectiveness." " RP-Plan: Continue gabapenting 400mg TID and Hydrocodone BID Will plan to schedule Tylenol in the RQ-Plan: Declines further intervention. State current medicate are effective. ¿ 1 complained of severe pain (7 10). RC-Plan: Has Doctor appoint	ordered odone M if N Will lenol D is enol ne to ises Order d, will Y) to more ule ent of ed nonitor PRN. AM. cions out of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	` '	SURVEY PLETED
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MAHNOI	MEN HEALTH CENTE	:K	1	MAHNOMEN, MN 56557		
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F 309	Continued From pa	age 17	F 309			
	tenderness over the revealed R18 was weeks.	ey of his collarbone with e joint. The note further to be seen again in four		01/31/2017 will request for Tylenol scheduled and continue hydrocodo PRN for breakthrough pain. " 01/30/2017 care plan policy developed and put into place effect	one	
	revealed R18 was physician regarding revealed R18 had	nysician note dated 12/7/16, seen by an orthopedic g his right shoulder. The note been having significant pain		immediately. All staff will be educathe policy by 02/03/2017 by the Dir Nursing or designee. Those staff working before 02/03/2017 will be	ector of not	
	the facility due to ridentified R18 had	ole to comply with therapy in ght arm pain. The note a healing right distal clavicle ole cuff dysfunction with his		educated on their next shift worked " 01/30/2017 pain management developed and reviewed by Medica Director and put into effect immedi	policy al	
		her revealed R18 had ernal rotation, that may have		All staff will be educated on the pol 02/03/2017 by the Director of Nurs designee. Those staff not working 02/03/2017 will be educated on the	ing or before	
	12/13/16, revealed identified R18 had acromial end of rig shoulder) with mal complained of ong The note revealed shoulder girdle atro of the distal clavicle	nysician progress note dated a nursing home note which a closed displaced fracture of ht clavicle (towards the union. The note revealed R18 oing pain in the right shoulder. R18 had significant right ophy with a marked deformity e. The note further revealed		shift worked. "By 02/03/2017 nursing staff receducation regarding pain manager residents. Staff not present during meeting will be educated on their floworked after 02/03/2017. o This education included: 1. How to recognize a resident is experiencing pain by monitoring fa	ceived ment for this irst shift cial	
	The note also reversible touch over the right R18 was to continut therapy and use Tymanagement. The to continue with particle (ROM) exerconsider adding actimprovement in R1	·		expressions, ability to perform ADL inability to sleep, presenting with behaviors, lack of appetite. 2. Monitoring and documentation effective of pain control medication 3. Communication with providers regarding medication effectiveness resident pain control. 4. Non pharmaceutical intervention the importance of utilization prior to administration of PRN pain medical.	of the n. s and ons and otation	
		Assessment, OT evaluation 6, revealed R18 had been		Staff discussion and brainstorr how to provide pain control and ho		

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		245238	B. WING _		01	/06/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
		_		414 WEST JEFFERSON AVENUE, F	O BOX 396	
MAHNON	MEN HEALTH CENTE	R		MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 18	F 30	09		
1 309	evaluated for therapher ROM both active are extremity. The assert referred to the facility program (FMP) three Review of a Therapher form dated 11/9/16, pain from a fracture and pain. The assessment reactive and pain. The assessment reactive and pain. The assessment reactive assessment revealed to move his arm and due to pain. The assessment revealed to move his arm and due to pain. The assessment fully 12/1/16 and R18 has three of the seven via 12/1/16 and R18 has three of the seven via 12/1/17, revealed The assessment fully to have pain in his service of the seven via 1/4/17, revealed The oriented, had comp 7 out of 10, received revealed R18 report was a 3 out of 10.	by and had impaired upper and passive of his right upper assment revealed R18 was ty functional maintenance be times a week for ROM. By Assessment, PT evaluation revealed R18 had shoulder and had decreased ROM assment identified R18 has a would shoot down his arm. Evealed R18 had reported bective in relieving his pain an 8 out of 10. The lead R18 understood the need bound, though did not want to sessment revealed PT had lead to be a participated in therapy on the revealed R18 continued shoulders. By Assessment, PT evaluation revealed R18 had shoulder had shoulder and had reported the rest. There revealed R18 continued shoulders.	F 31	recognize resident pain. By 02/03/17 Mahnomer Center Providers will evaluathe nursing home with comon a routine basis. Weekly at the IDT meer resident who receives pain has pain concerns, the IDT effectiveness of the medical interventions that are being concerns are determined, the follow up with the physician at the time of the Quark Assessment, the Minimum (MDS) coordinator, will interesident if the assessming pain concerns or if the resident on coordinator will follow up with physician regarding the indiconcerns. The MDS coord review and revise the care needed. By 02/03/2017 all licenseducated on the process to pain intensity rating pre/posadministration for PRN medication weelst the care plans for resident care plans for resident care plans for resident care plans are accurate interventions and residents. The DON, or her design monitor the documentation of PRN pain medications we	ate residents in plaints of pain sting, each medication or will review the ations and utilized. If he DON will aterly Data Set rview staff and ent leads to dent is The MDS with the ividual resident inator will plan as sed staff will be a document at dication in the mee will monitor dents who kly to ensure e as to status change.	
		revealed R18 complained of rated a 7 out of 10 and had 0 mg.		ensure the effectiveness is monitored and communicat physician.	being	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 309	right shoulder pain Tylenol 650 mg. The reported pain of 4 Tylenol. - A note on 11/6/16 right shoulder pain Tylenol 650 mg. The reported pain of 2 Tylenol. - A note on 11/7/16 due to right arm pain and the restorative ther 2 - 8, due to right arm pain and Tylenol ordered PT for shoulder pain and the rapeutic exercis ROM. -A note dated 12/2 11/15/16, revealed minutes by PT, recorded continued and the reported continued and reported	revealed R18 complained of rated 8 out of 10 and received ne note revealed R18 had out of 10 after receiving the street received ne note revealed R18 complained of rated 6 out of 10 and received ne note revealed R18 had out of 10 after he received the revealed R18 refused therapy	F 30	" The DON, or her designed monitor weekly the documental facial expression or objective is the resident who has pain condisplaying that would indicated resident was experiencing pair." The monitoring data will be through the Quality Assurance Performance Improvement (Quality determined compliant. The nemeeting is scheduled for Febru 2017.	ation of symptoms cerns, is I the n. e brought API) until ext QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245238	B. WING			01/0	06/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa		F3	809			
	-A note dated 11/19/16, revealed R18 complained of shoulder pain rated 6 out of 10 and received Tylenol 650 mg.						
		/16, as a late entry for R18 refused therapy.					
		/16, as a late entry for R18 refused therapy.					
	of shoulder pain rat Tylenol 650 mg. Th	8/16, revealed R18 complained ted 7 out of 10 and received e note revealed R18 had rated after he received the Tylenol.					
	and received Tylene	0/16, revealed R18 ulder pain rated a 7 out of 10 ol. The note revealed R18 had of 10 after he received the					
	revealed R18 was s	/16, late entry for 12/1/16, seen by PT, reported improved d 25 minutes of ROM					
	R18 complained of prior to admission. not addressed his s result was chronic R18 resisted therap	e note dated 12/1/16, revealed right shoulder pain from a fall The note revealed R18 had shoulder properly and the pain. The note further revealed by despite the benefit. The had been provided education nerapy.					
		/16, revealed R18 complained ted 6 out of 10, and received					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 309	Continued From pa		F 30	09		
		/16, revealed R18 complained ted 8 out of 10, and received				
		/16, revealed R18 complained ted 7 out of 10, and received				
	the NM twice and s done about his sho had planned to disc revealed the NM w further note reveale rated 7 out of 10 ar	116, revealed R18 spoken with stated something needed to be ulder. The note revealed PT continue services. The note ould speak with R18's MD. A ed R18 complained of pain and received Tylenol 650 mg. R18's pain level was 4 out of d the Tylenol.				
	revealed R18 recei sessions for the we	/16, a late entry for 12/6/16, ved 2 out of 3 restorative eek of 11/30/16 through eted upper extremity (U/E)				
	by an orthopedic M or interventions for NM encouraged R ² note revealed R18' 400 mg TID as nee note further revealed	716, revealed R18 was seen ID and received no new orders pain relief. The note revealed I8 to take Tylenol. A further IS MD had ordered ibuprofen IS MD had ordered ibupro				
	of right shoulder pa further note reveale maintenance progr	/16, revealed R18 complained ain and ibuprofen was given. A led R18's functional am (FMP) was updated to to his right upper extremity				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245238	B. WING			01/	06/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	R18 complained or received ibuprofer R18's pain level with ibuprofen. - A note dated 12/3 of pain rated 7 out 400 mg. The note rated 4 out of 10 at - A note dated 12/3 complained of pair received ibuprofen R18's pain level with received the ibuprofer R18's pain level R18's p	ies. A further note revealed f pain rated a 7 out of 10 and 400 mg. The note revealed as 3 out of 10 after he received of 10, and received ibuprofen revealed R18's pain level was fter he received the ibuprofen. In 1/16, revealed R18 and at 8 out of 10 and 400 mg. The note revealed as rated 3 out of 10 after he of en. In 1/16, revealed R18 and been y MD on a routine visit. The complained of continued a note further revealed R18 was shoulder for pain 15 minute	F3	309				
	received Tylenol 6	ted 8 out of 10 and had 50 mg. The note revealed R18 I 4 out of 10 after he received						
	approached NM and emergency room (pain. The note revibe seen at the clin revealed NM had in continued complained R18's MD had sentenced NM and	16/16, revealed R18 and requested to be seen in the ER) for continued shoulder ealed NM encouraged R18 to ic in the afternoon. The note informed R18's MD of his ants of pain. The note revealed t an order for gabapentin 300 and R18 was not seen						

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 309	in the clinic or ER. -A note on 12/20/16 pain in his arm and revealed R18 had be had to wait for the property of the pain in his arm and revealed R18 had be had to wait for the property holding his holding his holding his holding his holding his holding his holding exercise pressure on his right R18's medical recording exercise pressure on his right R18's medical recording been offered management. On 1/5/17, at 7:08 stationary chair in the cup in his left hand the elbow resting of received scrambled to to the state of the fork bites of scrambled to the fork bites of scramb fork to his right hand guarded his right are and moved his head sausage links. R18 arm/hand to eat the	6, revealed R18 complained of requested Tylenol. The note become "impatient" when he bain medication. 6, revealed R18 was observed ook upon his face and was is arm. The note further ed group activities and only eat and lay down. 6, revealed R18 had trouble es due to pain and too much	F3	809			

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	hot cereal, and place table. R18 picked us hand, ate two bites plate. R18 held the drank all of his coffinursing (DON) app had enough to eat. well and stated he At 7:22 a.m. R18 in dining room with his side, walked to the cigarette and lighte smoking room, pushand to open the disat on a chair. R18 hand and proceede while his right arm walked independen on his bed, while his to his side, brow wataut. On 1/5/17, at 7:26 adoing very well due could not sleep the pain. R18 stated thand it had not work severe pain. R18 further achopeless. R18 state when he had pain at the Tylenol or ibupor relieving pain. R18 was in pain and the ineffective in easing pain everyday and on 1/5/17, at 12:14	ced the spoon back on the up a piece a toast with his left and placed it back on his coffee cup in his left hand and ee. At 7:19 a.m. the director of roached R18 and asked if he R18 replied he was not feeling was going to go back to bed. Idependently walked out of the sight arm guarded to his right nurses station and obtained a r. R18 walked toward the hed the button with his left for, walked in the room and lit his cigarette with his left ed to smoke with his left hand, remained at his side. R18 then atly back to his room and sat sight arm remained guarded as furrowed, jaw tight and face a.m. R18 stated he was not to arm pain. R18 stated he previous night due to arm e nurse had given him Tylenoled, and he continued to have aid he was "so tired" of the dmitted he felt frustrated and ed he would tell the nurse and would tell the nurse side he told his physician he a Tylenol and ibuprofen were go the pain. R18 stated he had staff knew he was in pain.	F3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	right arm guarded brow was furrower and lips were pursuand lips were p	tightly to his right side. R18's d, cheeks and jaw were taut, ed. p.m. R18 walked who the hall toward the nurses of guarded toward his side, furrowed, lips and jaw tight. Garette, smoked with his left smoking room and walked R18's facial expression ged. a.m. R18 walked down the hall ard his room, lips and jaw tight, brow furrowed. At that time in a lot of pain, had received morning, and it had not been	F3	09		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	frequently. LPN-As with ordered PRN 1 reported pain. LPN-her both the Tyleno ineffective in relievi reported R18's conrecently as a couple she had not offered for pain.	tated she would provide R18 Tylenol and ibuprofen when he A stated R18 often reported to I and ibuprofen were ng pain. LPN-A stated she tinued pain to the NM as e of weeks ago. LPN-A stated I R18 any other interventions	F3	09		
	stated she had see station and compla NA-A stated R18 had her he had pain, mostated R18 had consince admission a finishe felt there were room due to being in R18 had also report due to pain and did she would inform the report pain to her.	o.m. nursing assistant (NA)-A n R18 walk up to the nurses in of pain on a routine basis. ad also frequently reported to est recently that week. NA-A inplained of right shoulder pain ew months ago. NA-A stated days R18 would stay in his in so much pain. NA-A stated ted to her he often laid down not sleep well. NA-A stated are nurse when R18 would NA-A stated she routinely acing when he moved his right issis.				
	reported to her he hunable to recall the she felt R18 often had to being in pair R18 walk up to the of pain frequently. It reported to the nursunable to recall the	o.m. NA- F stated R18 had had been in pain though was most recent time. NA-F stated held his right arm to his body in NA-F stated she had seen nurses station and complain NA-F stated she had also sees R18 had pain, though was most recent time.				
	stated she felt R18	was cognitively intact and able and wishes. The AD stated				

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		245238	B. WING _		01	/06/2017
	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R		STREET ADDRESS, CITY, STATE, ZIP (414 WEST JEFFERSON AVENUE, F MAHNOMEN, MN 56557	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)	N SHOULD BE	(X5) COMPLETION DATE
F 309	R18 had participate arrived at the facilit complained of right admission and had The AD stated she in his room per his R18 had stopped a his pain. On 1/6/17, at 8:23 completed resident R18 was supposed extremity exercises complete range of R18's right arm threin November. NA-Epain with movemer R18 had a fracture which she felt affect stated she had been week of survey due and not feeling well when he would be awhen he attempted shoulder away from had not seen an immanagement or R0 On 1/6/17, at 8:30 a frequently complair shoulder. NA-C star R18 guarding his rihis body. NA-C star his shoulder she well on 1/6/17, at 8:46 at to R18's primary principality's medical directions.	ed in activities briefly after he y. The AD stated R18 routinely shoulder/arm pain since stopped attending activities. completed 1:1 visits with R18 preference. The AD stated ttending group activities due to a.m. NA-D stated she restorative therapy daily and to have upper and lower and lower and lower are times a week which started a stated R18 complained of at of his right arm. NA-D stated a collar bone on the right side at the distribution of the range of motion. NA-D and the range of motion. NA-D are to R18's complaints of pain are weight with his right arm and to lift his right arm, moving his in his body. NA-D stated R18 had pain are weight with his right arm and to lift his right arm, moving his in his body. NA-D stated R18 hed of pain in R18's pain DM since he was admitted. a.m. NA-C stated R18 hed of pain in his right ted she frequently observed ght arm by holding it against ted when R18 reported pain in bould immediately tell the nurse. a.m. a phone call was placed hysician, who was also the rector. R18's primary MD was discould not return until 1/9/17.	F 3(09		

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F 309	to call back. MD di survey exit. A pho 1/10/17, at 4:20 p.I MD stated he was especially in his rignot aware of the or current pain regime R18's Tylenol and him on a schedule practice was to set they routinely received referred R18 to an felt an MRI was no considered adding prescription pain mandications or in prescribing thos would only order of medications in cas which he felt R18 of stated he had also pain in December would improve. ME heat and cold there staff had tried then On 1/6/17, at 1:56 old fracture to his recontinued to cause stated R18 received pain, which were of stated she had repreceiving relief from medications, most	age 28 It with MD's nurse line for MD Id not return phone call prior to the call was received by MD on Im. During the phone interview aware R18 had ongoing pain, Int shoulder. MD stated he was verall ineffectiveness of R18's en. MD stated he had thought ibuprofen were already given to Id basis. MD stated the usual medule PRN pain medication if ived it. MD stated he had orthopaedic MD and he had It necessary. MD stated he had Tramadol (non-opiate medication) to R18's medication of at that time. MD stated he to order opioid and/or narcotic flue to the monitoring involved the medications. MD stated he pioid and/or narcotic pain the sof acute injury or pain, did not meet that criteria. MD ordered gabapentin for R18's some time and had hoped that to stated R18 could have had apy, but was not sure if the the or their effectiveness. p.m. LPN-B stated R18 had an right collar bone which she felt the R18 frequent pain. LPN-B the d Tylenol and ibuprofen for verall not effective. LPN-B torted to the NM, R18 was not in pain with the current prin recently as the previous week. p.m. during a follow up	F 3	09			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 309	not receiving routin medications of Tyle stated she had bee cognition assessme surveyor due to R1 The NM stated she cognitively intact ar loss. The NM states source of informatic stated she had repocurrent pain medica. The NM stated she R18's MD regarding to an unwillingness. The NM stated R18 gabapentin and onl The NM stated she	rated she was aware R18 was e relief with the current PRN and and ibuprofen. The NM an unable to complete another ent as requested by the 8 not feeling well with a cough. If the felt R18 was overall and may have minimal memory dishe felt R18 was a reliable on regarding his pain. The NM ported to R18's primary MD the ation overall was not effective. Would routinely struggle with a R18's pain management due to try other pain medications. B's MD has started him on y saw minimal improvement. If the felt R18 continued to dishard the relief of the relief R18 continued to dishard the relief R18 continued t	F3	09				
F 323 SS=J	revealed it was the patients were free of management that we the highest degree enhance comfort. The licensed staff to compain assessment of directed licensed staff to compain assessment of directed licensed staff to schedule per 483.25(d)(1)(2)(n)(1)	edications and to evaluate if a rn pain medications. 1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 3	23		2/9/17		

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	(1) The resident en from accident haza (2) Each resident re and assistance dev (n) - Bed Rails. The appropriate alternation bed rail. If a bed on must ensure correct maintenance of bed to the following eler (1) Assess the resident or session formed consent p (3) Ensure that the appropriate for the This REQUIREMENT by: Based on observative review, the facility for residents (R32) who fractured wrist and facility was utilizing related to use of a confollow manufacture intervention ineffective.	vironment remains as free rds as is possible; and receives adequate supervision ices to prevent accidents. Perfectives adequate supervision ices to prevent accidents. Perfectives prior to installing a side or reside rail is used, the facility of installation, use, and dirails, including but not limited ments. The dent for risk of entrapment to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The and benefits of bed rails with dent representative and obtain rior to installation. The accidental representative and obtain rior to installation.	F 3:	ABATEMENT PLAN AS APPROMDH ON 1/6/2017: 1.) What are you going to do to the immediacy of the risk. a. Switched the Tab alarm and it with a mat alarm in the wheel based on root cause analysis a assessment. It was determined mat alarms would be more sen repositioning of the resident and does not need to be secured to chairs in order for the alarm to b. Staff on duty on 1/5/and 1/6 were educated by the RN and I SMART chair alarm utilizing the	o remove d replaced chair nd resident d that the sitive to the d the box any of the function. 5/2017 DON on the	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	related to the facility comprehensive assistances related to rise effective intervention administrator and on notified of the IJ on began on 9/20/16, of facility failed to compassessment of cause continued falls, in a interventions to mirright further falls. The IJ 4:00 p.m., however a scope and severificatual harm for R32 sustained during a assessment and in R32's diagnosis list diagnoses included activities due to dishistory of encephalma awareness), fracturn arthritis, osteoarthrick R32's admission M7/26/16, indicated frould be determined had severely impaired extensive assistance (ADLs), was occasion was not on a toileting medication and had which increased R35 further identified R35 further identified R35 further identified R55 further identif	ppardy (IJ) began on 9/20/16, y's failure to complete a sessment to determine causal sk for falls and implement ons for R32. The facility irector of nursing (DON) were 1/5/17, at 10:15 a.m. which when R32 had fallen and the aplete a comprehensive sal factors related to R32's effort to implement himize the risk of R32's risk for was removed on 1/6/17, at non-compliance remained at the level of G, which indicated 2 due to a left wrist fracture fall which required medical	F3	323	manufacturer s instructions. Staff educated did confirm they understor correct placement of the alarm ensithat proper placement and testing the performed so the alarm is able to fur properly. Staff that was not on duty and 1/6 will receive education as the come on duty. Staff educated on which use the mat alarms according to the individualized care plan. c. A comprehensive assessment completed on 1/5/2017 by RN and on the assessment there was no ching the resident in status since the lad quarterly assessment done in Octo 2016. Findings of the specific assessment requested are: i. Recliner assessment: 1. According to the definition of a restraint the chair when reclined can difficulty for this resident to transfer independently. Resident requests seated in the recliner with her feet elevated and her legs covered. Shable to cue staff by waving, asking has obvious agitation that she want repositioned or moved out of the received. Plan: a. Resident will be asked if she while to be placed in the recliner and would like her feet reclined or not. b. Staff will continue with hourly rewhile in the recliner. c. A Staff member will be monitor commons area at all times when rewith alarms are present in the command and alarms are present in the command. d. A mat alarm will be used at all the second and alarms are present in the command and alarms	uring vere unction on 1/5 ey when to e was based hange ast ber of uses to be e is and is to be cliner. ould if she bunding ing the esidents mons	

R32's Falls Care Area Assessment (CAA) dated

when seated in the recliner in the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	8/2/16, indicated R: 1 fall. R32 was four front of her recliner negative for a fracti fall risk. R32's Cognitive Lo. 8/2/16, indicated R: obtained a bladder of admission and re delirious at times. R32's Falls Risk Ad indicated R32 had required the use of lib and was contine took antihypertensi that increased R32 further indicated R3 with a decline in co depression and der R32 was at risk for PT and occupation care plan would be R32's care plan dat had memory and co to worsen with UTI' in all of her ADLs si delirium as she rea air. R32's care plan be safe in her surre and R32 would be R32's care plan ide incontinent of bowe and incontinence w recent UTI and fall. 2 hours. R32's care	32 had and on the floor in her room in . She had an x-ray which was ure, and R32 remained a high as/Dementia CAA dated 32 had infection during her first week emained very confused and suity report dated 7/21/16, poor safety awareness, assistive devices, was up ad nt. The report indicated R32 we and laxative medications is risk for falls. The report 32 had cognitive impairment gnitive function, delirium, mentia. The report identified falls and was to be seen by all therapy (OT) and a falls	F3	23	commons area as directed in the p care specifically for this resident. ii. Bowel and Bladder assessmer completed to determine resident is toileting pattern. 1. RN has reviewed bathroom pare over the last 7 days. This is a detain record in real time based on nursing assistant records. This was taken on actual times the resident was to or changed. Jan 5th, 2017: 6 am void, dressed for the day, was incontinent of bladd 7 am dry, 9 am dry, 11 am dry, 3 pm of 5 pm, 8 pm void washed up for bed, went to bed. 11 pm dry awake in be placed in her recliner for supervision night shift reported that she slept a supervision of the day was wet, 8 am dry void with 10 am dry void, 12 pm dry void, 4 prevoid, 8 pm dry void and dressed for placed in her bed but was awake or ounds, placed in recliner during the slept remaining night shift. Jan 3rd 2017: 12 am placed in recliner, 6 am void but pad was wet, drefor the day. 8 am dry void, 9 am dry 12 pm dry void, 3 pm dry void, 5 pm void, 8 pm dry void and dressed for Jan 2nd 2017: Up in her recliner ar 12-1 am due to being awake in bed wet, void and dressed for the day, to get up. 7 am dry void, 10 am dry void, 2 pm dry void, 4 pm dry void, 8 pm dry void,	tterns led g based ileted and up der. dry, then d, on and ll night. I, void a a BM; m dry bed, n e night, essed void, dry r bed. ound , 5am wanted void,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/0	06/2017
NAME OF F	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE		
		_		414 WEST JEFFERSON AVENUE, PO BOX 396		
MAHNON	MEN HEALTH CENTE	R		MAHNOMEN, MN 56557		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	and watch for her therself. The care p	rying to go to the bathroom by lan identified R32 had bed and	F 323	void and dressed for bed.		
	transferring, a tab a standing without pu within reach, no clu within reach, fall m and lipped mattres	d 7/27/16, due to R32 self alarm placed 9/20/16, due to urpose, all items were to be utter on the floor, call light at placed, bed in low position s. R32's care plan further on 7/27/16, and had no injury,		Jan 1st 2017: Resident slept fair be awake at 4 am, wet and void place recliner, 7am void, dressed for the 11am dry void, 12pm dry void, 4pm void, 7pm dry void, 8pm dry void addressed for bed.	d in day, n, dry	
	another fall 9/20/16 fracture, and fell ac The care plan faile	6, with skin tear and left wrist gain on 11/21/16, with no injury. d to identify R32's falls on 16. There were no injuries.		Dec 31 2016: Up and void at 5am, wet and placed in recliner, 9am dry 12pm dry void, 3pm dry void, 7pm void, 9pm dressed for bed, dry.	/ void,	
	nursing assistants R32 required the a which included trar	th Assignment sheet (tool use to direct care), indicated ssistance of 1-2 staff for ADLs asfers and toileting, and a bed and chair alarm.		Dec 30th 2016: Up at 4am wet and her recliner, 7am dry void, 10 am of 12pm dry void, 3pm dry void, 5 pm void, 8pm dry void and dressed for	dry void, dry bed.	
	Fall events:			RN has reviewed the bathroom parand Resident s incontinence patter been determined to improve since	ern has	
	fell on 7/27/16, at 7 to self transfer and room. The report in pain in her buttocks and UTI. The report checks (neuros) are checked and fall in	y Event report indicated R32 7:30 p.m. after she attempted was found on the floor in her ndicated R32 had complaints of a and right thigh, had a fever ort identified neurological nd vital signs (vitals) were terventions included edication), bed alarm and rest.		admission on 7/20/16. During the consist is kept continent and the assessment indicates the Resident is only incorpat night. There are very few occasis when she is incontinent, she does some urge tendencies but she see be able to hold her bladder and has continent void and BM. We do not her to toilet her due to her dementing can cause her to get her days and	day she ent date ntinent ons have ems to ve a wake a and it	
	p.m. indicated R32 room in a sitting poright side. R32 stat thigh hurt. The note	was found on the floor in her was found on the floor in her esition with both legs off to her ed her butt and right leg and e identified R32 denied hitting red to the fall safety event		mixed up. This has been discussed the family and they are in agreeme Staff attempts to place her in her be night, but during rounds the night sher awake often and due to her fall they get her up and assist the Resistence in the commons area for the recliner in the commons area for the recliner in the commons area for the recliner in the commons area.	d with ent. ed at staff find I risks ident to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245238	B. WING _		01/0	06/2017	
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				414 WEST JEFFERSON AVENUE.	PO BOX 396		
MAHNO	MEN HEALTH CENTE	R		MAHNOMEN, MN 56557			
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F 323	at 5:02 p.m. identifi projections through degenerative change 2. R32's Fall Safety fell on 8/27/16, at 1 R32's chair alarm s self transfer from he commode. R32 was the floor on her but bathroom door kno complained of sligh her vitals signs wer identify R32's ment factors, if current in any new intervention R32's PN dated 8/2 R32 slipped and fel head on the door kinglight pain in the mi were taken and the ensure R32 had he 3. R32's Fall Safety fell on 9/20/16, at attempted to self-trafloor in her room fa her right forearm. Tand vitals were common to the standard st	o X-ray report dated 7/31/16, ed R32 had abnormal bony out her pelvis and ges without definite fracture. Tevent report indicated R32 0:21 a.m. The report indicated ounded after she attempted to er wheelchair to the sobserved to slip and fall on and hit her head on the b. The report indicated R32 t pain in her lower back and e taken. The report failed to al status, possible contributing terventions were effective, or ns implemented after the fall. 17/16, at 10:38 a.m. indicated I on her butt and bumped her nob. R32 complained about ddle of her back. R32's vitals new intervention was to r shoes on. Tevent report indicated R32 ansfer. She was found on the cing her bed with a skin tear to the report indicated neuros npleted, there were no	F 3	closer monitoring. The RN family about bringing the F commons area to rest in the monitored. The family sis fine as long as she is ge sleep. The RN and staff as family that she does sleep recliner, but staff will continue to have her sleep in her be nursing will continue to mon Resident sleeping in the resident stoilet habits, it is she gets up for the day she the bathroom about 1-2 how arising. There is not a definition breakfast through lun many voiding times that do from day to day. After lunch the Resident is been to either roam in her be with staff at the desk or requests to sit in the reclin does rest well in her reclin usually nap for a few hours is toileted before supper or needs to use the bathroom.	has notified the Resident to the Resident to the Resident to the Resident that that titing enough assured the Well in the Resident the Resident and in the Resident and in the Resident and in the Resident and the Resident asked if she in.		
	were effective and a floor mat. The rec R32's risk for falls.	g factors, current interventions an additional intervention was cord lacked a reassessment of 20/16, at 10:30 p.m. indicated		she doesn't seem to use the after 5pm until around 7-8pm usually when she is getting. If the Resident is roaming above a page to be again.	om, this is g ready for bed. in her wheel		
	H32 was found sea	ted on her floor with her back		chair or appears to be agit	atea, staff is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	l'		(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/0	6/2017	
	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557			
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F 323	against the bed. R The note indicated be monitored ever R32 had no complidentified R32 sust forearm, neuros w would be requeste a.m. identified R32 in therapy. Swellin facial grimacing withe physician and left wrist X-ray repidentified a left wrist X-ray repidenti	32 stated she scooted down. I vitals were taken and would y 4 hours per facility policy. aints of pain. The report tained a skin tear to her right ere at baseline and a floor mat d. A PN dated 9/21/16 at 10:23 2 complained of wrist pain while g was noted in the wrist and hen touched. R32 was seen by an x-ray was ordered. R32's ort dated 9/21/16, at 4:03 p.m.	F 323	aware that she needs to be monimore closely for bathroom or any needs to be met. The Resident is capable of letting staff know that needs to use the restroom; she rome out and ask all the time but asked she does say yes or no. Plan: Care rounding has been implemented as of 01/05/2017 winvolves staff asking Charlotte exfrom 6AM to 10PM if she has any she requires or requests position she needs to utilize the bathroom ensure that her personal items a reach her needs are met. From AM staff observes her and meet needs every two hours. 2. RN's have reviewed and talk her bowel and bladder. She does have a better control of her bladd her admission. She seems that shaving less brief changes throug Due to the risk of falls she will be on a rounding program (rounding hour during the day and every 2 noc) for toileting, to try to anticipal needs to use the bathroom in att try and decrease falls and attemps self-transfers. iii. Fall risk assessment comple 1/5/2017for an updated score ris risk assessment score is 13 which same as the quarterly score done October 2016. We will continue the bed and chair alarms but will alarms instead of tab alarms for and all residents that have been	cother is fully she may not it when when when when when when when when		

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		245238	B. WING		01/06/2017	
	PROVIDER OR SUPPLIEF		4	STREET ADDRESS, CITY, STATE, ZIP CODE 114 WEST JEFFERSON AVENUE, PO BOX : MAHNOMEN, MN 56557		
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F 323	falls in the last 3 m decline in physical hypotension (low be cerebrovascular at to 1 side of her bowas at risk for falls and they were to compare the seast bathroom toilet and the wall. and vitals were taken and any new intervential to identify if current and any new intervential to identify if current and any new intervential to identify if current and she slid down the note indicated hand was sore and the report further R32's care plan we failed to identify ar implemented after to 1/3/17, at 1:44 in a recliner in the alarm (fall prevent clipped to the backnot attached to the arm chair cushions from sounding if R independently. We	nonths, loss of limb movement, status, incontinence, blood pressure), ccident (stroke) and weakness dy. The report identified R32 is, no referrals were necessary ontinue current plan of care. Y Event Report indicated R32 is 12:33 p.m. after she im the wheelchair to the toilet in R32 slid down between the The report indicated neuros are and R32 complained of the poof her hand. The report failed to interventions were effective ventions added after the fall. I R32 slid down between the The report failed to interventions were effective ventions added after the fall. I R32 complained her right dishe was emotionally upset, indicated vitals were taken and buld be updated. The note my new interventions	F 323	to utilize an alarm. 1. Fall risk assessment complete to removal of the Tab alarms. Resiremains a high risk for falls. Care I has been updated to include: Tab was removed due to risk of impropplacement and delayed alarm. Maimplemented in place of the tab alabecause it is more sensitive to chaposition and will sound faster where resident is attempting to self-transically. 2. Falls: a. July 27th 2016 1930 Resident found on the floor in her room: Fal unwitnessed. She was sitting in here prior to her fall with call light within b. 08-27-2016 1021 Resident was room alarm went off and staff enter room and resident was standing not the commode and was witnessed slid to the floor. c. 09/20/16 2230 Resident was in and stated I was scooting down staff ound her on the floor. (fx occurre this fall). d. 10/09/2016 1353 Resident was in the north bathroom and as staff the bathroom she was witnessed to off the toilet. e. 10/21/2016 1230 Resident was followed into the bathroom by staff they were unable to reach her beforstood up. Staff witnessed her slide against wall to the floor. i. The time line indicates that the pattern associated with time of day of the falls were in the bathroom, but were both witnessed falls and one	dent Plan alarm ber t alarm arm inge in tier. was I was er chair reach. s in her red ext to as she the bed aff d during s found entered to slide s and ore she er ere is no out they	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
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F 323	rest was up on the attempts to stand. Review of the Use Sentry Fall Monito identified the moni a chair or bed usin monitor, the magn was to be secured locking clip attache the top of the shouthe appropriate co for the person to a moved beyond the disc pulled from would sound. The to follow the install the warnings and committed monitoring system result in injury or do the control on 1/4/17, at 8:34 in a recliner in the alarm cord clipped TABS unit was not on the right arm of on the recliner was attempt to stand. -8:45 a.m. R32 was in the common are clipped to the back not attached to the the recliner chair. It alarm unit. R32 mare cliner footrest results are cliner footrest results.	r Instructions for the Personal ring System (TABS style unit) tor was to be mounted to either g the clip on the back of the etic disc from the pull string to the monitor magnet, and the ed to the resident's garment at alder or back of the neck with rd length determined in order ctivate alarm. When a resident determined length of the cord, in the monitor and the alarm user instructions directed staff ation instructions, particularly cautions when using the fall and failure to do so could eath. a.m. R32 was observed seated common area with a TABS to the back of R32's shirt. The attached to the recliner. It was the recliner chair. The footrest is elevated. R32 made no	F3	23	were in her room, but her motives a clear because they were not witnes and the resident could not verbalize intent. Only on one occasion could resident verbalize what she was do One of the falls occurred 7 days aft admission and she did have a diffict time adjusting to her new living arrangement. She has had 5 falls, month, but she hasn t fallen since 11/21/2016. As of today, the reside seems more content with her envirous with the exception of more stimulat the facility, her anxiety and agitation increase. ii. As we look at this data, it is determined that we will implement care rounding to try and anticipate aneed she may have to decrease he incidents of self-transferring. iii. Due to this data, we will be implementing a root cause analysis each fall through the falls prevention program. 3. Root cause Analysis: a. Current Reality: Resident atterindependent transfer but has fallen dementia, mobility issues, anxiety, acclamation to unfamiliar living environment. b. Desired Result: Resident will rattempt to self-transfer and Resident fall. c. Recommendations/Implementaplan: i. Care rounding-hourly and every hours to meet resident needs ii. Root cause analysis (RCA) doreach fall	sed e her the ing. er cult once a ent onment ion in n the any er safter in mpts due to and not nt will ation	

Facility ID: 00353

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245238	B. WING		01/0	6/2017
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F 323	in the common are clipped to the back not attached to the the recliner. R32 rd9:35 a.m. R32 wain the common are clipped to the back not attached to the the recliner chair. The remained elevated stand10:05 a.m. after a about R32's toileting was just about to do wanted to use the reached forward are wheelchair with bounded them in the placed them in the placed them in the her wheelchair. NA stood up slowly and wheelchair. R32 way unsteady. NA-B as with the gait belt are and sit down in her steps during transform moving slowly11:15 a.m. R32 way recliner in the common the recliner. The to the back of R32's attached to the recliner chair.	age 38 a with a TABS alarm cord of R32's shirt and the unit was recliner but on the right arm of The footrest remained up on nade no attempts to stand. Is observed seated in a recliner a with a TABS alarm cord of her shirt and the unit was recliner but on the right arm of The footrest on the recliner . R32 made no attempts to sking nursing assistant (NA)-B ag schedule NA-B stated, "I o that." NA-B asked R32 if she bathroom. R32 said yes. R32 and grabbed the seat of her th hands, patted the seat, and lichair arms with her right hand. ait belt and removed the TABS arecliner and R32's shirt and storage pouch on the back of as to stand up. R32 d held on to both arms of the as stooped over and very sisted R32, holding on to her and assisting her to turn around wheelchair. R32 took small er remaining stooped over and as observed seated in a mon area. The footrest was up the TABS alarm cord was clipped as shirt. The unit was not liner but was sitting on the right chair. R32 made no attempts	F 323	iii. Closer monitoring of resident i activities of interest iv. Bring to nurses station for activ. Supervision in dining room and common areas. vi. Assist to recliner and elevate fupon request. vii. Apply mat alarm viii. Educate staff on updated care ix. Monitoring of supervision x. January 9th the falls preventio program will meet to implement Rdd. Analysis: (complete this quartate. Reviewed 5 falls: determined in as of time of day. ii. Determined probable cause to toileting needs to be met by care rounding. iii. Bowel and bladder assessment indicated improvement since admitiv. Fall risk assessment remained same as upon admission. v. Resident has been here 6 more and has become more familiar with environment and staff making her comfortable and less anxious. vi. We did 3 root cause analysis is on issues identified by the surveyor related to the deficiency which lead staff education, change in the alart processes in place for closer obset d. RN updated Resident is care on 1/5 and 1/6/2017 and staff were educated via the communication be and verbal instruction per the RN and DON to review care plans. e. OT/PT evaluation/assessment conducted on 1/5/2017 to review self-transfer and self-ambulation in	vities d eet plan n CA erly) no trend be nt which ssion d at 13 nths n her more based rs d to m, and rvation. plans oard and	

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		_	4	114 WEST JEFFERSON AVENUE, PO BOX 3	96	
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	to stand. -12:27 p.m. NA-B to wheelchair to the mand physical assist her recliner when not feet with the recliner and stated loudly a up." NA-B said ok cord to the back of alarm unit loosely to cushion. The unit work chair. R32 leaned to the recliner seat art in recliner. R32 soon to had left the area. -12:33 p.m. R32 leaned to the alarm did not shad left the area. -12:36 p.m. No stall leaned forward and cord forward with the sound. There was the unit was unattain ineffective. R32 attrecliner. R32 was a edge of the recliner lift her bottom appropriation. Although the alarm to sound. R3 transfer. R32 leaner recliner chair arms attempted to standalarm failed to sound alarm failed to sound and the sound alarm failed to sound and the sound alarm failed to sound and the sound alarm failed to sound and the sound alarm failed to	ransferred R32 from her ecliner using a gait belt, cueing tance. R32 leaned forward in NA-B attempted to elevate her er leg rest. R32 became upset and harshly, "I don't want that and clipped the TABS alarm R32's shirt and placed the under the right recliner arm was not attached to R32's forward, lifted her bottom off and plopped herself back down boted herself back in the chair. It is sound during this activity. NA-B aned forward in the recliner, area and leaned back in the	F 323	i. PT determined to continue with same Functional Maintained Progre (FMP) and ambulation to and from with assistance of staff and assisting device. f. Care rounding has been imple as of 01/05/2017 which involves staking Charlotte every hour from 6 10PM if she has any pain, if she reor requests positioning, if she need utilize the bathroom, and to ensure her personal items are within reach needs are met. From 10PM to 6 AN observes her and meet her needs two hours. i. Staff was educated by the RN and 1/6/2017 and as the staff begin shifts will be educated by the chargenurse. g. A staff member will be present dining area at all times when reside in the dining room. Staff was educated communication board and verbal instruction per the RN and DON. 2.) Identify which residents are at the deficient practice and how they be affected. a. There was only one resident the using the Tab alarm which was the deficient practice when the IJ was After a root cause analysis and this resident assessment, the use and placement of tab alarms was to be longer be used and a mat alarm we the best option as they are more set to movement and do not required to secured to a chair to function proposition. Corrective measures to resolve prevent further risk to the identified	meals re meals re meals re meals re mented aff AM to quires at to that a her of staff every on 1/5 in their ge in the eated via risk for could at was assued. So no ould be ensitive to be early, e and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	assist R32. NA-C v bath. NA-C was ale transferring in the NA-A to help her in assisted R32 with recliner to her whe TABS alarm was n should have been. On 1/4/17, at 12:4 put the TABS alarm chair. She stated the attached to her alarm should have not resting on the aconfirmed she had operate and place On 1/5/17, at 9:13 propelling from the bathroom using on and opened the basounded. R32 contithe doorway and with chair. NA-D intervey wheeling R32 out to hallway. NA-D and in the hallway and bathroom and clos On 1/5/17, at 9:33 observed standing seated in her wheeling R32 phands on the wheeling R32 phands ph	vas found running water for a erted to R32's attempts at self day room. NA-C called for the day area. They physically cues and a gait belt from the elchair. NA-C confirmed the ot attached to R32's chair and p.m. NA-B stated they usually non the side of the bed or here was a clip on the unit to chair. NA-B confirmed R32's been attached to her chair and arms of the recliner. NA-B received education on how to the alarm when she was hired. a.m. R32 was observed self day room to the east ly her feet. R32 leaned forward throom door when the alarm inued to push herself through as scooting forward in her ened and redirected R32, of the bathroom into the R32 had a brief conversation NA-D assisted her into the	F 323	resident and other residents at risk a. Discontinue the utilization of Ta alarms in our facility. b. Education to staff on the use o alarms per manufacturer instruction proper placement of the mat, check mat to ensure proper functioning a monitoring and supervision of resid c. All residents who utilize mat alarm care plans were reviewed by the RN. d. Resident who utilize mat alarm care plans were reviewed by the R 4.) Provided Evidence of correctiv measures. a. Comprehensive assessments completed in Matrix b. PT evaluation completed in Ma c. Staff education information and d. Root Cause Analysis data e. Removal of Tab alarms from fa use f. Care Plan review/revision upda g. Care Rounding Logs at the Nu Station 5.) How will we educate staff to pre further accident and injury. a. All staff who provide direct care resident, who were on duty receive education on 1/5 and 1/6 2016 by t and DON. Staff who was not on du receive education prior to providing as they come on duty. Staff not pre this time, individual signature page be made and attached to the educate binder and the charge nurse will re packet of information with them be they step on the floor and have the the sheet once education has beer provided and they verbalize	f mat ns, the king the nd lents. arms s, the N. e trix d log acility ates rses event e to d he RN aty will a care sent at s will ation view fore m sign	

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F 323	her to stand. NA-D and NA-C followed wheelchair. R32 wa left arm handle of the walker. NA-D c walker handle with swung in front of he forward and her leg R32 had walked 10 farthest she ever w she walked an addi wanted to walk eve On 1/4/17 at 2:16 p event reports, prog interventions impled DON. The DON stated the ware not aware TABS alarm correct assumed they affixed The DON stated she board and R32's caunderstood how to the NAs had an assummarized R32's NA's chose not to she expected staff judgement" and R3 whether or not to a common area. The TABS alarm to be a or in her wheelchail For the fall of 7/27/verified the fall inforthought R32 tried to	provided R32 with a walker R32 and NA-D with a as confused and grabbed the ne walker and the front bar of ued R32 to grab the right her right hand. R32's left foot er right foot, R32 was leaned as were weak. NA-D confirmed to feet and that was the alked. NA-D later confirmed tional 80 feet and stated R32 n more. I.m. R32's falls including fall ress notes, care plan and mented were reviewed with the sted the following: The fall information and stated a staff was not placing R32's tly. She stated she just led it to her chair or recliner. The used a communication are plan to ensure staff care for her. She also stated signment sheet that care plan and stated some earry it with them. She stated to rely on their "best 2's care plan to determine only R32's TABS alarm in a DON stated she expected the affixed if she was in her room	F3	323	understanding. b. This education will be provided both verbal and written instructions. c. Up dated Care plans d. Manufacturer s instructions we reviewed and placed in communication book. e. Orientation information will inclustilization of mat alarms. This will be presented to all new staff and trave f. Education regarding the utilizat mat alarms will be presented annual staff. 6.) Evidence of audits and monitor a. Care rounding sheet will show hourly/2 hourly monitoring the resid b. Education log will indicated whith have received education. c. Maintenance staff will check the condition of the mat alarms monthly document the check. d. Four observations per week of presence in the dining room will be by facility leadership. e. Charge nurse will monitor presestaff when resident is in the common area. This will be documented in the EMR. 7.) Policy and Procedures reviewe changed. a. Bed and chair alarm policy upd b. Care planning policy reviewed c. Fall prevention program Meetin scheduled January 9, 2017 for progreview.	ere ude pe I staff. ion of ally to ing ent ch staff e y and staff made ence of on s ne d and ated	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245238	B. WING			01/06/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
		_		414 WEST JEFFERSON AVENUE,	PO BOX 396		
MAHNOI	MEN HEALTH CENTE	К		MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	and pain in her right sometimes R32 co. She stated bed and R32's care plan. The DON verified to 8/27/16, at 10:21 a self-transfer. R32 gwhen she tried to go the fall was witness make sure R32's s. The DON stated the resulted from R32 get out of bed, and R32 was trying to to documentation was sustained a left writunwitnessed fall and Agency. She stated the fall. The DON verified to the fall on 10/9/16, self transferred to to on the bathroom flounwitnessed, vitals not hit her head. The nonew intervention. The DON stated the at 12:33 p.m. was a bathroom and stoo to get to the toilet. Stoilet and the wall in stated after one of at the nurses station.	ad complained of a sore butt at thigh. The DON stated all not make sense of things. It chair alarms were added to the fall information dated a.m. She stated R32 tried to not herself up, slipped and fell go to the bathroom. She stated sed and the intervention was to hoes were on. The fall on 9/20/16, at 10:30 p.m. self transferring, attempting to stated she wasn't sure why cansfer. The DON verified the saccurate. She stated R32	F3	ADDITIONAL INFORMATI REGARDING ABOVE PLA CORRECTION: "Staff education began continues with all staff upo their first shift worked after binder with all the educatio employees has been creat the nurse s desk that is as staff at all times. The staff includes Charlottes update updated care plans for all tresidents who have mat alson care rounding, informat alarms (manufacturer s in review of all residents on balarms. Education include communication on the requision during meal times and commons area at all times with a recliner or wheelchat present. Education is provided by Director of Nursing or designated by a staff 4 times a week to ensign someone in the dining reduring meals. The common audited by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at least two ensures that it is being superesidents with recliner alarmated by DON at le	on 1/05/2017 and coming on on 1/05/2017. In and a list of the dand kept as vailable for all education and care plan, the other arms, education on the main and chair suirements of the dining and in the when a reside dir alarms are ided by the gnee. If of the dining administrative sure that there is on at all time on a rea will be vice a week to be evised when ms are present (QAPI) until timen Health in the men Health in the men Health in the men Health in the men Health in the coming are present the	A f at I ion	

Facility ID: 00353

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	E SURVEY IPLETED
		245238	B. WING		04/	00/0047
NAME OF			b. Willa_	OTDEET ADDRESS SITV STATE 7ID SODE	01/	06/2017
NAME OF	PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENT	ER		414 WEST JEFFERSON AVENUE, PO BO	X 396	
	_			MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	leaving R32 alone The DON stated F cognitive impairmetime, or where she last fall assessme There were no oth stated R32 was at amount of assista with ADLs. R32 ha mobile as she use up. She stated she bowel and bladderstated those were she had not considered to keep R32 something to do a like to leave her at periods of time. The DON confirme policy and would devent form in Matrix system) until they program and new On 1/4/17, at 12:4 risk for falls because and reached for the last time she of wheelchair was a she thought R32 in day she was admissed sild out of her after the fall. NA-A any other falls for interventions were	in the bathroom. R32 had moderate to severe ent and R32 had no concept of e was at. She confirmed R32's nt was completed on 10/25/16. Her fall assessments. The DON high risk for falls due to the nce and cueing she required ad forgotten she wasn't as and to be and would try to stand the had not considered doing a rassessment on R32, and only done quarterly. She stated dered any other fall prevention R32. The DON stated they also in their line of vision, give her to the nurses desk, and did not one in her room for extended they do not have a, "Falls," continue to use the current fall rix (clinical documentation developed a preventative	F 33	to include orientation to the maximum of 1/27/2017 all Residents can were reviewed for appropriate for interventions and care plans were adjusted accordingly. By 02/03 will be educated by the Director or designee of the changes and staff not working during this time will be educated on their first were after 02/03/17. 101/27/2017 all Residents were re-assessed for appropriateness and care plans adjusted accordingly. By 02/03 will be educated by the Director or designee of the changes and staff not working during this time educated on their first working so 02/03/17. 12 Fall prevention program methed 01/09/2017. 20 01/09/2017A falls tracker to identified and will be used to trapatterns and risks associated we and data will be brought throug on A falls prevention coordinated attend IDT meetings to aid in the prevention and intervention of a of 01/09/2016. 20 01/10/2017 the Falls Prevention committee will meet once a monex meeting is scheduled for 00 01/29/2017 falls prevention committee will meet once a monex meeting is scheduled for 00 01/29/2017 falls prevention members have been invited to one of the prevention of the prevention in the prevention committee will meet once a monex meeting is scheduled for 00 01/29/2017 falls prevention members have been invited to the prevention of the prevention of the prevention in the prevention of the prevention committee will meet once a monex meeting is scheduled for 00 01/29/2017 falls prevention members have been invited to the prevention in the prevention of the prevention in the prevention of the preventio	all re '2017 Staff of Nursing those e frame orking shift th mat were '2017 Staff of Nursing those e will be shift after eting was of was ck falls for ith falls or Will e Il falls as ntion updated ittee was rising of The oth. The 2/20/2016. committee	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245238	B. WING		01/0	06/2017
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX MAHNOMEN, MN 56557	-	33/ = 0 1 .
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	stated R32's tab al recliner today and secliner tod	r alarm was going off. She arm was not attached to the	F 323	committee meeting scheduled fo 02/20/2017 via outlook calendar posters. o A falls policy is being formed be completed by 02/08/2017. o A Post Fall Huddle Form will developed and completed by 02/o Education for staff will be corby 02/20/2017 on the falls prever program. All staff that is not worlduring this time frame will receive education on their next working so The Falls prevention coordinattend QAPI and bring forward fir the QAPI group in regards to falls prevention education. As of 02/09/2017 the MDS coord 01/27/2017 interviewed staff inclurestorative aid, nursing assistants activities and therapy staff and reprogress notes to determine that interventions for falls were approand care plans were updated acceptable findings. As of 02/08/2017 a fall risk assessis performed on admission, quart with significant change. As of 02 a fall risk assessment will be done each fall. As of 02/08/2017 a post fall hall he being conducted utilizing the Post Investigation tool which includes	and will be 08/2017. inpleted ation king e hift. ators will adings to and fall inator on uding s, viewed coriate cording to esments erly and (09/2017 e after auddle is t Fall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
	245238	B. WING	·····	01/	06/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
	_		414 WEST JEFFERSON AVENUE, PO	BOX 396	
MAHNOMEN HEALTH CENTER	₹		MAHNOMEN, MN 56557		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
when she was alone tried to stand up from stated the last time her own was 1/3/16 into the east bathroof tried to stand up on her not to and she with a stated he did not contherapy evaluation with a property discharge summary discharged from PT cognition dropped socuple weeks of additional her up to walk even from staff. He state PT because of sever impairment. He furth any progress during risk for falls. On 1/6/17, at 9:59 at (OT) confirmed R32 The OT stated R32 OT on 8/12/16. The completed a discharge stated she must have when R32 began the required supervision from staff with bed rused a walker. She 7/27/16, it became of sitting to standing positions.	ge 45 was at moderate risk for falls e in her room and when she m her wheelchair. The AD she saw R32 try to get up on when R32 wheeled herself om. She stated whenever R32 her own they would remind would reply, "I know." p.m. physical therapist (PT)-A mplete an initial physical when PT started on 8/2/16. did not complete a PT of r R32 when she was on 9/2/16. He stated R32's ignificantly within the first mission. It was difficult to get with cueing and assistance and R32 was discharged from the ere cognitive and balance her stated R32 did not make and part of the properties of the p	F3	Investigations will be reviewed IDT meetings and the data we into the Falls Tracker Tool. As of 02/09/2017 Care plans reviewed quarterly and with ensure the care plans are cue interventions are appropriate On 02/09/2017A Falls Tracked developed and will be used to for patterns and risks associated falls. The Falls Coordinator we data and present the data to Prevention Committee month meetings weekly and QAPI of patterns are identified, intervers are identified, intervers are identified on resident to ensure the interventions of interventions are identified on resident to ensure the interventions are properly implemented. The will be conducted daily x 2 weekly for one month, then not determined compliant throug Assurance Performance Impercent (QAPI). The next QAPI meet scheduled for February 21, 20 and 30 and 3	will be entered will be each fall to rrent and er tool was o track falls ated with will input the the Falls hly IDT quarterly. If entions and nd updated or designee erventions t care plans re being observations eeks, then nonthly until h Quality brovement ting is 2017. t with a mat he nurses to and proper Residents vill be tings to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245238	B. WING _		01	/06/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 414 WEST JEFFERSON AVENUE, PO MAHNOMEN, MN 56557	ODE	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 323	weakness in her leg transitioning from s when R32 was disc she was more conf difficultly following opain was a limiting her fall on 7/27/16. The OT stated they 11/7/16, after R32's she was able to use OT stated R32 was 11/23/16, and R32's limited flexion and s limiting factors and on 11/23/16, was distated R32 required ambulate with her we continued to be at required assistance OT additionally stated R32 was able to see wheelchair using on The immediate jeog 9/20/16, was removafter the facility continued to the see wheelchair using on The immediate jeog 9/20/16, was removafter the facility continuerventions as parenase was compreherase was compreherase was compreherased was compreherased was compreherased was compreherased was compreherased was compreherading licer interviewed staff was saff, including licer interviewed staff was saff was also was as saff was a saff	of staff for ADLs, had gs and had a difficult time itting to standing. She stated charged from OT on 8/12/16, used, and had increased directions. She further stated factor for OT progress after started OT with R32 again on a splint had been removed and the her left wrist for ADLs. The discharged again from OT on a left hand was swollen, had some pain. She stated R32's reason for discharge from OT use to poor cognition. She distaff assistance and cues to walker. The OT stated R32 risk for falls because she with ADLs and cognition. The led the last time she saw her, If propel herself in the	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245238	B. WING _		01/0	06/2017
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
F 323 F 334 SS=D	(i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octobannually, unless the contraindicated or timmunized during the contraindicated or the contraindicated or the contraindicated or timmunized during the contraindicated or the contraindicated o	LUENZA AND IMMUNIZATIONS neumococcal immunizations acility must develop policies ensure that- ne influenza immunization, e resident's representative regarding the benefits and es of the immunization; offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the	F 3:	23		2/9/17
		disease. The facility must				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	SURVEY PLETED
		245238	B. WING _		01/0	6/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX MAHNOMEN, MN 56557	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	(i) Before offering the immunization, each representative recebenefits and potent immunization; (ii) Each resident is immunization, unless medically contrained already been immunized immunization. The resident or has the opportunity (iv) The resident's redocumentation that following: (A) That the resident was provided educe and potential side elimnunization; and (B) That the resident pneumococcal immunization or This REQUIREMENT by: Based on interview facility failed to ensign conjugate Vaccine offered to 4 of 5 reserecommended by the search of the search received to the search received	d procedures to ensure that- ne pneumococcal resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal ss the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the offered a pneumococcal ss the immunization is icated or the resident has nized; the resident's representative ation regarding the benefits effects of pneumococcal of either received the nunization or did not receive immunization due to medical refusal. NT is not met as evidenced of, and document review, the ure the Pneumococcal -13 (PCV13) vaccines were sidents (R1, R5, R13, R19) as ne Centers for Disease Control OC) and failed to develop	F 33	" All residents vaccines were reviewed and were updated with t pneumonia vaccines 23 and 13 by 01/17/2017 with the exception of t residents. Those residents were scheduled with White Earth Home and received the vaccination on 01/26/2017. All residents are now	/ wo e Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` '		DECTION DENTIER ATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		RVEY TED
		245238	B. WING		01/06/2	2017		
	PROVIDER OR SUPPLIER	R	'	STREET ADDRESS, CITY, STATE, ZIP CODE 114 WEST JEFFERSON AVENUE, PO BOX MAHNOMEN, MN 56557	-			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CO	(X5) MPLETION DATE		
F 334	the pneumococcal protected against the pneumonia, and the Immunization Practadults 65 years of a PCV13. R1's Complete Immunifold 17, indicated the doses of the pneumonial vaccine (PPV23) of Face Sheet indicated on 10/13/14. R1's evidence the PCV1 offered. R5's Complete Immunifold 1/6/17, indicated the PPV23 on 9/13/11, Face Sheet indicated the PPV23 on 9/13/11, Face Sheet indicated the PPV23 on 11/01/19 acked evidence the 1/6/17, indicated the PPV23 on 11/01/19 lacked evidence the offered. R19's Complete Immunifold 1/6/17, and R19's Fevidence the 74 ye Pneumovax vaccin	s updated 7/16/14, identified conjugate vaccine (PCV13), ne 13 most common types of e Advisory Committee on tices (ACIP) recommended allage or older receive a dose of munization Record printed e 68 year old had received 2 nococcal polysaccharide	F 334	updated with the pneumonia vacci " 01/09/2017 the admission che was updated to ensure that the pneumonia shots (both PVC 13 a PPSV-23) have been administere not, offered upon admission. If the choose not to receive the vaccina declination form will be filled out a signed. " As of 01/27/2017, all immunia will be reviewed quarterly by the filled out a coordinator to ensure all recomm vaccines are administered or offe will be brought through QAPI. " 01/27/2017 education provide Director of Nursing to the admiss on recommended vaccinations ar to monitor. " This will be monitored by the of Nursing or designee and broug through QAPI until determined co As of 02/09/2017 at the time of ac nursing will review each resident immunization history to ensure th immunizations are current. On 01/09/2017, the admission check updated to ensure that the pneum vaccinations (both PVC 13 and P have been administered. If the re has no record of receiving the immunizations, the vaccines will to offered. If resident chooses not to the vaccination, a declination form filled out and signed and placed in resident is medical record.	ecklist nd ed and if eey tion a and eations RN unit ended red and ed by the ion staff ed plans Director tht impliant. dmission, s e list was nonia PSV-23) esident oe o receive in the			
	record also lacked	e. However, the medical evidence R19 was offered the nended by the CDC.		As of 02/08/2017 the Director of N				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NILIMBED.		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245238	B. WING _		01/0	06/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MAHNOI	MEN HEALTH CENTE	R		414 WEST JEFFERSON AVENUE, PO	BOX 396	
	- -			MAHNOMEN, MN 56557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	who was currently rinfection control procontrol nurse was a ware many reside received the PCV-1 facility had received residents in the facility had not be. The facility's LTC In Vaccines policy revindicated Administrations would current Centers for	pm, nurse manager (NM)-A esponsible for the facility's ogram while the infection inavailable confirmed she was nts in the facility had not 3 vaccine. NM-A stated the d a list from the clinic of illity that required the vaccine,	F 3:	immunizations for new admis weekly IDT meeting to verify immunizations are current. A 01/26/2017 all resident immunizations will be reviewed (first quarter Jan-March 2017 Registered Nurse (RN) unit densure all recommended vactoring data will be broug the Quality Assurance Perfor Improvement (QAPI) until decompliant. The next QAPI mescheduled for February 21, 2	that As of Inizations are I resident ed quarterly by the coordinator to ccines have ered. The ht through mance termined eeting is	

PRINTED: 02/03/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - 1969 BUILDING WITH 1975 ADDITION 245238 B. WING 01/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 **MAHNOMEN HEALTH CENTER** MAHNOMEN, MN 56557 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. Mahnomen Health Center (Nursing Home) 01 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483,70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

02/01/2017

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - 1969 BUILDING WITH 1975 ADDITION		E SURVEY PLETED
		245238	B. WING			01/0	05/2017
	PROVIDER OR SUPPLIER MEN HEALTH CENTE	R		4	TREET ADDRESS, CITY, STATE, ZIP CODE 14 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557	***	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSED TO THE APPROP	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of various to correct the deficition of various and to correct the deficition of various and to correct the actual, or provide a reoccurred. Mahnomen Health built at three differed building was added Hospital. It is 1-stor Type II(111) construte north of the kitch basement and Type additions of 1-story Type II(000) construte 1969 building a building, The 1969 2-hour fire barrier firm the 2000 east smoke compartment minute fire barriers. The facility is protes sprinkler system instructions of various and various fire partiers.	state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. Center (Nursing Home) was ent times. In 1969 the main to the east of the Mahnomen y, without a basement and is action. In 1996 an addition to then was added, is 1-story, no ell (111) construction, In 2000, without basements and of fuction were built to the west of not to the north of the 1996 building is separated by a rom the Hospital building and addition. The facility has 3 ints separated by at least 30	K	000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1) / included a second control of the second		PLE CONSTRUCTION IG 01 - 1969 BUILDING WITH 1975 ADDITION		(X3) DATE SURVEY COMPLETED	
		245238	B. WING_		01/0	5/2017	
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557	396		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	has a fire alarm sy detection, sleeping smoke detection ir with NFPA 72 "The The facility has a census of 25 at the The requirement a NOT MET.	age 2 ek response heads. The facility stem with corridor smoke groom smoke detection, and a common areas in accordance National Fire Alarm Code". Exapacity of 32 beds and had a set time of the survey. Et 42 CFR, Subpart 483.70(a) is er System - Maintenance and	K 00			1/17/17	
	Sprinkler System - Automatic sprinkle inspected, tested, with NFPA 25, Star Testing, and Maint Protection System maintenance, insp maintained in a se available. a) Date sprinkler b) Who provided c) Water system Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This STANDARD Based on observat facility failed to ma accordance with the	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source		" 4 residents□ room sprinkler he were cleaned on 01/17/17 by Allied Protection. " Main resident dining sprinkler	eads d Fire		

245238 B. WING		
		01/05/2017
MAHNOMEN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557	96
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 353 Continued From page 3 standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 01/04/2017 observations and staff interview revealed 5 sprinkler heads not properly maintained in the following locations. Resident rooms 41 & 43, 4 heads covered with lint Main resident dining area, one head with clear liquid in the frangible bulb instead of red. This deficient condition was confirmed by the Facility Operations Manager. K 363 SS=E Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on	was replaced by allied fire protection 01/17/17 "Sprinkler system and sprinkler will continue to be monitored by Far Director on a quarterly a year time and annual by Allied Fire Protection monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determine compliant. See Attached work order sprinkler head replacement from Alfire Protection Form A.	heads cility frame a The bugh e ed er for

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - 1969 BUILDING WITH 1975 ADDITION	(X3) DATE SUR COMPLETE	
		245238	B. WING _		01/05/20	017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 3 MAHNOMEN, MN 56557	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) IPLETION DATE
K 363	or combustible mate complying with 7.2. devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 Door frames shall to or other materials in the smoke comparation window assemblies sprinklered comparaticitions in area frames in window at 19.3.6.3, 42 CFR Frand 485 Show in REMARKS protection ratings, at etc. This STANDARD is Based on observation facility failed to promeans suitable for resist the passage the 2012 Life Safet 19.3.6.3.1 & 19.3.6 could allow for smomaking it difficult to affecting 17 of the sundetermined amount of 104/2017 observealed resident in the suitable for revealed resident in the suitable for smomaking it difficult to affecting 17 of the sundetermined amount of 104/2017 observealed resident in the suitable fraction	rooms containing flammable rerials. Powered doors 1.9 are permissible. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors are permitted. De labeled and made of steel in compliance with 8.3, unless them the sprinklered. Fixed fire are allowed per 8.3. In the tree are no or fire resistance of glass or	K 36	" Fire and smoke seal was instathe frame in resident room door 3' 31 door now fits tight and seals co on 01/12/2017. " A new latch was installed on room door 24. Room 24 now latch code. Completed on 01/12/2017. Continue to be monitored by Facili Director monthly. The monitoring be brought through the Quality Ass Performance Improvement (QAPI) determined compliant	room. mpleted esident nes per ty data will surance	

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

PRINTED: 02/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1969 BUILDING WITH 1975 ADDITION		(X3) DATE SURVEY COMPLETED	
		245238	B. WING		01/05/2017	
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 363	Continued From pa This deficient cond Facility Operations	ition was confirmed by the	K	363		
					,	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 24, 2017

Mr. Dale Kruger, Administrator Mahnomen Health Center 414 West Jefferson Avenue, PO Box 396 Mahnomen, Minnesota 56557

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5238027

Dear Mr. Kruger:

The above facility was surveyed on January 3, 2017 through January 6, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Mahnomen Health Center January 24, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	R	「JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department.					
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.com/	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/01/17

STATE FORM 6899 TXE111 If continuation sheet 1 of 55

TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE		F JEFFERSO EN, MN 565	ON AVENUE, PO BOX 396 157		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department be State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To state Licensing federal software. To state and replaces the "It statute/rule out of computer the statement evidence by." Followare the Suggested Time period for Country Provider's PLASE DISREGATOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDERATOR TO STATE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Igh 1/6/2017, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. In ent of Health is documenting. Correction Orders using ag numbers have been cota state statutes/rules for In the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. IND THE HEADING OF THE	2 000			

Minnesota Department of Health STATE FORM

DRM TXE111 If continuation sheet 2 of 55

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/0	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	R	ΓJEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/6/17
	Subp. 3. Use. A co	omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fainterventions related prevention monitor care plan for 1 of 3	ent is not met as evidenced on, interview and document ailed to implement fall d to the placement of a fall (tabs alarm) as directed by the (R32) residents reviewed for erved to have incorrect abs alarm.		corrected		
	had memory and co decline and had sig for things she saw i further indicated R3 her surroundings, h R32 would be moni care plan identified placed 7/27/16 due R32 had a tabs alar	red 12/30/16 indicated R32 ognitive problems, physical ns of delirium as she reached n the air. R32's care plan 82's goals was to be safe in er needs would be met and tored for safety concerns. The R32 had bed and chair alarms to R32 self transferring, and rm placed 9/20/16 due to rpose. R32's care plan further				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00353	B. WING		01/	01/06/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
MAHNOMEN HEALTH CENTER		T JEFFERSON MEN, MN 5655	N AVENUE, PO BOX 396 7			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
another fall 9/20/16 we fracture, and fell again in injury. The care plan on 8/27/16 and 10/9/ R32's North Assignment assistants us R32 required the assistant which included transition in a recliner in the coalarm adjustable core R32's shirt and the urecliner but placed by R32 made no attempt of the unit was not attact the right arm of the reattempt to stand. -8:45 a.m. R32 was a in the common area clipped to the back on the recliner chair. R3 alarm unit. R32 made -9:27 a.m. R32 was a in the common area clipped to the back on the common area clipped to the	7/27/16 and had no injury, with skin tear and left wrist in on 11/21/16 and had no failed to identify R32's falls /16. The teat the teat and teat the teat and teat to identify R32's falls /16. The teat the te					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00353	B. WING		01/0	01/06/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
MAHNOI	MEN HEALTH CENTE	R	T JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 565	in the common area clipped to the back not attached to the the recliner chair. Find the recliner with dot and picked at the wind hand. NA-B applies the tabs alarm unit shirt and put them is storage pouch. NA-the count of 3, R32 to both arms of the over and very unstabled onto to her wit to turn around and from a standing posturing transfer and counting transfer and recliner in the commond clipped to the unit was not attached attempt to stand. -12:27 p.m. NA-B to with the recliner when NA-B feet with the recliner and stated out loud up." NA-B said ok a cord to the back of	a with a tabs alarm cord of R32's shirt and the unit was recliner but on the right arm of t32 made no attempt to stand. Sking nursing assistant (NA-B) g schedule she stated I was t. NA-B asked R32 is she pathroom. R32 said yes. R32 and grabbed the seat of her h hands and patted the seat, wheelchair arms with her right d R32's gait belt and removed from the recliner and R32's in the back of her wheelchair. B cued R32 to stand up on stood up slowly and held on wheelchair. R32 was stooped eady. NA-B assisted R32 and h the gait belt and assisted her sit down in her wheelchair sition. R32 took small steps her legs appeared weak. Its observed seated in a mon area with a tabs alarm back of R32's shirt and the liner chair. R32 made no Tansferred R32 from her er using gait belt, cueing and a R32 leaned forward in her attempted to elevate R32's or leg rest. R32 became upset and gruff, "I don't want that and clipped the tabs alarm R32's shirt and put the alarm R32's shirt and put the alarm	2 565				
	cord to the back of						

Minnesota Department of Health

STATE FORM TXE111 If continuation sheet 5 of 55

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	К	TJEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	and did not attach it leaned forward and recliner and ploppe recliner. R32 appear the chair and alarm area. -12:33 p.m. R32 lead looked around the and staff were preseded and the understand and cord forward with the sound. There appears the cord and the understand and cord forward with the cord and the understand and the cord and the understand and the condition and the stand get help. Surveyor around the day area and with gait belt and condition and the day area and with gait belt and condition and the day area and with gait belt and condition. NA-C condition and the day area and with gait belt and condition and the day area and with gait belt and condition. NA-C condition and the day area and with gait belt and condition and the day area and with gait belt and condition. NA-C condition and the day area and with gait belt and conditions. NA-C condition and the day area and with gait belt and conditions. NA-C conditions are standard to R32's conditions. She stated to R32's conditions are standard to her conditions.	t to R32's chair. Resident lifted up her bottom up off the d herself back down in ared to scoot herself back in didn't sound. NA-B left the aned forward in the recliner, area and sat back in the chair.	2 565			

Minnesota Department of Health

STATE FORM TXE111 If continuation sheet 6 of 55

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	K	T JEFFERSO EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From page 6		2 565			
	NA-B confirmed sh	d on the arms of the recliner. e had received education on place the alarm when she				
	at risk for falls becastand up and reach stated the last time from her wheelchai stated R32's fall int alarm and to keep tried to keep R32 b was going off. She	8 p.m. NA-A stated R32 was ause she wandered, tried to led forward in her chair. She she observed R32 get up r was a couple days ago. She erventions were the tabs R32 busy. She stated they y them otherwise her alarm stated R32's tabs alarm was recliner today and should				
	(CM-A) stated a fal have a tabs alarm i her recliner or chair alarm because she transferring and R3 to this. She stated I because she had n	3 p.m. clinical manager I intervention for R32 was to n place and and be secured to r. She stated R32 had the tabs had a history of self 2 had sustained an injury due R32 was at risk for falls o safety awareness and stated urse on duty to make sure her correctly.				
	(LPN-A) stated R32 secured. She stated wedge the alarm un	p.m. licensed practical nurse 2's tabs alarm should be d she hated to see the NA's nit in the arm of the recliner he had educated the NA's in R32's tabs alarm.				
	confirmed R32's ca expected staff to fo	o.m. Director of Nursing (DON) are plan. DON stated she llow R32's care plan, and affix to her recliner when in use.				

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Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	IEN, MN 565	DN AVENUE, PO BOX 396 557		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Review of the User Sentry Fall Monitor monitor was to be a bed using the clip of magnetic disc from secured to the more clip attached to the of the shoulder or be appropriate cord lethe person to activa moved beyond the the disc pulled from would sound. The atto follow the installative warnings and comonitoring system result in injury or defended and was a ln addition the facility requested and was a ln addition the facility requested and was a ln addition the facility requested and was ln add	Instructions for the Personal ing System identified the mounted to either a chair or on the back of the monitor, the the pull string was to be nitor magnet, and the locking resident's garment at the top back of the neck with the ngth determined in order for ate alarm. When a resident determined length of the cord, in the monitor and the alarm user instructions directed staff ation instructions, particularly autions when using the fall and failure to do so could eath.	2 565			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	R	JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Manager (RNM) state improved since his longer had moderatime of the survey at RNM stated she fel impairment and R1 needs and wishes with R18 would be a relisted and be a relisted and the rounds. Review of R18's Part (CAA) dated 11/2/1 complaints about state and the collar bone. The CAE examined by his print home rounds. Review of R18's part 10/27/16, revealed interview he had freshoulder and clavic with movement. The had described the production with movement and clavic with movement and described the production with movement. The moderate intensity interventions were milligrams (mgs) by as needed (prn.) are occupational therapy. Review of R18's carevealed R18 had controlled to a history recent collar bone for revealed R18 had controlled the rapy, he had been therapy despite the	ated R18's cognition had admission assessment and no te cognitive impairment at the and had improved in cognition. It R18 had minimal cognitive 8 was able to verbalize his without difficulty. RNM stated able source of information evel. Ain Care Area Assessment 6, identified R18 had many houlder, neck and back pain. R18 had a history of a broken Arevealed R18 was to be imary physician upon nursing in assessment dated R18 had stated upon staff equent pain of the right ele (collar bone,) with an onset e assessment revealed R18 bain as an ache and was of a The assessment revealed in place of Tylenol 650 or mouth (po) every four hours and a referral for PT and by (OT.) The plan dated 11/15/16, complaints of chronic pain of alcohol abuse and falls with racture. R18's care plan complained of pain with en educated to continue pain as he had not been opain. R18's care plan	2 565			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
		414 WFS		N AVENUE, PO BOX 396		
MAHNO	MEN HEALTH CENTE	K	MEN, MN 5655			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETE DATE
2 565	warm/cold packs. F physical therapy (P' shoulder pain and F pain medications or as of 11/8/16. The had enjoyed activitive western movies shoulder pain attending activities. R18's shoulder pain attending activities. R18 preferred to lay declined further act On 1/4/17, at 12:40 side in bed, facing the R18 had his right at had a furrowed broweyes, grimacing. On 1/4/17, at 2:37 pedge of his bed, his was guarded to his grimaced with a furthad been experience before he was adm. October. R18 contingrimaced and state started at his collar hand. R18 stated at collar bone to his hapain was severe, be numeric pain scale pain with 0 being not imaginable.) R18 st was independent wheen hard as he exmoved his right arm hard for him to slee	g medication,) and al pain interventions as R18's care plan revealed T) has been ordered for R18's MD had declined further r diagnostic testing of an MRI care plan further revealed R18 es of trivia, reminiscing, ortly after he was admitted and n had prevented him from The care plan also revealed y in bed for comfort and had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/0	6/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MAHNOMEN HEALTH CENTER			T JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
	stated the nurses of Tylenol for the pain ineffective. R18 stanurses to work with stated he could not causing too much precently started him gabapentin (a med pain from neuropatitaking the gabapen not had relief from thad a high pain tole to pain, and he felt listen to him when hot reliving his pain offered ice packs right was also ineffectifurrowed brow, squistated he felt the path of the felt depressed a tried to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country and he did not feel related to sleep the pastated he felt his country chair in the cup in his left hand the elbow rested or received his breakfattwo sausage links, proceeded to lift his fork. At that time, R	ne had pain everyday. R18 Iffered him ibuprofen and and was frequently Ited he had been told by the Interapy for the pain and It work with therapy due to it It bain. R18 stated his MD had In on another medication of Idication used to treat nerve Interaction of Idication used to treat nerve Interaction interaction of Idication used to treat nerve Interaction interaction of Idication used to treat nerve Interaction interact	2 565			

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	JEFFERSO EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	hand, grabbed the fork bites of scramb fork to his right han and proceeded to gbent his elbow and the fork and ate the picked up a spoon bites of his hot cere back onto the table toast with his left haback onto his plate. left hand and drank the director of nursi and asked if he had replied he was not going to go back to independently walk his right arm guarde the nurses station a lighter. R18 walked pushed to button widoor, walked into the R18 lit his cigarette proceeded to smok right arm remained independently back bed, while his right side, brow was furre was taunt. On 1/5/17, at 7:26 a doing good that day he could not sleep to pain. R18 stated the and id had not work have severe pain we further stated he fel R18 stated he woul pain and would tell	ge 11 fork and proceeded to eat 4 bled eggs. R18 then moved his d, pierced the sausage links uard his right arm to his chest, moved his head down towards e sausage links. R18 then with his left hand and ate three eal, then placed the spoon eal, then placed the was placed it and and ate two bites, placed it and eal, the spoon eal, the spoon eal, the spoon eal, the substituting the same eal, the stated he was to the spoon eal, the stated he was not with his left hand and eal, the with his left hand and eal, with his left hand and eal, with his left hand and eal, the stated he was not with his left hand and eal, the stated he was not with his left hand and eal, the stated he was not with his left hand and eal, the stated he was not with his left hand and eal, the stated he was not with his left hand and eal, the stated he was not with his left hand and eal, the stated he continued to his previous night due to arm eal, the stated he continued to his trustrated and felt hopeless detell the nurse when he had the nurses when the Tylenol or eactive in relieving pain. R18	2 565			

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	/IDER/SUPPLIER/CLIA FIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
003	353	B. WING		01/	06/2017
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
MAHNOMEN HEALTH CENTER		T JEFFERSOI MEN, MN 5655	N AVENUE, PO BOX 396 57		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
stated he had told his MD he Tylenol and ibuprofen were i the pain. R18 stated he had stated he felt the staff knew On 1/5/17, at 12:14 p.m. R18 independently in the hallway his right arm was held guard R18's brow was furrowed, of was tight and lips were purse. On 1/5/17, at 2:15 p.m. R18 independently down the hall station, his right arm was gu side, cheeks taunt, brow furr were tight. R18 proceeded to smoked with his left hand in room and walked back to his expression remained unchain on 1/6/17, at 9:16 a.m. R18 independently towards his rowere tight, forehead was creat that time R18 stated he whad received some Tylenol to stated it had not been effecting pain. On 1/5/17, at 12:27 p.m. the (DM) stated she was aware been using his right arm commeals. DM stated she felt Riwould improve with therapy. R18 did not want to use his into and would not participate that. On 1/5/17, at 12:43 p.m. PT	neffective in easing pain everyday and he was in pain. B walked towards his room, ed to his right side. neeks were taunt, jaw ed. walked towards the nurses arded towards his owed, lips and jaw o obtain a cigarette, the facility smoking room. R18's facial nged. walked down the hall om, lips and jaw ased, brow furrowed. as in a lot of pain, hat morning and ve in reducing his dietary manager R18 had been not sistently during 18's use of his arm DM stated she felt right arm like he used				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 565 Continued From page 13 right shoulder. PT stated he felt R18 was a reliable source of information regarding his pain and was unsure when PT was last completed. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and was able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain frequently. LPN-A stated she would provide R18 with ordered prn Tylenol and Ibuprofen when he reported pain. LPN-A stated R18 often reported to her both the Tylenol and Ibuprofen were ineffective in relieving pain. LPN-A stated she had reported to the NM of R18's continued pain as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
MAHNOMEN HEALTH CENTER 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECOEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 13 right shoulder. PT stated he felt R18 was a reliable source of information regarding his pain and was unsure when PT was last completed. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and was able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain frequently. LPN-A stated she would provide R18 with ordered prin Tylenol and Ibuprofen when he reported pain. LPN-A stated she lad not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A			00353	B. WING		01/0	06/2017
MAHNOMEN, MN 56557 Xa D	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 13 right shoulder. PT stated he felt R18 was a reliable source of information regarding his pain and was unsure when PT was last completed. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and was able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain frequently. LPN-A stated she would provide R18 with ordered prn Tylenol and Ibuprofen when he reported pain. LPN-A stated R18 often reported to the NM of R18's continued pain as recently as a couple of weeks ago. LPN-A stated she had reported to the NM of R18's continued pain as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A	MAHNO	MEN HEALTH CENTE	R				
right shoulder. PT stated he felt R18 was a reliable source of information regarding his pain and was unsure when PT was last completed. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and was able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain frequently. LPN-A stated she would provide R18 with ordered prn Tylenol and Ibuprofen when he reported pain. LPN-A stated R18 often reported to her both the Tylenol and Ibuprofen were ineffective in relieving pain. LPN-A stated she had reported to the NM of R18's continued pain as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
stated she had seen R18 walk up to the nurses station and complain of pain on a routine basis. NA-A stated R18 had also reported to her he had pain frequently, with the most recent time that week. NA-A stated R18 had complained of right shoulder pain since admission a few months ago. NA-A stated she felt there were days R18 would stay in his room due to being in so much pain. NA-A stated R18 had also reported to her he often laid down due to pain and did not sleep well. NA-A stated she would inform the nurse when R18 would report pain to her. NA-A stated she had observed R18 grimacing when he moved his right arm on a routine basis. On 1/5/17, at 3:18 p.m. NA- F stated R18 had reported to her he had been in pain though was unable to recall the most recent time. NA-F stated she felt R18 often held his right arm to his body due to being in pain. NA-F stated she had seen R18 walk up to the nurses station and complain	2 565	right shoulder. PT seliable source of in and was unsure who on 1/5/17, at 1:55 p (LPN)-A stated she and was able to voi LPN-A stated R18 opain frequently. LPI R18 with ordered phe reported to her both were ineffective in right she had reported to pain as recently as stated she had not interventions for particular pain as recently as stated she had see station and complain NA-A stated R18 had pain frequently, with week. NA-A stated she felstay in his room due NA-A stated she wood shoulder pain since NA-A stated she wood shoulder pain since NA-A stated she wood stay in his room due NA-A stated she wood R18 would report phad observed R18 right arm on a roution of 1/5/17, at 3:18 preported to her her unable to recall the she felt R18 often had to being in pain	stated he felt R18 was a aformation regarding his pain en PT was last completed. D.m. licensed practical nurse felt R18 was cognitively intact ce his needs and wishes. Complained of right shoulder N-A stated she would provide rn Tylenol and Ibuprofen when PN-A stated R18 often the Tylenol and Ibuprofen elieving pain. LPN-A stated the NM of R18's continued a couple of weeks ago. LPN-A offered R18 any other in. D.m. nursing assistant (NA)-A n R18 walk up to the nurses in of pain on a routine basis. And also reported to her he had a the most recent time that R18 had complained of right admission a few months ago. It there were days R18 would be to being in so much pain. And also reported to her he be to pain and did not sleep well. Duld inform the nurse when ain to her. NA-A stated she grimacing when he moved his ne basis. D.M. NA-F stated R18 had and been in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most recent time. NA-F stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most her stated she had seen in pain though was most				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
71101271	TO COMMENTAL	BENTILION NOMBER.	A. BUILDING:		CON	LLTLD
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	FJEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	of pain frequently. It reported to the nursunable to recall the On 1/6/17, at 1:59 pstated she felt R18 able to voice his ne R18 had participate arrived at the facility complained of right admission and had AD stated she comhis room per his pro R18 had stopped a his pain. On 1/6/17, at 8:23 a completed resident which R18 was suplower extremity exe to complete range owith R18's right arm started in November complained of pain arm. NA-D stated From the right side whof motion. NA-D stated From the right arm, moving body. NA-D stated improvement in R18 since he was admit On 1/6/17, at 8:30 a frequently complain shoulder. NA-C stated From the right arm and the right arm and the right arm and the right arm and the right arm, moving body. NA-D stated improvement in R18 since he was admit on 1/6/17, at 8:30 a frequently complain shoulder. NA-C stated From the right arm and the right arm.	NA-F stated she had also sees R18 had pain, though was most recent time. p.m. activity director (AD) was cognitively intact and was seds and wishes. AD stated ad in activities briefly after he y. AD stated R18 had routinely a shoulder/arm pain since stopped attending activities. pleted 1:1 visits with R18 in eference. AD stated she felt attending group activities due to a.m. NA-D stated she arestorative therapy daily sposed to have upper and ercises. NA-D stated she was of motion (ROM) exercises in three times a week which er. NA-D stated R18 with movement of his right R18 had a fractured collar bone and she had been unable to week of survey due to R18's and not feeling well. NA-D in when he would bear weight and when he attempted to lifting his shoulder away from his she had not seen an 8's pain management or ROM	2 565			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLISHING. COMPLE	
A. BUILDING:	
00353 B. WING 01/06/	6/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MAHNOMEN HEALTH CENTER 414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
his body. NA-C stated when R18 reported pain in his shoulder she would immediately tell the nurse. On 1/6/17, at 8:46 a.m. a phone call was placed to R18's primary physician, who was also the tacilities medical director. R18's primary MD was not in the office would not return until 1/9/17, a message was left with MD's nurse line for MD to call back. MD did not return phone call prior to survey exit. A phone call was received by MD on 1/10/17, at 4/20 p.m. During the phone interview MD stated he was aware R18 had ongoing pain, especially in his right shoulder. MD stated he was not aware of the overall ineffectiveness of R18's current pain regimen. MD stated he had thought R18's Tylenol and ibuprofen were already given to him on a scheduled basis. MD stated the usual practice was to schedule prn pain medication if they routinely received it. MD stated he had referred R18 to an orthopaedic MD and he had felt an MRI was not necessary. MD stated he had considered adding Tramadol (non-opiate prescription pain medication) to R18's medication regimen but had not at that time. MD stated he was very reluctant to order opioid and/or narcotic pain medications due to the monitoring involved in prescribing those medications. MD stated he would only order opioid and/or narcotic pain medications in cases of acute injury or pain, which he felt R18 did not meet that criteria. MD stated he had also ordered gabapentin for R18's pain in December some time and had hoped that would improve. MD stated R18 could have had heat and cold therapy, but was not suce if the staff had tried them or their effectiveness. On 1/6/17, at 1:56 p.m. LPN-B stated R18 had an old fracture to his right collar bone which she felt continued to cause R18 frequent pain. LPN-B	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
712 1 271	0. 0020		A. BUILDING:			
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	F JEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 157		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	pain, which were of stated she had reported receiving relief from medications, most. On 1/6/17, at 2:23 pinterview NM stated receiving routine remediations of Tyler she had been unable cognition assessment of the stated she felt R18 and may have minishe felt R18 was a regarding his pain. R18's primary MD to was overall not effect routinely struggle with pain management of the pain medication of the pain medication of the pain medication of the patients were free of management that with the highest degree enhance comfort. The licensed staff to compain assessment of directed licensed staff to compain assessment of directed licensed staff to compain assessment of directed licensed staff to schedule process of medical staff to schedule process of medical staff to schedule process.	verall not effective. LPN-B orted to the NM, R18 was not a pain with the current professor at the previous week. p.m. during a follow up dishe was aware R18 was not elief with the current professor and ibuprofen. NM stated ole to complete another ent as requested by surveyor ing well with a cough. NM was overall cognitively intact mal memory loss. NM stated reliable source of information NM stated she had reported to the current pain medication ective. NM stated she would with R18's MD regarding R18's due to unwillingness to try ions. NM stated R18's MD has apentin and only saw minimal stated she felt R18 continued and that is pain was not me. d, Pain, reviewed 5/2016, facilities policy to ensure of pain or would receive pain would allow them to maintain of functioning and well being, The policy directed facility mplete an initial and ongoing f prn medications. The policy	2 565			

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		00353	B. WING		01/0	6/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE				
MAHNO	MEN HEALTH CENTE	K	JEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 17	2 565				
	The director of nurs review and revise p to ensuring the care resident is followed compliance, the DC a system to educate monitoring system care as directed by	THOD OF CORRECTION: sing (DON) or designee could solicies and procedures related e plan for each individual. To ensure ongoing DN or designee could develop e staff and develop a to ensure staff are providing the written plan of care.					
2 830		O Subp. 1 Adequate and	2 830			1/6/17	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident					
	by: Based on observati review, the facility fassess, thoroughly implement interven	ent is not met as evidenced on, interview, and document ailed to comprehensively investigate causal factors and tions in order to minimize the ry for 1 of 3 residents (R32)		corrected			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE		T JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	who had repeated required medical in immediate jeopard. Findings include: The Immediate Jeorelated to the facilit comprehensive ass factors and implem sustained a signific occurred on 9/20/1 placed R32 at signiand/or death. The director of nursing on 1/5/17, at 10:15 when R23 had falle complete a comprefactors related to R to implement interv R23's risk for further 1/6/17, at 4:00 p.m remained at a scop which indicated act wrist fracture sustained medical as R32's diagnoses included activities due to dishistory of encephal awareness), fracture arthritis, osteoarthrical severely impair and severely impair immedical immediate severely impair immediate severely immediate s	falls with serious injury which tervention. This resulted in an	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	R	JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	(ADLs), was occasi was not on a toiletir medication and had which increased R3 further identified R3 wandered which puinjury.	onally incontinent of urine, ag program, received antibiotic a urinary tract infection (UTI) 32's risk for falls. R32's MDS 32 had hallucinations and t R32 at significant risk for	2 830			
	8/2/16, indicated R3 1 fall. R32 was four front of her recliner.	rea Assessment (CAA) dated 32 had and on the floor in her room in . She had an x-ray which was ure, and R32 remained a high				
	8/2/16, indicated R3 obtained a bladder of admission and redelirious at times. T	infection during her first week emained very confused and The CAA further indicated uld be monitored through the				
	confirmed he did not therapy evaluation of PT-A confirmed he discharge summary discharged from PT cognition dropped so couple weeks of adher up to walk even from staff. He state PT because of seven impairment. He furt	p.m. physical therapist (PT)-A of complete an initial physical when PT started on 8/2/16. did not complete a PT of for R32 when she was on 9/2/16. He stated R32's significantly within the first mission. It was difficult to get with cueing and assistance and R32 was discharged from the ere cognitive and balance her stated R32 did not make g PT and continued to be at				

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NAME OF	PROVIDER OR SUPPLIER			TATE ZID CODE	1 01/0	10/2017
		414 WFS1		STATE, ZIP CODE IN AVENUE, PO BOX 396		
MAHNOI	MEN HEALTH CENTE		EN, MN 565			
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2 830	Continued From pa	ige 20	2 830			
	had memory and composed to worsen with UTI' in all of her ADLs so delirium as she readir. R32's care plan be safe in her surround R32 would be R32's care plan ideincontinent of bower and incontinence wore worself. The care put and watch for her to herself. The care put chair alarms placed transferring, a tab a standing without put within reach, no cluwithin reach, fall mand lipped mattressidentified R32 fell of another fall 9/20/16 fracture, and fell agonther fall 9/20/16 fracture, and fell 9/20/16	ted 12/30/16, indicated R32 ognitive problems that seemed is. R32 had a physical decline ince the UTI, and signs of ched for things she saw in the indicated the goals were to bundings, needs would be met monitored for safety concerns. Intified R32 had been and bladder since admission was possibly related to her R32 was to be toileted every a plan indicated as of 11/21/16, we R32 alone in the bathroom rying to go to the bathroom by lan identified R32 had bed and da 7/27/16, due to R32 self alarm placed 9/20/16, due to prose, all items were to be after on the floor, call light at placed, bed in low position is. R32's care plan further in 7/27/16, and had no injury, if, with skin tear and left wrist pain on 11/21/16, with no injury. It to identify R32's falls on 6. There were no injuries. The Assignment sheet (tool use to direct care), indicated sistance of 1-2 staff for ADLs as fers and toileting, and a bed and chair alarm.				
		cuity report dated 7/21/16, poor safety awareness,				

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2 830	required the use of lib and was contine took antihypertensing that increased R32' further indicated R3 with a decline in condepression and der R32 was at risk for PT and occupations care plan would be Fall events: 1. R32's Fall Safety fell on 7/27/16, at 7 to self transfer and room. The report in pain in her buttocks and UTI. The report in pain in her buttocks and UTI. The report checks (neuro's) are checked and fall into analgesics (pain medicated her butt and note identified R32 referred to the fall series of the same condensation of the stated her butt and note identified R32 referred to the fall series of the same condensation of the	assistive devices, was up ad nt. The report indicated R32 we and laxative medications is risk for falls. The report is 2 had cognitive impairment gnitive function, delirium, mentia. The report identified falls and was to be seen by all therapy (OT) and a falls initiated. Tevent report indicated R32 7:30 p.m. after she attempted was found on the floor in her dicated R32 had complaints of and right thigh, had a fever rt identified neurological nd vital signs (vitals) were rerventions included edication), bed alarm and rest. 17/16, at 7:30 p.m. indicated edication), bed alarm and rest. 17/16, at 7:30 p.m. indicated edication in her room in a sitting regs off to her right side. R32 right leg and thigh hurt. The denied hitting her head and rafety event report. 10 X-ray report dated 7/31/16, red R32 had abnormal bony out her pelvis and reserved report indicated R32 reserved report					
		0:21 a.m. The report indicated ounded after she attempted to					

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2 830	self transfer from h commode. R32 was the floor on her but bathroom door kno complained of sligh her vitals signs wer identify R32's ment factors, if current in any new intervention. R32's PN dated 8/2 R32 slipped and fel head on the door k slight pain in the miswere taken and the ensure R32 had he attempted to self-trafloor in her room father right forearm. The and vitals were compossible contribution were effective and a floor mat. R32's PN dated 9/2 R32 was found seat against the bed. R3 The note indicated be monitored every R32 had no complained the requested a.m. identified R32 sustaforearm, neuro's we would be requested a.m. identified R32 in therapy. Swelling	er wheelchair to the sobserved to slip and fall on tand hit her head on the b. The report indicated R32 t pain in her lower back and e taken. The report failed to al status, possible contributing terventions were effective, or ns implemented after the fall. 27/16, at 10:38 a.m. indicated I on her butt and bumped her nob. R32 complained about ddle of her back. R32's vitals new intervention was to				

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2 830	left wrist X-ray reportion identified a left wrist 4. R32's Fall Safety fell on 10/9/16, at 1 self-transferred from her bathroom. R32 indicated R32 did not complaints of pain at The report failed to were effective or an R32's PN dated 10/R32 was found on a slid off the toilet on indicated R32 had a complaints of pain at The note failed to identify a feet of the toilet on indicated R32 had a complaints of pain at The note failed to identify a feet of the toilet on indicated R32 was safety awareness, and indicated R32 was safety awareness, and evices, had impair with staff assistance took antihypertens medications that in The report further in falls in the last 3 modecline in physical shypotension (low blocerebrovascular acto 1 side of her bod was at risk for falls,	in x-ray was ordered. R32's ort dated 9/21/16, at 4:03 p.m. at fracture. The Event Report indicated R32:53 p.m. after she in a wheelchair to the toilet in slid onto her butt. The report of hit her head, had no and vitals were completed. identify if current interventions by new interventions. The report indicated R32 p.m. identified the bathroom floor after she to the floor. The report not hit her head, had no and her vital signs were taken. Identify any new interventions with the report indicated R32 in the report indicated R32 in the report indicated R32 in the report indicated R32 indicated R32 had 3 or more onths, loss of limb movement, status, incontinence,	2 830	DEFICIENCY			
	5. R32's Fall Safety	Event Report indicated R32					

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2 830	fell on 11/21/16, at self-transferred from the east bathroom. toilet and the wall. and vitals were take pain on the right top to identify if current and any new interverse R32's PN dated 11/R32 self transferred toilet in the bathroo and she slid down to the toilet in the bathroo and she slid down to the report further in R32's care plan wo failed to identify any implemented after long a recliner in the calarm (fall prevention clipped to the back not attached to the arm chair cushions from sounding if R3 independently. What the cord can stay a not separate, the all staff to the independently and the cord can stay and the cord can s	12:33 p.m. after shem the wheelchair to the toilet in R32 slid down between the The report indicated neuro's en and R32 complained of of her hand. The report failed interventions were effective entions added after the fall. 21/16, at 12:11 p.m. identified of from her wheelchair to the most before staff could get to her between the toilet and the wall. R32 complained her right she was emotionally upset. Indicated vitals were taken and uld be updated. The note of new interventions	2 830			
	tabs unit was not at	tached to the recliner. It was the recliner chair. R32 made				

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2 830	Continued From pa	ige 25	2 830			
	in the common are clipped to the back not attached to the the recliner chair. Falarm unit. R32 marks and attached to the back not attached to the the recliner chair. Fatand. -9:35 a.m. R32 was in the common are clipped to the back not attached to the the recliner chair. Fatand.	s observed seated in a recliner a with a tabs alarm cord of R32's shirt and the unit was recliner but on the right arm of R32's right arm was in front of de no attempts to stand. s observed seated in a recliner a with a tabs alarm cord of R32's shirt and the unit was recliner but on the right arm of R32 made no attempts to s observed seated in a recliner a with a tabs alarm cord of her shirt and the unit was recliner but on the right arm of R32 made no attempts to				
	about R32's toiletin just about to do that wanted to use the beginning treached forward are wheelchair with both picked at the whee NA-B applied the galarm unit from the placed them in the her wheelchair. NA stood up slowly and wheelchair. R32 was unsteady. NA-B as with the gait belt are and sit down in her	sking nursing assistant (NA)-B g schedule NA-B stated "I was it." NA-B asked R32 is she pathroom. R32 said yes. R32 and grabbed the seat of her ith hands, patted the seat, and lichair arms with her right hand. ait belt and removed the tabs recliner and R32's shirt and storage pouch on the back of -B cued R32 to stand up. R32 id held on to both arms of the as stooped over and very sisted R32, holding on to her and assisting her to turn around wheelchair. R32 took small er remaining stooped over and				

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2 830	Continued From pa	ge 26	2 830			
	recliner in the common was clipped to the to was not attached to the right arm of the attempts to stand. -12:27 p.m. NA-B to wheelchair to the read physical assistance recliner when Notes the recliner with the recliner and stated loudly at up." NA-B said ok a cord to the back of alarm unit loosely used to the cushion. The unit work chair. R32 leaned for the recliner seat an in recliner. R32 sco	as observed seated in a mon area. The tabs alarm cord back of R32's shirt. The unit of the recliner but was sitting on recliner chair. R32 made no recliner chair. R32 made no recliner using a gait belt, cueing ance. R32 leaned forward in IA-B attempted to elevate her releg rest. R32 became upset and harshly, "I don't want that and clipped the tabs alarm R32's shirt and placed the under the right recliner arm ras not attached to R32's orward, lifted her bottom off d plopped herself back down oted herself back in the chair. cound during this activity. NA-B				
		aned forward in the recliner, area and leaned back in the present in area.				
	leaned forward and cord forward with the sound. There was the unit was unattaineffective. R32 atterecliner. R32 was a edge of the recliner lift her bottom approchair. Although the as she moved, there	f were present in area. R32 pulled some of the alarm unit ne unit. The alarm did not oo much slack in the cord and ched making the alarm empted to get up from the ble to get her bottom to the chair. She was then able to eximately 2 inches from the cord pulled slightly with R32 e was too much slack for the 2 then attempted to self				

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2 830	transfer. R32 leaner ecliner chair arms attempted to stand. alarm failed to sour with R32 while and assist R32. NA-C who bath. NA-C was ale transferring in the control of NA-A to help her in assisted R32 with crecliner to her wheet tabs alarm was not should have been. On 1/4/17, at 12:41 put the tabs alarm of She stated there was attached to her chail alarm should have not resting on the aconfirmed she had operate and place to the doorway and work of the do	d forward, pushed off of the with both hands and No staff was present, and the id, so one surveyor remained ther surveyor left to find staff to was found running water for a priced to R32's attempts at self lay room. NA-C called for the day area. They physically sues and a gait belt from the elchair. NA-C confirmed the attached to R32's chair and p.m. NA-B stated they usually on the side of the bed or chair. as a clip on the unit to be ir. NA-B confirmed R32's been attached to her chair and rms of the recliner. NA-B received education on how to the alarm when she was hired. a.m. R32 was observed self day room to the east y her feet. R32 leaned forward throom door when the alarm inued to push herself through as scooting forward in her ned and redirected R32, if the bathroom into the R32 had a brief conversation NA-D assisted her into the	2 830			
		Ichair. NA-D stated they were				

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AND DI AN OF CORRECTION IN INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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2 830	going to assist R32 applied a gait belt a and NA-C cued R3: to stand up. R32 pu hands on the wheel gain momentum an her to stand. NA-D and NA-C followed wheelchair. R32 waleft arm handle of the walker. NA-D cwalker handle with swung in front of he forward and her leg R32 had walked 10 farthest she ever wishe walked an addiwanted to walk eve. On 1/4/17 at 2:16 pevent reports, progrinterventions implements.	with ambulation. NA-D pround R32's waist and NA-D and physically assisted her ushed herself up with her lichair arms a couple times to d NA-D and NA-C assisted provided R32 with a walker R32 and NA-D with a seconfused and grabbed the ne walker and the front bar of ued R32 to grab the right her right hand. R32's left footer right foot, R32 was leaned as were weak. NA-D confirmed to feet and that was the alked. NA-D later confirmed tional 80 feet and stated R32 n more.				
	she was not aware tabs alarm correctly assumed they affixed. The DON stated should be and R32's caunderstood how to the NA's had an assummarized R32's NA's chose not to a she expected staffing judgement" and R3 whether or not to as	ne fall information and stated staff was not placing R32's a. She stated she just ed it to her chair or recliner. e used a communication are plan to ensure staff care for her. She also stated signment sheet that care plan and stated some earry it with them. She stated to rely on their "best 2's care plan to determine oply R32's tabs alarm in a DON stated she expected the				

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in her wheelchal For the fall of 7/ verified the fall i thought R32 trie bed. She stated after the fall R3; and pain in her sometimes R32 She stated bed R32's care plan The DON verifie 8/27/16, at 10:2 self-transfer. R3 when she tried the fall was with make sure R32 The DON stated resulted from R get out of bed, a R32 was trying documentation sustained a left unwitnessed fall Agency. She state fall. The DON verifie the fall on 10/9/ self transferred on the bathroon unwitnessed, vir not hit her head no new interventage.	e affixed if she was in her room or ir. 27/16, at 7:30 p.m. the DON information and stated she id to self-transfer and get out of the fall was unwitnessed and in the properties of the half was unwitnessed and in the properties of the properties					

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2 830	bathroom and stood to get to the toilet. Stoilet and the wall in stated after one of at the nurses station. She stated the new leaving R32 alone in the DON stated R3 cognitive impairment time, or where she last fall assessmen. The DON stated R3 to the amount of as required with ADLs as mobile as she us stand up. She stated doing a bowel and land stated those which stated she had not prevention intervent they also tried to ke give her something did not like to leave extended periods on the DON confirmer policy and would conceive the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and reached for the last time she obtained the policy and the polic	d up from her wheelchair trying She said R32 fell between the a the bathroom. The DON her falls staff tried to keep her and give her things to do. intervention added was not an the bathroom. B2 had moderate to severe at and R32 had no concept of was at. She confirmed R32's to was completed on 10/25/16. Was at high risk for falls due sistance and cueing she and R32 had forgotten she wasn't sed to be and would try to be dished had not considered colladder assessment on R32, were only done quarterly. She considered any other fall tions for R32. The DON stated sep R32 in their line of vision, to do at the nurses desk, and her alone in her room for fitime. If they do not have a, "Falls," ontinue to use the current fall of (clinical documentation eveloped a preventative)	2 830			

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2 830	she slid out of her tafter the fall. NA-A any other falls for Finterventions were R32 busy. She statthem otherwise her stated R32's tab alarecliner today and secured a fall interve tab alarm in place so She stated R32 had had a history of sel sustained an injury was at risk for falls awareness. CM-A son duty to make su correctly. On 1/4/17, at 1:06 place in the NA's to secure the NA's to secure. On 1/5/17, at 8:56 a a restorative prograshe was currently and lower extremity about 3 times per vishe felt R32 had mand some day's R3 stated R32 was at the R32	bed and had to wear a cast stated she was not aware of R32. She stated R32's fall the tabs alarm and to keep ed they tried to keep R32 by alarm was going off. She arm was not attached to the should have been. B p.m. clinical manager (CM)-A notion for R32 was to have a secured to her recliner or chair. If the tab alarm because she for transferring and R32 had as a result. She stated R32 because she had no safety stated she expected the nurse are her alarm was placed p.m. licensed practical nurse alarm should be do she hated to see the NA's not it in the arm of the recliner alshe had previously educated	2 830			

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		00353	B. WING		01/0	06/2017
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MAHNO	MEN HEALTH CENTE	К	T JEFFERSO IEN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	didn't attempt to ge her cognition was, ' last time she obser 2-3 weeks ago. On 1/5/17, at 9:25 a stated she felt R32 when she was alon	. NA-D stated she felt R32 t up that often except when 'off" that day. She stated the ved R32 try to stand up was a.m. the activities director (AD) was at moderate risk for falls e in her room and when she				
	stated the last time her own was 1/3/16 into the east bathro tried to stand up on	om her wheelchair. The AD she saw R32 try to get up on when R32 wheeled herself om. She stated whenever R32 her own they would remind would reply, "I know."				
	(OT) confirmed R3: The OT stated R32 OT on 8/12/16. The completed a discha stated she must ha when R32 began th required supervisio from staff with bed used a walker. She 7/27/16, it became sitting to standing p point R32 could not she would lose her R32 was at risk for physical assistance weakness in her leg transitioning from s when R32 was disc she was more conf difficultly following of	a.m. the occupational therapist 2's OT evaluation on 7/22/16. had been discharged from a OT confirmed she had not arge evaluation for R32 and we overlooked it. She stated arrapy she was confused and an and physical assistance mobility and transfers and stated after R32 fell on difficult for R32 to go from a position. The OT stated at that is be left unattended because balance. The OT confirmed falling because she required a falling because she required a falling to standing. She stated tharged from OT on 8/12/16, sused, and had increased directions. She further stated factor for OT progress after				

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			7. BOILDING.			
		00353	B. WING		01/0	6/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE		FJEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 33	2 830			
	her fall on 7/27/16.					
	11/7/16, after R32's she was able to use OT stated R32 was 11/23/16, and R32' limited flexion and on 11/23/16, was don 11/23/16, was don the stated R32 required ambulate with her was continued to be at a required assistance OT additionally stated R32 required	r started OT with R32 again on a splint had been removed and the her left wrist for ADLs. The state discharged again from OT on a left hand was swollen, had some pain. She stated R32's reason for discharge from OT use to poor cognition. She distaff assistance and cues to walker. The OT stated R32 risk for falls because she with ADLs and cognition. The ted the last time she saw her, all propel herself in the only her feet.				
	Sentry Fall Monitor monitor was to be a bed using the clip of magnetic disc from secured to the more clip attached to the of the shoulder or be appropriate cord let the person to activate moved beyond the the disc pulled from would sound. The auto follow the installative warnings and control or the security of the security for	Instructions for the Personal ing System identified the mounted to either a chair or on the back of the monitor, the the pull string was to be nitor magnet, and the locking resident's garment at the top back of the neck with the night determined in order for ate alarm. When a resident determined length of the cord, in the monitor and the alarm user instructions directed staff ation instructions, particularly autions when using the fall and failure to do so could eath.				
		pardy which started on ved on 1/6/17, at 4:00 p.m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	F JEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	after the facility con interventions as par-R32 was comprehe-R32's care plan was assessment for cur interventions -Staff were educate-On 1/6/17 from 3:0 staff, including licer interviewed regardinerviewed staff we falls, and the fall interviewed staff we falls, and the fall interviewed, the facility faimplement intervent moderate to severe the right clavicle for reviewed for pain. Tactual harm to R18 Findings Include: R18's admission Minimal serving and seizure of the pain of upper extrement and had pain of upper extrement and seizure of the MDS identified scheduled pain medical serving as pain of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain medical serving as part of the MDS identified scheduled pain serving as part of the MDS identified scheduled pain serving as part of the MDS identified scheduled pain serving as part of the MDS identified scheduled scheduled pain serving as part of the MDS identified scheduled scheduled scheduled scheduled	inpleted the following it of their removal plan: ensively assessed for falls as updated to reflect R32's rent risks for falls and fall and on R32's fall interventions to p.m. to 4:00 p.m. direct care in the fall in the ensed nursing staff were in the ensemble ensembl	2 830			
		a.m. Registered Nurse ed R18's cognition had				

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		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 35	2 830			
	longer had moderatime of the survey F NM stated R18 had and was able to ver without difficulty. NI	admission assessment and no te cognitive impairment. At the R18 had improved in cognition. I minimal cognitive impairment balize his needs and wishes M stated R18 would be a aformation regarding his pain				
	(CAA) dated 11/2/1 complaints about sl The CAA identified collar bone. The CA	nin Care Area Assessment 6, identified R18 had many noulder, neck and back pain. R18 had a history of a broken AA revealed R18 was to be mary physician with nursing				
	10/27/16, revealed interview he had fre shoulder and clavic movement. The ass described the pain moderate intensity. interventions were imilligrams (mg) by as needed (prn,) ar	in assessment dated R18 had stated upon staff equent pain of the right le (collar bone) with onset with sessment revealed R18 had as an ache and was of a The assessment revealed in place of Tylenol 650 mouth (po) every four hours and a referral for physical ecupational therapy (OT).				
	revealed R18 had of related to a history recent collar bone for revealed R18 had of therapy, he had been therapy despite the using his arm due to directed staff to pro	eeze (an over the counter				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		414 WFS		N AVENUE, PO BOX 396		
MAHNO	MEN HEALTH CENTE	MAHNON	MEN, MN 565	57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	non-pharmacologic warm/cold packs. Fhas been ordered for MD had declined fur diagnostic testing of care plan further reactivities of trivia, removies shortly after shoulder pain preveativities. The care preferred to lay in bedelined further act identified care plan coping strategies to On 1/4/17, at 12:40 side in bed, facing the R18 had his right are furrowed brow, clerwith facial grimacing. On 1/4/17, at 2:37 pedge of his bed, his arm was tightly gual coughed, R18 grims R18 stated he had be following a fall prior late October. R18 carm, and grimace. If which started at his down to his hand. Find was severe, being a of 0 to 10 with 10 be pain. R18 stated he independent with his hard as he experier his right arm. R18 shim to sleep at night increased his pain I	al pain interventions of R18's care plan revealed PT or shoulder pain and R18's rther pain medications or f an MRI as of 11/8/16. The vealed R18 had enjoyed eminiscing, and western the was admitted and R18's ented him from attending plan also revealed R18 ed for comfort and had ivities due to pain. An goal was for R18 to develop help adapt to pain. p.m. R18 was lying on his left he TV with his eyes open. If m guarded to his chest and a ached jaw and squinted eyes,				

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/0	6/2017
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOME	EN HEALTH CENTER	₹	JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
n ph the stituth a h " s whae gah b ph Fine II riog F (12 p -1	pain which was frequent had been told by the had been told by the herapy for the pain with therapy due to stated his physician the medication, gab reat nerve pain from the had not had reliated had not had reliated here had a high mostranger to pain should listen to him were not reliving his had offered ice packed that was also in exhibit a furrowed by the did was smoke a state of the highest had been to the highest had been to him isolated that was also in exhibit a furrowed by the him isolated his well being his himself. Review of R18's cure 2/13/16, revealed the himself. Review of R18's cure 2/13/16, revealed the himself had a pain (start by the himself) and the himself had a pain (start by the himself) for October, the himself had a pain medications are cotober 2016, revealed the form medications are cotober 2016, revealed the fo	ge 37 ibuprofen and Tylenol for the juently ineffective. R18 stated the nurses to work with and stated he could not work it causing too much pain. R18 had recently started him on apentin (a medication used to meuropathy). R18 stated he gabapentin since December ief from the pain. R18 stated in pain tolerance as he was ", and the nurses and doctor when he said the medications is pain. R18 stated the staff is right after he was admitted in pain tolerance as he was admitted in pain tolerance as he was admitted in pain. R18 stated the staff is right after he was admitted in pain. R18 stated the staff is right after he was admitted in pain. R18 stated the staff is right after he was admitted in pain. R18 stated the felt the pain had in try to sleep the pain away 18 stated he felt his continued in and try to sleep the pain away 18 stated he felt his continued in and he did not feel like in the following orders for pain in (a) 325 mg, take two tablets popain (start date 10/27/16), here times a day (tid) pofor date 12/7/16). A hand written 6, revealed an order for soly mouth tid for pain. Redication administration record November and December following administration of printed the effectiveness: Realed R18 had reported pain and had received printed pain and had received printed in the effective pain and had received printed pain and had received printed pain and had received printed in the effective pain and had received printed pain and had received printe	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00353	B. WING	····	01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MAHNO	MEN HEALTH CENTE	K	JEFFERSO EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLETE DATE
2 830	Tylenol 650 mg 10 R18 had received reported somewhat times. -November 2016, remoderate to severe Tylenol 650 mg 44 26 out of the 44 tim Tylenol it had been out of 44 times it wapain. R18 had reported in the severe Tylenol 650 mg 32 18 times R18 had resomewhat effective times was effective had received ibuprothe month, out of the ibuprofen was sem effective and 18 times. -January 2017, revenued and 18 times and out of the had somewhat effective and 18 times and out of the had somewhat effective and out of the had somewhat effective and 18 times and out of the had somewhat effective and 18 times and out of the had somewhat effective and somewhat effective an	times and one out of 10 times elief from the Tylenol. R18 had a effective relief the other nine evealed R18 reported e pain and had received prn times. The MAR revealed on les R18 had received the somewhat effective and three as ineffective in relieving R18's rted effective results the other evealed R18 had reported e pain and had received prn times and out of the 32 times, eported the medication was and 3 times ineffective and 11. The MAR also revealed R18 often 400 mg 31 times during the 31 times 10 times the ineffective, three times not the was effective. The effective pain relief. The MAR also revealed R18 had reported the medication was the ineffective for the same and out of the three times are effective pain relief. The MAR also revealed R18 had reported the pain and had received the same and out of the three times are effective pain relief. The MAR are eight times two times R18 crive pain relief and six times effective. The part of the three times are effective to the are the pain and the pain and the pain and six times effective.	2 830			

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STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00353	B. WING		01/0	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	K	JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	11/8/16, revealed R visit. The note revertherapy at the time extremity and staff minutes per hour as revealed R18 had scollarbone on 10/14 constant, sharp pai collarbone down his any type of activity. significant deformity tenderness over the revealed R18 was to weeks. Review of R18's phorevealed R18 was sphysician regarding revealed R18 had and had been unable the facility due to rigidentified R18 had a fracture with possib pain. The note furth weakness with extended R18's phorevealed R18's phorevealed R18 had a fracture with possib pain. The note furth weakness with extended R18's phorevealed R18's phorevealed R18 had a fracture with possib pain. The note furth weakness with extended R18's phorevealed	18 had been seen for an initial aled R18 had attended of the note for right upper could apply moist heat 15 is able for the pain. The note suffered a fracture of his right late of the his right and had suffered in which radiated from his is right arm and occurred with the note revealed R18 had by of his collarbone with the joint. The note further to be seen again in four seen by an orthopedic his right shoulder. The note been having significant pain le to comply with therapy in 18 the pain le to comply with therapy in 18 the le cuff dysfunction with his 18 there revealed R18 had 18 that le revealed R18 had 18 t	2 830			
	identified R18 had a acromial end of right shoulder) with malu complained of ongo. The note revealed I shoulder girdle atro of the distal clavicle R18's internal and a The note also reveatouch over the right	a nursing home note which a closed displaced fracture of at clavicle (towards the inion. The note revealed R18 bing pain in the right shoulder. R18 had significant right phy with a marked deformity at the note further revealed external rotation were limited. Aled R18 had tenderness to shoulder. The note revealed et o receive heat application				

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		00353	B. WING		01/0	6/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/0	0/2011	
MAHNO	MEN HEALTH CENTE	K	JEFFERSO	N AVENUE, PO BOX 396 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 830	therapy and use Ty management. The to continue with parmotion (ROM) exerconsider adding ad improvement in R1 Review of Therapy form dated 10/28/1 evaluated for theraph ROM both active are extremity. The assereferred to the faciliprogram (FMP) three Review of a Theraph form dated 11/9/16. pain from a fracture and pain. The asseconstant pain which The assessment reveal to move his arm and due to pain. The assessment reveal to move his arm and due to pain. The assessment reveal to move his arm and the top pain. The assessment form the assessment form the seven with 12/1/16 and R18 has three of the seven with 12/1/16 and R18 has thre	lenol and ibuprofen for pain note further revealed R18 was saive and active range of cises and the physician would ditional pain medication if no 8's pain. Assessment, OT evaluation 6, revealed R18 had been by and had impaired upper not passive of his right upper essment revealed R18 was sity functional maintenance are times a week for ROM. By Assessment, PT evaluation are revealed R18 had shoulder and had decreased ROM assment identified R18 has a would shoot down his arm. Evealed R18 had reported ective in relieving his pain an 8 out of 10. The led R18 understood the need bound, though did not want to sessment revealed PT had sits with R18 from 11/11/16 to ad participated in therapy on wisits and had refused the rest. In the revealed R18 continued shoulders.	2 830				

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		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	K	T JEFFERSC EN, MN 565	ON AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 41	2 830			
		6, revealed R18 complained of 10 and received Tylenol 650				
	 -A note on 11/04/16, revealed R18 complained of right shoulder pain rated a 7 out of 10 and had received Tylenol 650 mg. -A note on 11/5/16, revealed R18 complained of right shoulder pain, rated 8 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 4 out of 10 after receiving the Tylenol. - A note on 11/6/16, revealed R18 complained of right shoulder pain, rated 6 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 2 out of 10 after he received the Tylenol. 					
	- A note on 11/7/16, due to right arm pai	revealed R18 refused therapy n.				
	for restorative thera 2 - 8, due to right she revealed R18 had be primary physician. Complained of right an MRI. The note fu	revealed R18 was not seen upy for the week of November noulder pain. Another note been seen in the facility by his The note revealed R18 shoulder pain and requested urther revealed R18's MD ulder pain and ROM.				
	11/11/16, revealed I shoulder pain and o	16, as a late entry for R18 was seen by PT for right completed ultrasound and es which included passive				
	-A note dated 12/2/	16, as a late entry for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/0	06/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAHNOI	MEN HEALTH CENTE	K	T JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 42	2 830				
	minutes by PT, rec	R18 had been seen for 25 eived ROM exercises and pain of the right shoulder.					
		ated 12/2/16, as late entries for revealed R18 refused					
		0/16, revealed R18 complained ted 6 out of 10 and received					
		/16, as a late entry for R18 refused therapy.					
		/16, as a late entry for R18 refused therapy.					
	-A note dated 11/28/16, revealed R18 complained of shoulder pain rated 7 out of 10 and received Tylenol 650 mg. The note revealed R18 had rated his pain 4 out of 10 after he received the Tylenol.						
	and received Tylen	0/16, revealed R18 ulder pain rated a 7 out of 10 ol. The note revealed R18 had of 10 after he received the					
	revealed R18 was	/16, late entry for 12/1/16, seen by PT, reported improved d 25 minutes of ROM					
	R18 complained of prior to admission. not addressed his sresult was chronic	e note dated 12/1/16, revealed right shoulder pain from a fall The note revealed R18 had shoulder properly and the pain. The note further revealed by despite the benefit. The					

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	00353		B. WING		01/0	6/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 43	2 830			
	note revealed R18 had been provided education on the benefits of therapy.					
		/16, revealed R18 complained ed 6 out of 10, and received				
		/16, revealed R18 complained ed 8 out of 10, and received				
		/16, revealed R18 complained ed 7 out of 10, and received				
	the NM twice and s done about his show had planned to disc revealed the NM wo further note reveale rated 7 out of 10 and	16, revealed R18 spoken with tated something needed to be ulder. The note revealed PT continue services. The note ould speak with R18's MD. And R18 complained of pain and received Tylenol 650 mg. R18's pain level was 4 out of the Tylenol.				
	revealed R18 received sessions for the we	/16, a late entry for 12/6/16, wed 2 out of 3 restorative ek of 11/30/16 through eted upper extremity (U/E)				
	by an orthopedic M or interventions for NM encouraged R1 note revealed R18's 400 mg tid as need	/16, revealed R18 was seen D and received no new orders pain relief. The note revealed 8 to take Tylenol. A further MD had ordered ibuprofen ed for right arm pain. The note 8 was to keep using ice and n with gentle ROM.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00353	B. WING		01/	06/2017
NAME OF PROVIDER	OR SUPPLIER			STATE, ZIP CODE		
MAHNOMEN HEA	ALTH CENTE	R	T JEFFERSO IEN, MN 565	N AVENUE, PO BOX 396 57		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
- A note of right further mainter include and low R18 correceive R18's part the ibu A note of pain 400 mg rated 4 - A note complareceive R18's pareceive R1	shoulder parenote revealed nance progressed	/16, revealed R18 complained ain and ibuprofen was given. A red R18's functional am (FMP) was updated to fl to his right upper extremity res. A further note revealed pain rated a 7 out of 10 and 400 mg. The note revealed as 3 out of 10 after he received revealed R18 complained of 10, and received ibuprofen revealed R18's pain level was ter he received the ibuprofen. 1/16, revealed R18 rated at 8 out of 10 and 400 mg. The note revealed as rated 3 out of 10 after he	2 830			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00353	B. WING		01/0	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOMEN HEALTH CENTER			JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 557		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	continued complain R18's MD had sent mg tid for increased in the clinic or ER. -A note on 12/20/16 pain in his arm and revealed R18 had be had to wait for the property of the pain in his arm and revealed R18 had be had to wait for the property of the pr	Informed R18's MD of his ats of pain. The note revealed an order for gabapentin 300 dipain and R18 was not seen at a pain and R18 complained of requested Tylenol. The note become "impatient" when he pain medication. 6, revealed R18 was observed obtain medication. 6, revealed R18 was observed obtain medication. 6, revealed R18 was observed and upon his face and was is arm. The note further ed group activities and only eat and lay down. 6, revealed R18 had trouble es due to pain and too much	2 830			

Minnesota Department of Health

Millinesc	ita Department of He	aim				,
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00353	B. WING		01/0	6/2017
		00000			01/0	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MALINIO	ACN LICALTIL OCNEC	414 WEST	JEFFERSO	N AVENUE, PO BOX 396		
MAHNOI	MEN HEALTH CENTE	MAHNOM	EN, MN 565	57		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 46	2 830			
	•					
		did not raise his right				
		e sausage. R18 picked up a				
		nand and ate three bites of his				
		ced the spoon back on the				
		p a piece a toast with his left				
		, and placed it back on his				
	•	coffee cup in his left hand and				
		ee. At 7:19 a.m. the director of				
		roached R18 and asked if he				
		R18 replied he was not feeling				
		was going to go back to bed.				
		dependently walked out of the				
		s right arm guarded to his right				
		nurses station and obtained a				
		r. R18 walked toward the				
		hed to button with his left hand				
		alked in the room and sat on a				
		garette with his left hand and				
		e with his left hand, while his				
		at his side. R18 then walked				
		to his room and sat on his				
		arm remained guarded to his				
	side, brow was furr	owed, jaw tight and face taut.				
	O: 1/5/17 -1.7:00 :	D10 stated be				
		a.m. R18 stated he was not				
		to arm pain. R18 stated he				
		previous night due to arm				
		e nurse had given him Tylenol				
		ed, and he continued to have				
	•	aid he was "so tired" of the				
		dmitted he felt frustrated and				
		ed he would tell the nurse				
		and would tell the nurses when				
		ofen was ineffective in				
		said he told his physician he				
		Tylenol and ibuprofen were				
		the pain. R18 stated he had				
	pain everyday and s	staff knew he was in pain.				

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Minnesota Department of Health STATE FORM

On 1/5/17, at 12:14 p.m. R18 walked

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOMEN HEALTH CENTER			JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 47	2 830			
	right arm guarded t	e hallway toward his room, his ightly to his right side. R18's, cheeks and jaw were taut, ed.				
	station, his right arr cheeks taut, brow f R18 obtained a ciga hand in the facility s	n the hall toward the nurses in guarded toward his side, urrowed, lips and jaw tight. arette, smoked with his left smoking room and walked 118's facial expression				
	independently towa forehead creased, l R18 stated he was	a.m. R18 walked down the hall rd his room, lips and jaw tight, brow furrowed. At that time in a lot of pain, had received norning, and it had not been g his pain.				
	(DM) stated she wa using his right arm DM stated she felt improve with therap want to use his righ	p.m. the dietary manager as aware R18 had not been consistently during meals. The R18's use of his arm would by. She stated R18 did not arm like he used to and the in therapy because of that.				
	refused to participa right shoulder. The reliable source of ir	p.m. the PT stated R18 had te in therapy due to pain in his PT stated he felt R18 was a iformation regarding his pain the last time PT was				
	(LPN)-A stated she and able to voice hi	o.m. licensed practical nurse felt R18 was cognitively intact is needs and wishes. LPN-A ined of right shoulder pain				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MAHNOMEN HEALTH CENTER			JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	frequently. LPN-As with ordered prn Ty reported pain. LPN-her both the Tyleno ineffective in relievi reported R18's conrecently as a couple	ge 48 tated she would provide R18 lenol and ibuprofen when he A stated R18 often reported to I and ibuprofen were ng pain. LPN-A stated she tinued pain to the NM as e of weeks ago. LPN-A stated R18 any other interventions	2 830			
	stated she had see station and compla NA-A stated R18 had her he had pain, mostated R18 had consince admission a fishe felt there were room due to being in R18 had also repordue to pain and did she would inform the report pain to her.	o.m. nursing assistant (NA)-A n R18 walk up to the nurses n of pain on a routine basis. ad also frequently reported to est recently that week. NA-A applained of right shoulder pain ew months ago. NA-A stated days R18 would stay in his n so much pain. NA-A stated ted to her he often laid down not sleep well. NA-A stated the nurse when R18 would NA-A stated she routinely acing when he moved his right asis.				
	reported to her he hunable to recall the she felt R18 often haue to being in pair R18 walk up to the of pain frequently.	o.m. NA- F stated R18 had had been in pain though was most recent time. NA-F stated held his right arm to his body in NA-F stated she had seen nurses station and complain NA-F stated she had also sees R18 had pain, though was most recent time.				
	stated she felt R18 to voice his needs a	o.m. the activity director (AD) was cognitively intact and able and wishes. The AD stated and in activities briefly after he				

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	K	TJEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	arrived at the facility complained of right admission and had The AD stated she in his room per his R18 had stopped at his pain. On 1/6/17, at 8:23 a completed resident R18 was supposed extremity exercises complete range of R18's right arm three in November. NA-D pain with movemen R18 had a fractured which she felt affect stated she had bee week of survey due and not feeling well when he would beat when he attempted shoulder away from had not seen an immanagement or RC On 1/6/17, at 8:30 a frequently complaint shoulder. NA-C stat R18 guarding his rights body. NA-C stat his shoulder she wood.	y. The AD stated R18 routinely shoulder/arm pain since stopped attending activities. completed 1:1 visits with R18 preference. The AD stated ttending group activities due to a.m. NA-D stated she restorative therapy daily and to have upper and lower. NA-D stated she was to motion (ROM) exercises with the times a week which started a stated R18 complained of the of his right arm. NA-D stated decollar bone on the right side ted his range of motion. NA-D in unable to work with R18 the to R18's complaints of pain. NA-D stated R18 had pain in weight with his right arm and to lift his right arm, moving his in his body. NA-D stated she provement in R18's pain DM since he was admitted. a.m. NA-C stated R18 led of pain in his right ted she frequently observed ght arm by holding it against ed when R18 reported pain in build immediately tell the nurse.	2 830			
	to R18's primary ph facilities medical dir not in the office wou	ysician, who was also the rector. R18's primary MD was ald not return until 1/9/17, a with MD's nurse line for MD to				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00353	B. WING		01/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOI	MEN HEALTH CENTE	К	F JEFFERSO EN, MN 565	ON AVENUE, PO BOX 396 557		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 50	2 830			
	survey exit. A phor 1/10/17, at 4:20 p.m MD stated he was a especially in his rigin not aware of the overrent pain regime R18's Tylenol and il him on a scheduled practice was to scheding the regiment of the proutinely received and many regiment but had not considered adding prescription pain more regiment but had not was very reluctant the pain medications of the pain medications in case which he felt R18 do stated he had also pain in December of would improve. MD heat and cold there staff had tried them. On 1/6/17, at 1:56 pold fracture to his ricontinued to cause stated R18 received pain, which were on stated she had reported to the pain medications, most. On 1/6/17, at 2:23 per section of the pain medications, most.	ot return phone call prior to ne call was received by MD on m. During the phone interview aware R18 had ongoing pain, ht shoulder. MD stated he was rerall ineffectiveness of R18's en. MD stated he had thought buprofen were already given to d basis. MD stated the usual redule prn pain medication if wed it. MD stated he had orthopaedic MD and he had to necessary. MD stated he had Tramadol (non-opiate edication) to R18's medication at that time. MD stated he to order opioid and/or narcotic ue to the monitoring involved e medications. MD stated he bioid and/or narcotic pain res of acute injury or pain, lid not meet that criteria. MD ordered gabapentin for R18's some time and had hoped that to stated R18 could have had apy, but was not sure if the nor their effectiveness p.m. LPN-B stated R18 had an ight collar bone which she felt R18 frequent pain. LPN-B at Tylenol and ibuprofen for verall not effective. LPN-B orted to the NM, R18 was not in pain with the current prin recently as the previous week.				

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not receiving routine relief with the current prn

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00353	B. WING		01/0	6/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MAHNOMEN HEALTH CENTER		JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
stated she had been a cognition assessment surveyor due to R18 r. The NM stated she fer cognitively intact and loss. The NM stated source of information stated she had report current pain medication. The NM stated she we R18's MD regarding for an unwillingness to the NM stated R18's gabapentin and only source of the NM stated she fer experience pain and the managed at that time. A facility policy titled, he revealed it was the far patients were free of patie	and ibuprofen. The NM unable to complete another it as requested by the not feeling well with a cough. Left R18 was overall may have minimal memory she felt R18 was a reliable regarding his pain. The NM ted to R18's primary MD the on overall was not effective. Yould routinely struggle with R18's pain management due of try other pain medications. MD has started him on saw minimal improvement. Left R18 continued to that his pain was not effective pain or would receive pain and allow them to maintain functioning and well being, the policy directed facility polete an initial and ongoing orn medications. The policy if to monitor the dications and to evaluate if a pain medications. IOD OF CORRECTION: IOD OF CORRECTION:	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00353	B. WING		01/0	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOMEN HEALTH CENTER			JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 52	2 830			
	appropriately implemented, revised, and monitored. The results of the audits could be reported to quality assurance committee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			2/3/17
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and document alled to ensure residents were ed manner for 1 of 2 residents dignity concerns.		corrected		
	Findings include:					
	11/16/16, indicated and Alzheimer's dis R22 had severely in incontinent of urine	num Data Set (MDS) dated R22 had Parkinson's disease ease. The MDS identified mpaired cognition, was , and required extensive sing and ambulation.				
	required the assista belt, and walker for	ted 12/12/16, indicated R22 ance of one to two staff, a gait ambulation, and assistance of ang needs and incontinence				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00353	B. WING		01/0	06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAHNOMEN HEALTH CENTER		JEFFERSO EN, MN 565	N AVENUE, PO BOX 396 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	On 1/3/17, at 5:00 pin a recliner in the robserved wearing a had a hole below the approximately four pants which expose thigh. A staff meming R22 to stand, then walker and ambulated down the hall, and in Throughout the obsersidents were observed with his com filled with resipants gaped open a outer left thigh and Throughout the diminant from 4:58 p.m. to 5 past R22 on the weattempts or offers to On 1/5/17, at 7:51 a verified R22 required dressing, ambulation NA-E stated R22 had R22 should had changed because in around with torn sweet exposed skin. On 1/5/17, at 12:01 (LPN)-A verified R2 have been changed	o.m. R22 was observed seated esident lounge area. R22 was a pair of gray sweat pants that he left front pocket inches long in the seam of the ed R22's left upper, outer per was observed to assist instructed R22 to use the ted from the resident lounge, not the dining room. Servation, staff and other erved to walk near and around on. R22 was seated in a ne dining room outside of the selft side facing the dining dents. The hole in R22's and exposed R22's upper, white incontinence brief. In gobservation on 1/3/17, 149 p.m. multiple staff walked by to the serving door, with no conclude R22's pants. The nursing assistant (NA)-Event extensive assistance with an and incontinence cares. The death of the sweat pants was not dignified to walk event pants that showed. The p.m. licensed practical nurse 12's torn sweat pants should a right away, and stated it was seated in the dining room with seated in the dining room with	21805			

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PRINTED: 02/10/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00353 01/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE, PO BOX 396 **MAHNOMEN HEALTH CENTER** MAHNOMEN, MN 56557 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21805 Continued From page 54 21805 On 1/5/17, at 2:12 p.m. the dietary manager (DM)-A confirmed she observed the hole in R22's pants on 1/5/17. DM-A confirmed she could see skin of the left leg, and white material hanging out of the torn area of the sweat pants as R22 was seated in a chair in the dining room. DM-A confirmed staff was aware that R22's clothes were not in the best shape, and stated R22 had a history of picking at his clothing. On 1/5/17, 3:20 p.m. registered nurse (RN)-A

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found the pair of pants R22 was wearing on 1/3, and confirmed the hole was approximately four inches long and stated R22 should not have been dressed in them.

On 1/5/17, at 3:27 p.m. clinical manager (CM)-A confirmed the hole in R22's pants was not dignified, and would have expected staff to change R22's pants.

The facility's Quality of Life-Dignity policy dated 3/2016, indicated each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring residents are dressed in a dignified manner. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days