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

ID: U84B
Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245563**

2. STATE VENDOR OR MEDICAID NO. (L2) **475240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/07/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds 65 (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Supervisor 01/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

ID: U84B
Facility ID: 00678

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(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

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7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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(L37)	(L38)	(L39)	(L42)	(L43)

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18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/16/2015 (L20)

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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5563

Electronically Delivered: January 29, 2015

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

Dear Mr. Erickson:

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 December 30, 2014 the above facility is certified for:

65 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please feel free to call me with any questions about this electronic notice.

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

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5563

Electronically Delivered: January 16, 2015

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

Dear Mr. Erickson:

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.

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Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 13, 2015

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

RE: Project Number S5563025

Dear Mr. Erickson:

On December 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 20, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harmwith potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 7, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 29, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 20, 2014, effective December 30, 2014 and therefore remedies outlined in our letter to you dated December 5, 2014, will not be imposed.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245563	A. Building B. Wing	1/7/2015

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0221** Reg. # **483.13(a)** LSC	**12/20/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**12/20/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**12/20/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/20/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**12/20/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	**12/20/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**12/20/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/30/2014**
ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	**12/20/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**12/30/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/AK	01/13/2015	28035	01/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/20/2014

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

AH Form Approved
1/13/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00678	A. Building B. Wing	1/7/2015

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21990 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 12/20/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/AK	01/13/2015	28035	01/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/20/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245563	01 - MAIN BUILDING 01	12/29/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	12/11/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	01/14/2015	27200	12/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/20/2014

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

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

Form Approved
OMB NO. 0938-0390

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245563	03 - KITCHEN ADDITION	12/29/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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ID Prefix Reg. # **NFPA 101** LSC K0062	**12/11/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
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Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	01/14/2015	27200	12/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/20/2014

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

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

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* Code: **B*** (L12)

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17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NEII 12/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/28/2015 (L20)

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30. REMARKS
Posted 01/29/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 5, 2014

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

RE: Project Number S5563025

Dear Mr. Erickson:

On November 20, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 30, 2014 the following remedy will be imposed:

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

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 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 remedies be imposed:

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

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

Failure to submit an acceptable 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
December 5, 2014

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5563025

Dear Mr. Erickson:

The above facility was surveyed on November 17, 2014 through November 20, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 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 at: 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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

cc: Original - Facility
Licensing and Certification File

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING ______ B. WING ______	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R72) with a wheelchair (w/c) lap tray restraint, was released from the restraint while supervised during 1 of 2 meal observations in order to maintain the least restrictive device for the least amount of time. Findings include: R72's quarterly Minimum Data Set (MDS) dated 8/14/14, indicated his cognition was severely impaired and he required extensive assistance	F 221	R 72 is the only resident of our facility utilizing a restraint at this time. R 72 utilizes lap tray and documentation is in place for restraint protocol to be reviewed Q 6 months by primary RN. Care plan has been reviewed and corrected to remove lap tray at meals and times of 1:1 supervision and staff has been educated on protocol for restraints. There are no other residents utilizing restraints in facility at this time, but continued monitoring will be in place as observation for following of policy by DON should another resident	12/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 12/12/2014

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

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F 221	Continued From page 1 with all activities of daily living (ADLs). The 11/14, care plan indicated R72 was at risk for falls, with a tray table on his w/c to minimize this risk. The care plan identified R72's lap tray as a restraint and directed staff to remove the tray from the w/c when staff were feeding him. During observation of the evening meal on 11/17/14, from 5:30 p.m. to 6:25 p.m. nursing assistant (NA)-E was observed feeding R72 his meal. Throughout the observation R72 was observed with a full lap tray in place and secured by bilateral Velcro straps in which R72 could not reach to independently release. NA-E sat next to R72 throughout the meal and never removed or released the lap tray as directed. On 11/19/14, at 6:38 p.m. during the supper meal, the director of nursing (DON) was heard to advise NA-E to remove R72's w/c lap tray for the meal. R72's tray remained off throughout the meal. On 11/20/14, at 10:45 a.m. NA-E verified R72's lap tray was not removed on the evening of 11/17/14. She reported she was unaware his lap tray was to be removed at meal time. On 11/20/14, at 10:50 a.m. registered nurse (RN)-B stated it was her expectation that staff removed R72's lap tray while feeding him. RN-B stated a restraint was to be released whenever R72 was in a supervised setting. The facility's Physical Restraints policy dated 6/5/12, indicated the purpose for a physical restraint was to prevent injury. The policy directed a resident was to be released from a restraint every two to three hours.	F 221	utilize a restraint in the future. Policy indicates that a restraint should be released at least every two hours and at any time resident is under direct supervision including during activities and mealtime. Staff educated on care plan and will be reviewed again at next staff meetings 12/16/14 and continued monitoring will be completed by DON with supervision 3 x/week x 1 month, then weekly x 3 months at different meal times, and monthly there after. Prompting placed in residents EMAR for cart nurse to sign to ensure lap tray was removed during periods of 1:1 supervision including meal time. This has been reviewed a QA meeting on 12/9/14.	

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GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		12/20/14

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F 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential abuse/ neglect to the state agency (SA), for 2 of 6 residents (R89 and R8) reviewed with resident-to-resident altercations. Findings include: Review of a resident-to-resident abuse report dated 6/29/14, indicated R89 (a male resident with dementia) was found touching R8 (a female resident with dementia) inappropriately. The report indicated R89 rubbed his hands over R8's breasts. The allegation of sexual abuse was reported to the SA on 6/30/14. On 11/19/14, at 11:40 a.m. the director of nursing (DON) confirmed the SA was not immediately notified of this allegation. Review of the facility's Neglect/ Abuse Policy dated 12/28/11, instructed staff to notify the administrator and SA of any suspected allegations of abuse or neglect immediately. The policy defined 'immediately' as "within 24 hours."	F 225	It is the policy of Green Pine Acres to report suspicion of Vulnerable Adult cases immediately, without delay, to OHFC and Common Entry Point as well as administrator. Incidents that occur during the hours the DON is in the building the initial report will be immediately submitted by DON with administrator notified. If DON is not in the building the the administrator and DON will be notified via phone immediately and the report will be submitted by either the RN unit manager or LPN that is working. Both RNs and LPNs have been educated on submission of the electronic document to OHFC and Common Entry Point reporting along with updated policy. After initial report an investigation occurs and is completed and submitted within 5 days by DON or designee. A Vulnerable Adult Reporting form has been created for in hours monitoring and will be required to be filled out with the reporting of each case. The form will be returned to the Director of Nursing upon completion with a printed copy of the submitted report. The new form that has been created includes the documentation of time and date the administrator was notified in addition to the time nursing was made aware of the situation. The Vulnerable Adult Policy has been updated with current standards. The nursing department will be educated on new form, updated policy, and additional training in Vulnerable Adult	

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

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F 225	Continued From page 4	F 225	reporting requirements at next staff meetings no later than December 20th. Compliance will be monitored by Director of Nursing or designee with each incident. Failure to have report completed will prompt re-education of nurse filling out report. Investigations will be completed by Director of Nursing or designee. This has been reviewed at QA meeting 12/09/2114.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's abuse prohibition policies failed to direct immediate reporting to the facility administrator and state agency (SA) for allegations of potential abuse/ neglect, resulting in delayed reporting for 2 of 6 residents (R89 and R8) reviewed for resident-to-resident altercations. Findings include: Review of the facility's Neglect/Abuse Policy dated 12/28/11, instructed staff to notify the administrator and SA of any suspected allegations of abuse or neglect immediately. The policy defined 'immediately' as "within 24 hours." Review of a resident-to-resident abuse report	F 226	Policy has been updated with current recommendations by the Department of Health. Updates completed prior to Department of Health exit. Policy that was in place indicated that the reporting of Vulnerable Adult cases would occur immediately (within 24 hours), verbiage was changed to Immediately, without delay also the order in which department heads were notified was rearranged on the policy to read Administer to be notified first and immediately. Immediate reporting to OHFC, Common Entry Point, and Administrator were already in practice at time of survey but policy now does reflect this order appropriately. Current practice is for DON to submit	12/20/14

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F 226	Continued From page 5 dated 6/29/14, indicated R89 (a male resident with dementia) was found touching R8 (a female resident with dementia) inappropriately. The report indicated R89 rubbed his hands over R8's breasts. The allegation of sexual abuse was reported to the SA on 6/30/14. On 11/19/14, at 11:40 a.m. the director of nursing (DON) confirmed the SA was not immediately notified of this allegation. At 12:30 p.m. the DON stated it was the facility's practice to immediately notify the administrator and the SA of any concerns related to abuse and neglect. She reported 'immediately' meant as soon as possible and as soon as the involved residents were safe. She stated allegations of abuse/ neglect were to be reported within a few hours of the incident and the staff were not to wait up to 24 hours to notify the SA and administrator. The DON confirmed the facility's policy was not consistent with the reporting requirements for incidents of potential abuse/ neglect.	F 226	incident immediately when DON is in house. If DON is not in facility the RN unit manager or LPN are to submit immediately. The RN unit manager or LPN will immediately call administrator, DON, submit electronic report, and notify Common Entry Point. Staff has been educated on electronic form, notifying common entry point, and policy update. A new form has been created to indicate the time and date nurse was made aware of incident and when all parties were notified. The new form will be reviewed by DON after each incident. Monitoring will occur for compliance by DON or designee with each incident with re-education as indicated. This was reviewed at QA meeting 12/09/2014.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		12/20/14

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	245563	A. BUILDING ______ B. WING ______	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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F 279	Continued From page 6 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions for consistent management of maladaptive behaviors, for 1 of 1 resident (R89) with a history of inappropriate touching and invasion of personal space. Findings include: R89's care plan dated 7/2/14, identified increased confusion, poor eyesight and a hearing impairment. The plan directed staff to complete accurate mood/ behavior documentation and monitor R89's whereabouts every half hour. The care plan directed staff to keep R89 away from an unidentified female resident, as they had been involved in an "altercation." The care plan also directed diversional activities be provided for R89. The plan did not describe R89's maladaptive behaviors, nor did it direct the staff as to the type of activities that were most appropriate for him, in order to consistently manage and/or proactively address his behavior concerns. R89's Care Area Assessment (CAA) dated 8/20/14, identified he displayed behaviors, with worsening mental status. The behaviors were directed toward both staff members and other	F 279	The care plan of R 89 has been reviewed and corrected to indicate target behaviors as well as specific interventions. The Care Plans of all residents with behaviors have been reviewed and updated with target behaviors and interventions. Staff has been educated on care planning for target behaviors and interventions. All resident care plans with behaviors will be reviewed and monitored by DON or designee weekly for 3 months until compliance is assured then will be reviewed monthly by behavior committee with DON monitoring. Staff will continue to be educated on behavior care planning and will be reviewed again at next RN meeting on 12/17/14 This has been reviewed at QA meeting 12/09/2014	

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F 279	Continued From page 7	F 279		

residents. The behaviors were to be monitored, but were not to be care planned until "another incident occurs." No further description of R89's behaviors was included in the CAA.

Intermittent observations of R89 were conducted during the following: 11/17/14, from 4:00 p.m. to 8:00 p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and; 11/20/14, from 7:00 a.m. to 2:00 p.m. During these observations, R89 ambulated independently throughout the facility, approaching staff, peers and visitors in order to initiate conversations. R89 routinely invaded the personal space of others by putting his face near or next to others when he spoke to them.

Review of R89's progress notes from 6/29/14, through 10/24/14, revealed the following:

- R89 had physical altercations with other residents on two occasions.
- Staff members had to intervene to prevent altercations between R89 and other residents on five occasions.
- R89 physically touched staff members on 12 occasions.
- After each incident of maladaptive behavior, R89 was able to be redirected; however, the specific interventions/ techniques used to effectively redirect him were not consistently documented.

On 11/19/14, at 12:00 p.m. the director of nurses (DON) reviewed R89's progress notes. She verified R89 displayed behaviors such as invading others' personal space, attempting to irritate others for his personal enjoyment and inappropriately touching staff members. She stated staff were to redirect R89 when he

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F 279	Continued From page 8 displayed inappropriate behaviors and conduct monitoring checks every 30 minutes. She confirmed R89's behaviors had not been clearly described and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. At 12:45 p.m., the DON reviewed R89's care plan and confirmed it did not address target behaviors or interventions used to prevent/ deter his behaviors effectively. She confirmed a comprehensive care plan to manage R89's behavior had not been developed. On 11/19/14, at 12:50 p.m. social worker (SW)-A stated he was not aware of any type of pattern with R89's behaviors. SW-A reported that at the time the CAAs were completed, he understood R89's behaviors to be isolated incidents that did not necessitate care planning. He confirmed R89 had since displayed a pattern of behaviors and those behaviors had not been clearly specified and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. The undated Comprehensive Resident Care Plan Policy indicated each resident's care plan was to include measurable objectives and time tables to meet all needs identified in the comprehensive assessment.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		12/20/14

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F 280	Continued From page 9 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised to include the correct dialysis access site for 1 of 1 resident (R80) who received dialysis and had a change in access sites. Findings include: R80's quarterly Minimum Data Set dated 10/23/14, indicated R80 was cognitively intact. R80's care plan reviewed 10/27/14, indicated R80 was diagnosed with chronic kidney disease and received dialysis, via a right arm fistula (a connection between an artery and vein to receive a dialysis treatment) access site, from an outside service three times week. R80's Transfer/Discharge Report dated 6/18/14, indicated the right arm dialysis access site had	F 280	R 80 did not have dialysis access site updated in care plan appropriately at time of survey. Care plan has been reviewed and updated with ETAR updated as well to ensure staff aware of dialysis access site. DON has reviewed the Care Plans of all dialysis residents and ensured accuracy. RNs have been educated on care planning importance of appropriate dialysis access sites. The care plan of R 80 did read to not do blood pressures on right arm d/t fistula site; this site is not being used but should still not be used for blood pressure monitoring. Care plans will be monitored by DON with all new dialysis patients or upon change of dialysis site to ensure care plan has been updated from here forward. This was reviewed at QA meeting on 12/09/2014	

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F 280	Continued From page 10 clogged and a chest port was placed. On 11/18/14, at 3:43 p.m. R80 was observed to have a left sided chest dialysis catheter access site. The access site was covered with a dressing. At this time, R80 stated the right arm fistula had clotted off and failed about four months ago. On 11/20/14, at 9:30 a.m. the director of nursing (DON) stated the fistulas had clotted off a few times and therefore the chest port access site was placed on 6/18/14. The DON stated the care plan should be revised. The undated Comprehensive Resident Care Plan Policy indicated the care plan should be revised as necessary to reflect the resident's current care needs.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R31 and R102), received ambulation services in accordance with the care plan. In addition, the facility failed to ensure a secured wheelchair lap tray restraint was removed for 1 of 1 resident (R72) observed during 1 of 2 meal observations with a lap tray which was not removed as directed	F 282	R 31 and R102 ambulation was not being documented correctly and as indicated in care plan. NARs have been educated on appropriate documentation and computer program adjusted to prevent the documentation of 0 for walking with need to select an appropriate response. NARs will be educated again on documentation	12/20/14

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F 282	Continued From page 11 by the care plan. Findings include: R31 was not assisted with ambulation as directed by the care plan. R31's revised care plan dated 11/20/14, directed one staff assistance for ambulation, using a front wheeled walker, with a caregiver following with his wheelchair. The care plan instructed staff to assist R31 with ambulating to the dining room for all meals. On 11/18/14, at 4:04 p.m. R31 stated, "I am supposed to walk to the [dining room] table three times a day, I don't have a walker to do that and I am supposed to. I have not been walked for two weeks." During observation on 11/19/14, at approximately 8:00 a.m. R31 propelled himself in his wheelchair to the dining room for breakfast. After breakfast, R31 propelled himself in his wheelchair to an activity area. At 11:20 a.m., R31 again propelled himself in his wheelchair to the dining room for lunch. After lunch, R31 propelled himself in his wheelchair out of the dining room. R31 was not observed to be ambulated to/ from meals. On 11/20/14, at 7:11 a.m. registered nurse (RN)-D confirmed R31 had not received ambulation assistance as directed by the care plan and stated it was her expectation that staff provided ambulation services to the residents as directed. On 11/20/14 at 1:20 p.m. director of nursing (DON) stated, "I agree that we have not been	F 282	appropriately r/t ambulation of residents at NAR meeting 12/16/14. Documentation review will be done weekly by DON or designee with weekly walking list checks. R 31 had been instructed by PT to ambulate TID which was not reflected in care plan as therapy staff had not made primary RN aware. PT has been educated on policy r/t communication with nursing. PT has been observed to be in compliance as evidenced by proper documentation being utilized. This will be monitored weekly by DON or designee at Medicare meetings via communication with therapy. R 72 is the only resident of our facility utilizing a restraint at this time. R 72 utilizes lap tray and documentation is in place for restraint protocol to be reviewed Q 6 months by primary RN. Care plan has been reviewed and corrected to remove lap tray at meals and times of 1:1 supervision and staff has been educated on protocol for restraints. There are no other residents utilizing restraints in facility at this time, but continued monitoring will be in place as observation for following of policy by DON should another resident utilize a restraint in the future. Policy indicates that a restraint should be released at least every two hours and at any time resident is under direct supervision including during activities and mealtime. Staff educated on care plan and will be reviewed again at next staff meetings 12/16/14 and continued monitoring will be	

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F 282	Continued From page 12 ambulating him [R31] as often as we should." R102 was not assisted with ambulation as directed by the care plan R102's care plan revised 11/20/14, identified she required assistance from one staff for ambulation. The care plan directed staff to ambulate R102, with a walker and transfer belt, 100 feet twice daily, as tolerated. Review of NA [nursing assistant] Walking forms from 10/13/14, through 11/19/14, revealed the following: · From 10/13/14, through 10/31/14, R102 was ambulated 20 out of 38, or 53% of opportunities. · From 11/1/14, through 11/19/14, R102 was ambulated 16 out of 38, or 42% of opportunities. On 11/20/14, at 8:05 a.m. DON stated the NA ambulation program was initiated for R102 on 10/13/14, when PT was discontinued. DON verified R102 was not ambulated according to the care plan. R72's wheelchair lap tray restraint was not removed when supervised as directed by the care plan. R72's care plan dated 11/14, care plan indicated R72 was at risk for falls, with a tray table on his wheelchair to minimize this risk. The care plan identified R72's lap tray as a restraint and directed staff to remove the tray from the wheelchair when staff were feeding him. During observation of the evening meal on 11/17/14, from 5:30 p.m. to 6:25 p.m. nursing assistant (NA)-E was observed feeding R72 his meal. Throughout the observation R72 was	F 282	completed by DON with supervision 3 x/week x 1 month, then weekly x 3 months at different meal times, and monthly there after. Prompting placed in residents EMAR for cart nurse to sign to ensure lap tray was removed during periods of 1:1 supervision including meal time. F tag 0282 has been reviewed a QA meeting on 12/9/14.	

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F 282	Continued From page 13 observed with a full lap tray in place and secured by bilateral Velcro straps in which R72 could not reach to independently release. NA-E sat next to R72 throughout the meal and never removed or released the lap tray as directed. On 11/19/14, at 6:38 p.m. during the supper meal, the director of nursing (DON) was heard to advise NA-E to remove R72's wheelchair lap tray for the meal. R72's tray remained off throughout the meal. On 11/20/14, at 10:45 a.m. NA-E verified R72's lap tray was not removed on the evening of 11/17/14. She reported she was unaware his lap tray was to be removed at meal time. On 11/20/14, at 10:50 a.m. registered nurse (RN)-B stated it was her expectation that staff removed R72's lap tray while feeding him as directed by the care plan. RN-B stated a restraint was to be released whenever R72 was in a supervised setting. The facility's Physical Restraints policy dated 6/5/12, indicated the purpose for a physical restraint was to prevent injury. The policy directed a resident was to be released from a restraint every two to three hours.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		12/20/14

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F 309	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and establish planned interventions to consistently manage and proactively address maladaptive behaviors for 1 of 1 resident (R89) with dementia and a history of exhibiting behaviors that irritated others, including inappropriate touching and invasion of personal space. Findings include: R89's quarterly Minimum Data Set (MDS) dated 11/5/14, identified diagnoses of dementia and depression. The assessment indicated R89 displayed cognitive impairment and mood disorders such as feeling down / depressed, feeling hopeless and moving or speaking slowly. The MDS also identified R89 exhibited verbal and physical behaviors toward others. R89's care plan dated 7/2/14, identified increased confusion, poor eyesight and a hearing impairment. The plan directed the staff to complete accurate mood or behavior documentation and to monitor R89's whereabouts every half hour. The care plan directed staff to keep R89 away from an unidentified female resident, as they had been involved in an "altercation." The plan did not describe the maladaptive behaviors nor did it direct the staff as to the type of activities that were most appropriate for him, in order to consistently manage and/or proactively address R89's behavior concerns.	F 309	The care plan of R 89 has been reviewed and corrected to indicate target behaviors as well as specific interventions. The Care Plans of all residents with behaviors have been reviewed and updated with target behaviors and interventions. Staff has been educated on care planning for target behaviors and interventions. All resident care plans with behaviors will be reviewed and monitored by DON or designee weekly for 3 months until compliance is assured then will be reviewed monthly by behavior committee with DON monitoring. Staff will continue to be educated on behavior care planning and will be reviewed again at next RN meeting on 12/17/14 This has been reviewed at QA meeting 12/09/2014	

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R89's Care Area Assessment (CAA) dated 8/20/14, identified he displayed behaviors, with worsening mental status. The behaviors were directed toward both staff members and other residents. The behaviors were to be monitored, but were not to be care planned until "another incident occurs." The CAA failed to further specify, describe or evaluate R89's behaviors.

Review of R89's progress notes from 6/29/14, through 10/24/14, revealed the following:

- On 6/29/14, at 9:50 p.m. R89 was found touching an unidentified female resident inappropriately. R89 was redirected and the staff were to "continue to monitor this behavior."
- On 7/6/14, at 5:26 p.m. R89 "got close" to an unidentified female resident. The female resident directed R89 to leave the area, but he then began looking through the female resident's personal belongings. The female resident left the area and the staff members informed R89 he was acting inappropriately. R89 responded by stating "I'm not doing anything."
- On 8/8/14, at 3:30 p.m. R89 was involved in an altercation with another resident. The second resident stated R89 had pushed him, causing him to fall. R89 denied the accusations. He stated, "I didn't touch him." The staff implemented routine checks for R89, which were to be conducted every thirty minutes.
- On 9/3/14, at 3:16 p.m. the staff witnessed R89 "forcefully" pushing another unidentified resident in a wheelchair. The staff members intervened without incident.
- On 9/25/14, at 11:50 p.m. R89 was noted to "taunt" an unidentified female resident from the hallway. The unidentified female resident stated she was going to slap him. Staff members intervened to prevent the two residents from

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having a physical altercation.

· On 10/11/14, at 10:04 p.m. the staff noted R89 had been redirected several times during the evening shift as he came quite close to another resident's face. The documentation indicated this behavior caused the other residents to feel "uncomfortable."

· On 10/24/14, at 10:22 p.m. R89 was observed before supper to touch an unidentified male resident's thigh. When R89 was redirected, he laughed at the staff and removed his hands.

Further review of the progress notes revealed R89 had a pattern of touching staff in private areas, making inappropriate comments to the staff about female residents / other staff and attempting to physically push staff members while they were walking.

Review of Point of Care Behavior documentation for 10/14, to 11/14, indicated R89 displayed sporadic behaviors such as inappropriate touch, verbal abuse, socially inappropriate behaviors and sexually inappropriate remarks. Although the staff identified the type of behavior R89 displayed, the clinical record did not describe the behaviors in sufficient detail to allow for a comprehensive analysis of his maladaptive behaviors and potential environmental factors precipitating the behaviors. The documentation also lacked description of the redirection interventions attempted and whether the interventions were successful or unsuccessful.

On 11/18/14, at 2:05 p.m. R89 was observed by the nurse's station outside of the dining room. R89 was able to ambulate independently without assistive devices. He initiated conversations with staff, peers and visitors without difficulty.

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F 309	Continued From page 17 However, when R89 approached the person(s) he wished to speak to, he routinely invaded their personal space leaning toward the speaker and asking questions. He was frequently observed to be within a few inches of the other person's face. On 11/18/14, at 3:00 p.m. R89 approached and initiated a conversation with writer. He stood within inches while conversing, but did not attempt to threaten or touch. Once R89 finished speaking, he left the area without incident. On 11/18/14, at 3:40 p.m. activity aide (AA)-A confirmed R89 participated in activity programs within the facility. AA-A stated she was aware R89 occasionally displayed behaviors. An example of his behaviors included taking a single puzzle piece from a puzzle that other residents were working on. She stated R89 was easily redirected but would occasionally make snide remarks about having to return the puzzle piece. On 11/18/14, at 3:45 p.m. AA-B stated R89 had dementia and was easily redirected. She stated R89 displayed behaviors during activities. An example of his behaviors included throwing the ball (during a ball toss activity) at the other residents, with more force than what the other residents were able to manage. She stated R89 modified his behavior when directed by staff to do so. On 11/18/14, at 3:50 p.m. registered nurse (RN)-C stated she was in charge during the evening shifts. She was not aware of any concerns with R89. On 11/18/14, at 4:00 p.m. nursing assistant (NA)-K stated R89 frequently invaded other	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309		F 309		

Continued From page 18
residents' personal space. She stated R89's invasion of person space made whomever he was speaking to feel uncomfortable.

On 11/18/14, at 4:12 p.m. licensed practical nurse (LPN)-A stated R89 frequently got into the personal space of others. He had incidents in which he had touched both residents and staff inappropriately. LPN-A stated for this reason, R89 received monitoring checks every 30 minutes and was redirected as needed.

On 11/19/14, at 10:20 a.m. LPN-B stated R89 invaded the personal space of others. She described R89's behaviors as "very intimidating" and indicated this behavior not only made the other resident uncomfortable, but put R89 at risk of being hit by other residents. She stated she redirected R89 as needed.

On 11/19/14, at 12:00 p.m. the director of nurses (DON) reviewed R89's progress notes. She verified R89 displayed behaviors such as invading others' personal space, attempting to irritate others for his personal enjoyment and inappropriately touching staff members. She stated staff were to redirect R89 when he displayed inappropriate behaviors and conduct monitoring checks every 30 minutes. She confirmed R89's behaviors had not been clearly specified, comprehensively assessed and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner.

On 11/19/14, at 12:50 p.m. social worker (SW)-A stated he was not aware of any type of pattern with R89's behaviors. SW-A reported that at the time the CAAs were completed, he understood

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	245563	A. BUILDING ______ B. WING ______	11/20/2014

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F 309	Continued From page 19 R89's behaviors to be isolated incidents that did not necessitate care planning. He confirmed R89 had since displayed a pattern of behaviors and those behaviors had not been clearly specified, comprehensively assessed and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. A policy related to behavioral interventions for the care of persons with dementia was requested, but was not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R31 and R102) received ambulation services in accordance with their assessed needs. Findings include: R31 was not provided ambulation assistance as directed by the care plan. R31's quarterly Minimum Data Set (MDS) dated 8/5/14, indicated his cognition was intact. The MDS also indicated R31 was independent with transfers and he required extensive assistance of one staff to walk in the corridor. The MDS identified R31 received restorative nursing, range of motion training and skill practice in walking. A Nursing Rehab note dated 10/2/14, indicated R31	F 311	R 31 and R102 ambulation was not being documented correctly and as indicated in care plan. NARs have been educated on appropriate documentation and computer program adjusted to prevent the documentation of 0 for walking with need to select an appropriate response. NARs will be educated again on documentation appropriately r/t ambulation of residents at NAR meeting 12/16/14. Documentation review will be done weekly by DON or designee with weekly walking list checks. Residents observation checks will be completed on a weekly basis to ensure that all residents on list are in fact walking as indicated by the individualized care plan. Monitoring will be completed by	12/20/14

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F 311	Continued From page 20 had diagnoses including osteoarthritis, depression and spinal stenosis. The nursing rehab plan directed R31 was to be ambulated, 200 feet with a front wheeled walker and standby assistance from one staff. R31's revised care plan dated 11/20/14, directed one staff assistance for ambulation, using a front wheeled walker, with a caregiver following with his wheelchair. The care plan instructed staff to assist R31 with ambulating to the dining room for all meals. On 11/18/14, at 4:04 p.m. R31 stated, "I am supposed to walk to the [dining room] table three times a day, I don't have a walker to do that and I am supposed to. I have not been walked for two weeks." During observation on 11/19/14, at approximately 8:00 a.m. R31 propelled himself in his wheelchair to the dining room for breakfast. After breakfast, R31 propelled himself in his wheelchair to an activity area. At 11:20 a.m., R31 again propelled himself in his wheelchair to the dining room for lunch. After lunch, R31 propelled himself in his wheelchair out of the dining room. R31 was not observed to be ambulated to/ from meals. On 11/19/14, at 9:15 a.m. nursing assistant (NA)-C stated, "We do not walk him [referring to R31]. If he walks, it is with therapy. You would have to ask them how often he walks." On 11/19/14, at 9:23 a.m. physical therapist (PT) stated, "He [R31] is not to be ambulating on his own. He is on a walking program. He walks with therapy three to five times per week and I did put a recommendation in for nursing to be walking him to meals three times a day. It [the recommendation] is in the communication book."	F 311	DON or designee. R 31 had been instructed by PT to ambulate TID which was not reflected in care plan as therapy staff had not made primary RN aware. PT has been educated on policy r/t communication with nursing. PT has been observed to be in compliance as evidenced by proper documentation being utilized. This will be monitored weekly by DON or designee at Medicare meetings via communication with therapy. Tag F 0311 has been reviewed at Q A meeting 12/09/2014	

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F 311	Continued From page 21 PT continued, "My expectation is that nursing should be doing it [following the recommendation for walking to meals] and that it should be on his care plan." The PT then checked R31's room and there was no walker in the room. The PT stated, "It must still be in therapy." On 11/19/14, at 9:35 a.m. trained medication aide (TMA)-A stated, "I believe he [R31] is on an ambulation program. I would have to check his program. I have never walked him." On 11/19/14, at 9:44 a.m. NA-J stated, "He [R31] uses his wheelchair to get around. I have not walked him to meals." NA-J verified she had never ambulated R31. On 11/19/14, at 9:28 a.m. NA-D stated, "He [R31] doesn't walk. He can transfer himself. We do not walk him. He would walk with therapy, but nursing does not walk him." On 11/20/14, at 7:11 a.m. registered nurse (RN)-D confirmed R31 had not received the PT recommended ambulation services, but should have. RN-D stated it was her expectation that staff provided ambulation services to residents as directed. On 11/20/14 at 1:20 p.m. director of nursing (DON) stated, "I agree that we have not been ambulating him [R31] as often as we should." R102 was not provided ambulation assistance as directed by the care plan. R102's admission MDS dated 9/29/14, revealed her cognition was moderately impaired, with diagnoses including dementia and anxiety. The MDS also identified R102 sustained falls prior to	F 311		

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admission and required extensive assistance with transfers, locomotion and ambulation in her room. R102's care plan revised 11/20/14, identified she required assistance from one staff for ambulation. The care plan directed staff to ambulate R102, with a walker and transfer belt, 100 feet twice daily, as tolerated.

Review of NA Walking forms from 10/13/14, through 11/19/14, revealed the following:
- From 10/13/14, through 10/31/14, R102 was ambulated 20 out of 38, or 53% of opportunities.
- From 11/1/14, through 11/19/14, R102 was ambulated 16 out of 38, or 42% of opportunities.

On 11/20/14, at 8:05 a.m. DON stated the NA ambulation program was initiated for R102 on 10/13/14, when PT was discontinued. DON verified R102 was not ambulated according to the care plan. DON added she observed staff ambulating R102 and wondered if the staff were not taking credit for ambulating her, including ambulating her to and from the bathroom. DON further added she had been working with the staff on documentation.

On 11/20/14, at 8:42 a.m. NA-A confirmed she did not include ambulation for toileting on the NA Walking form. NA-A stated she documented "0" on the NA Walking form, if/ when R102 did not ambulate a full 100 feet.

The facility's undated Ambulation Policy indicated appropriate documentation for ambulation services was to be on the resident's care plan as well as on therapy and/ or rehab flow sheets. In addition, the policy indicated residents were to receive ambulation services to increase or maintain their function.

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medical justification for the continued use Seroquel (an antipsychotic medication), for 1 of 6 residents (R19) reviewed for unnecessary medications. Findings include: R19's Care Are Assessment (CAA) for	F 329	R 19 received Seroquel with dx of agitation and depression with pharmacy consultant reviewing monthly and medication reviewed by MD Q 6 months for reduction. Medication has been reviewed and reduced on 11/25/14 with request of MD to change dx on medication to aggression as appropriate for resident. Staff has been educated on	12/30/14

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F 329	Continued From page 24 psychotropic drug use dated 6/24/14, indicated he received Seroquel, 25 mg for agitation and depression. The assessment indicated R19 displayed "behaviors" and he was to be redirected as possible during periods of agitation. The assessment did not specify the type of behaviors R19 displayed, nor did it direct the staff on interventions that were to be used for redirection. R19's care plan dated 6/24/14, identified he was confabulating stories (fabricating stories without the intent to deceive/ misinterpreted memories) and directed the staff to document his mood/ behaviors, encourage activities and redirect him as needed. The care plan did not describe R19's specific behaviors or provide direction for staff on how to effectively redirect him when he exhibited behaviors. R19's quarterly Minimum Data Set (MDS) dated 9/9/14, identified diagnoses of mild intellectual disabilities and depression. The MDS revealed R19 had mood indicators of feeing down and depressed, but did not display behavioral symptoms. The MDS indicated R19 received antipsychotic medications daily. R19's current physician orders dated 10/3/14, directed administration of Seroquel, 12.5 milligrams (mg) twice daily, for the treatment of agitation and depression. Further review of the orders revealed R19 had received Seroquel, 25 mg twice daily from 5/12/14, to 9/10/14. Intermittent observations of R19 were conducted on the following: 11/17/14, from 4:00 p.m. to 8:00 p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and;	F 329	diagnosis r/t psychotropic medication and plan to have pharmacy consultant complete an in-service for staff including RNs, DON, and invitation to medical director, on 01/08/14 to continue education. Psychotropic medications will continue to be monitored monthly by pharmacy consultant. DON will monitor Psychotropic medications weekly for 1 month until in compliance then monthly at behavior meetings after compliance is met. This has been reviewed at QA meeting on 12/09/2014.	

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11/20/14, from 7:00 a.m. to 2:00 p.m. During observations, R19 was noted to watch television in his room, eat meals in the main dining room, and interact appropriately with staff, peers and visitors. At no time was R19 observed to display maladaptive behaviors.

Review of R19's Behavior Documentation from 1/1/14- 9/1/14, indicated he displayed verbal aggression towards others on eight occasions. During each of the incidents, R19 was noted as being directed by others, when he yelled at the staff/ peer and strongly informed them he was his own boss and would do whatever he wished to do. At no time did the documentation indicate R19 was not redirectable. Review of R19's Behavior Documentation from 9/1/14, to 11/20/14, revealed no maladaptive behaviors were displayed.

Pharmacy Recommendations dated 6/5/14, indicated R19 was started on Seroquel, 25 mg twice a day for agitation and depression. The pharmacist noted an antipsychotic medication required an appropriate diagnosis or physician justification to indicate why use of the medication was warranted. The pharmacy consultant recommended R19's Seroquel be reduced. On 6/17/14, the medication was reduced to 12.5 mg, twice daily. On 11/13/14, the consultant pharmacist again recommended the medication to be reduced, but did not request an appropriate indication for the continued use of Seroquel.

On 11/20/14, at 10:20 a.m. registered nurse (RN)-D stated R19 displayed verbal outbursts towards others and made up stories. She stated R19 was easily redirected if he was left alone. She confirmed R19 did not have a diagnosis to

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F 329	Continued From page 26 warrant the use of an antipsychotic medication. On 11/20/14, at 10:40 a.m. the director of nurses (DON) stated R19 displayed verbal aggression toward other residents. She confirmed R19 did not have a diagnosis for the continued use of Seroquel and confirmed the care plan did not direct staff on effective interventions to implement when R19 displayed verbal aggression. On 11/20/14, at 1:30 p.m. licensed practical nurse (LPN)-B stated R19 had a history of being verbally aggressive with others but he did not currently display any type of maladaptive behaviors. The undated Behavior Monitoring policy directed the staff to monitor the behaviors and frequency of maladaptive behaviors and determine appropriate interventions. The policy did not direct the staff to ensure all residents receiving antipsychotic medications had appropriate diagnosis for the continued use of the medication.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food at the proper temperature for 4 of 4 residents (R9, R54,	F 364	NARs had served residents food that required assistance eating, but did not sit down immediately as they should have to	12/20/14

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F 364	Continued From page 27 R43, R65) for 1 of 2 meal observations in the main dining room. Findings include: On 11/17/14, during continuous observations of the main dining room supper meal from 5:35 p.m. until 6:50 p.m. the following was observed: -At 6:00 p.m., cognitively impaired tablemate's R9, R54, R43 and R65 were served their meals, but were noted as unable to eat without staff assistance. At 6:12 p.m., 12 minutes later, three nursing assistants (NAs) began assisting R65, R54, R43 and R9 with eating their meals. NA-F was observed to assist R43 with eating a pureed meal of waffles and sausage. At that time, NA-F was asked to check the temperature of R43's food. NA-F brought the plate to the kitchen where the cook checked the temperature of the waffles and sausage. The waffles were 102 degrees Fahrenheit (F) and the sausage was 86 degrees F. The cook stated temperatures were checked for all foods before meal service began. The cook confirmed temperatures for the evening meal on 11/17/14, were adequate prior to service. The cook placed R43's plate of food in the microwave and gave the plate back to NA-F. A microwave was also observed stationed in the dining room which when asked, NA-F stated it was available for staff to use to warm food if it got cold. On 11/20/14, at 11:30 a.m. the director of nursing (DON) stated any resident who required staff assistance to eat should received assistance as soon as the meal was served.	F 364	assist the residents to eat. NARs have been educated on sitting down right away to help those that need help eat and will be re-educated on 12/17/14. LPNs have been instructed to monitor dinning room activity with one nurse to stay near dinning room during meal time. Observational monitoring will occur by DON or designee during various meal times 3x/week x 1 month then weekly x 2 months and periodically thereafter. DON and Dietary will weekly x 3 months then periodically after compliance is met ask residents that are cognitively intact if they felt there food was warm enough during the last meal service. This was reviewed at Q A meeting 12/09/14.	

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F 364	Continued From page 28 The facility's Meal Policy dated 12/19/12, directed all residents were to be provided a home-like environment for meals to the greatest extent possible.	F 364		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the licensed pharmacist reported medication irregularities appropriately to the attending physician and the director of nursing to be acted upon for 1 of 6 residents (R19) reviewed for unnecessary medications. Findings include: R19's Care Are Assessment (CAA) for psychotropic drug use dated 6/24/14, indicated he received Seroquel, 25 mg for agitation and depression. The assessment indicated R19 displayed "behaviors" and he was to be redirected as possible during periods of agitation.	F 428	R 19 received Seroquel with dx of agitation and depression with pharmacy consultant reviewing monthly and medication reviewed by MD Q 6 months for reduction. Medication has been reviewed and reduced on 11/25/2014 with request of MD to change dx on medication to aggression as appropriate for resident. Staff has been educated on diagnosis r/t psychotropic medication and plan to have pharmacy consultant complete an in-service for staff including RNs, DON, and invitation to medical director, on 01/08/14 to continue education. Psychotropic medications will continue to be monitored monthly by	12/30/14

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F 428	Continued From page 29 The assessment did not specify the type of behaviors R19 displayed, nor did it direct the staff on interventions that were to be used for redirection. R19's care plan dated 6/24/14, identified he was confabulating stories (fabricating stories without the intent to deceive/ misinterpreted memories) and directed the staff to document his mood/ behaviors, encourage activities and redirect him as needed. The care plan did not describe R19's specific behaviors or provide direction for staff on how to effectively redirect R19 when he exhibited behaviors. R19's quarterly Minimum Data Set (MDS) dated 9/9/14, identified diagnoses including mild intellectual disabilities and depression. The MDS revealed R19 had mood indicators of feeing down and depressed, but did not display behavioral symptoms. The MDS indicated R19 received antipsychotic medications daily. R19's current physician orders dated 10/3/14, directed administration of Seroquel, 12.5 milligrams (mg) twice daily, for the treatment of agitation and depression. Further review of the orders revealed R19 had received Seroquel, 25 mg twice daily from 5/12/14, to 9/10/14. Intermittent observations of R19 were conducted on the following: 11/17/14, from 4:00 p.m. to 8:00 p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and; 11/20/14, from 7:00 a.m. to 2:00 p.m. During observations, R19 was noted to watch television in his room, eat meals in the main dining room, and interact appropriately with staff, peers and visitors. At no time was R19 observed to display	F 428	pharmacy consultant. DON will monitor Psychotropic medications weekly for 1 month until in compliance then monthly at behavior meetings after compliance is met. This has been reviewed at QA meeting on 12/09/2014.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428		F 428		

Continued From page 30
maladaptive behaviors.

Review of the Behavior Documentation from 1/1/14- 9/1/14, indicated R19 had displayed verbal aggression towards others on eight occasions. During each of the incidents, R19 was noted as being directed by others, when he yelled at the staff/ peer and strongly informed them he was his own boss and would do whatever he wished to do. At no time did the documentation indicated R19 was not able to be redirected. Review of R19's Behavior Documentation from 9/1/14, to 11/20/14, revealed no maladaptive behaviors were displayed.

Pharmacy Recommendations dated 6/5/14, indicated R19 had been started on Seroquel, 25 mg twice a day for agitation and depression. The pharmacist noted an antipsychotic medication required an appropriate diagnosis or physician justification to indicate why use of the medication was warranted. The pharmacy consultant recommended R19's Seroquel be reduced. On 6/17/14, the medication was reduced to 12.5 mg, twice daily. On 11/13/14, the consultant pharmacist again recommended the medication to be reduced, but did not request an appropriate indication for the continued use of Seroquel.

On 11/20/14, at 10:20 a.m. registered nurse (RN)-D stated R19 displayed verbal outbursts towards others and made up stories. She stated R19 was easily redirected if he was left alone. She confirmed R19 did not have a diagnosis to warrant the use of an antipsychotic medication.

On 11/20/14, at 10:40 a.m. the director of nurses (DON) stated R19 displayed verbal aggression toward other residents. She confirmed R19 did

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	245563	A. BUILDING ______ B. WING ______	**11/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

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F 428	Continued From page 31	F 428		

not have a diagnosis for the continued use of Seroquel and confirmed the care plan did not direct staff on effective interventions to implement when R19 displayed verbal aggression.

On 11/20/14, at 1:30 p.m. licensed practical nurse (LPN)-B stated R19 had a history of being verbally aggressive with others but he did not currently display any type of maladaptive behaviors.

On 11/20/14, at 12:50 p.m. the consultant pharmacist was interviewed via telephone. He confirmed R19 did not have appropriate justification for the continued use of Seroquel. He added, since R19 did not have a diagnosis, he recommended the medication be reduced. The consultant pharmacist reported the physician was reducing the medication, so he did not request documented clinical justification. He stated the goal was for R19's Seroquel to be discontinued.

The undated Behavior Monitoring policy directed the staff to monitor the behaviors and frequency of maladaptive behaviors and determine appropriate interventions. The policy did not direct the staff to ensure all residents receiving antipsychotic medications to have appropriate diagnosis for the continued use of the medication.

The facility's Pharmacy Consultant policy dated 2/97, directed the pharmacist to review each resident's chart on a monthly basis and report irregularities to the DON. The policy did not direct the pharmacy consultant to ensure all residents who received antipsychotic medications had a appropriate indications prior to the initiation of the medication.

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

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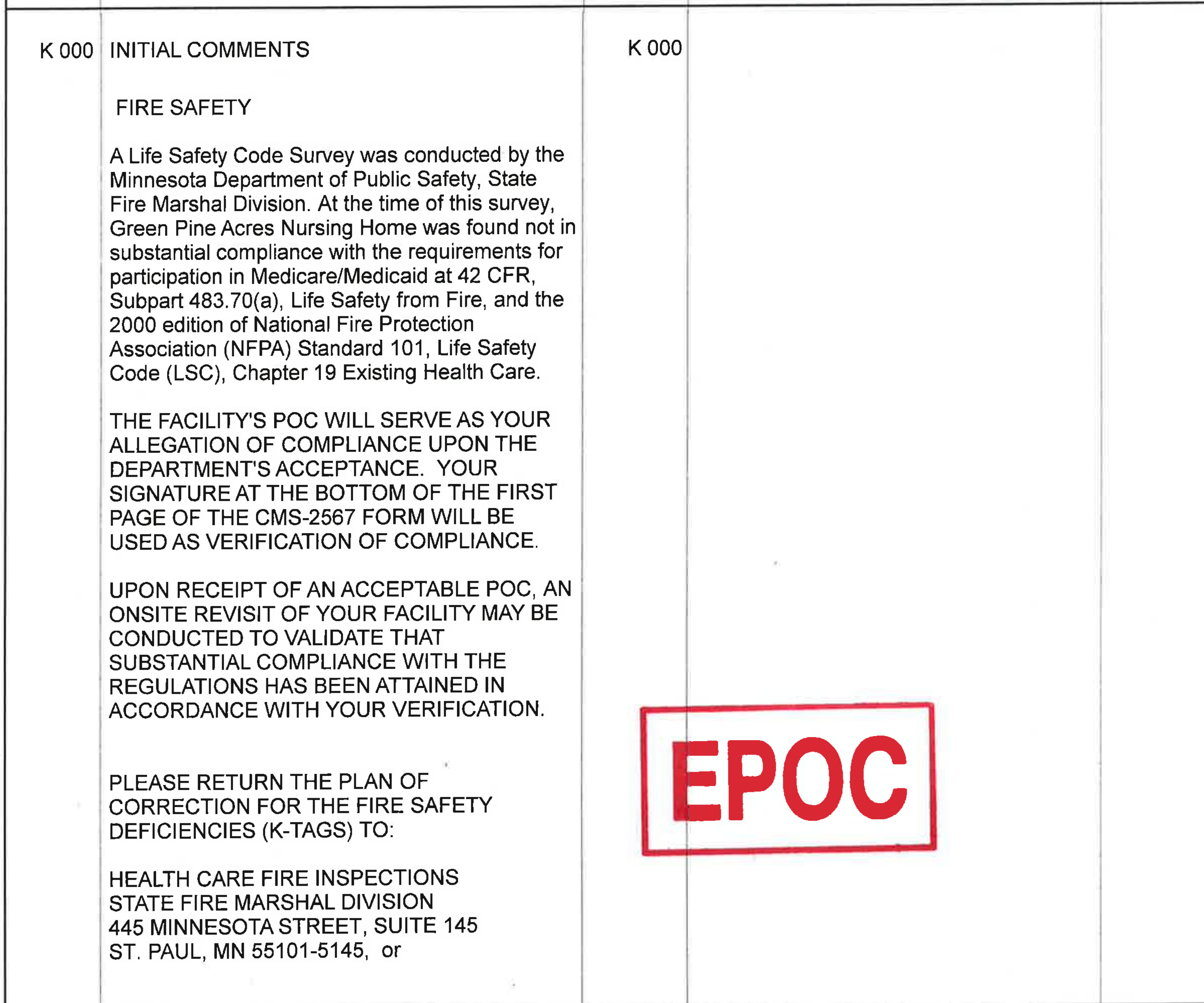
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**



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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Green Pine Acres Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility has been inspected as two buildings: Green Pine Acres Nursing Home was constructed in five different years. The original building is a 1-story building with partial basement build in 1964 and was determined to be of Type II(111) construction. In 1969 a 1-story building without basement was added to the west of the original building and was determined to be of Type II(111) construction. In 1996 the administration addition and connecting link was constructed to the southeast corner of the original build that is a 1-story building without basement that was determined to be of Type V(111) construction. In 1999 a 1-story building without basement addition was added to the northwest of the original building that was determined to be of II(111) construction. In 2004 a 1-story addition without basement was added to the original building and was determined to be of Type II(111) construction. The entire facility is protected by a complete fire sprinkler system. The facility has a complete fire	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/20/2014**

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GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

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K 000	Continued From page 2 alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 10:30 AM and 1:30 PM	K 062	Simplex Grinnell was notified that their contract was out of compliance, in that the required quarterly flow tests and quarterly maintenance was not conducted within the timeframes required in that contract. They came and did the required work on 11-19-2014, and have assured us that they will meet the required timeframe requirements going forward. This will be monitored by the Maintenance Supervisor to assure compliance in the future.	12/11/14

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K 062	Continued From page 3 on 11/19/2014, a review of documentation and interview with the Facility Administrator (CE), revealed the facility failed to conduct 2 of 4 quarterly fire sprinkler flow tests required by NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Facility Administrator (CE).	K 062		

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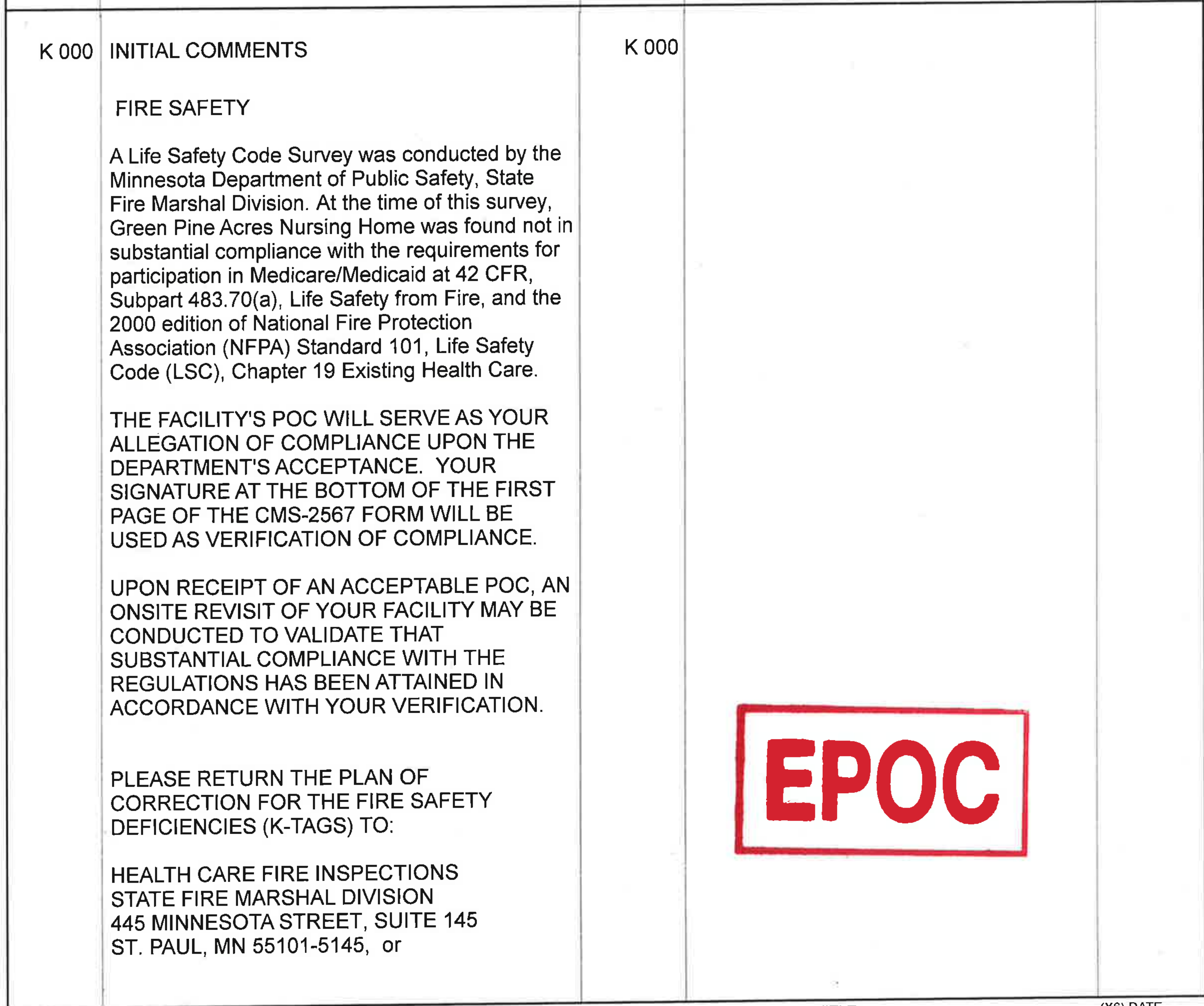
	245563	A. BUILDING **03 - KITCHEN ADDITION** B. WING ______	**11/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**



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	00678	A. BUILDING: ______ B. WING ______	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 11/17/14, 11/18/14, 11/19/14, and 11/20/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and elimination needs; C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and D. release the resident from the restraint as quickly as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R72) with a wheelchair (w/c) lap tray restraint, was released from the restraint while supervised during 1 of 2 meal observations in order to maintain the least restrictive device for the least amount of time. Findings include: R72's quarterly Minimum Data Set (MDS) dated	2 535	Corrected	12/20/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 535	Continued From page 3 8/14/14, indicated his cognition was severely impaired and he required extensive assistance with all activities of daily living (ADLs). The 11/14, care plan indicated R72 was at risk for falls, with a tray table on his w/c to minimize this risk. The care plan identified R72's lap tray as a restraint and directed staff to remove the tray from the w/c when staff were feeding him. During observation of the evening meal on 11/17/14, from 5:30 p.m. to 6:25 p.m. nursing assistant (NA)-E was observed feeding R72 his meal. Throughout the observation R72 was observed with a full lap tray in place and secured by bilateral Velcro straps in which R72 could not reach to independently release. NA-E sat next to R72 throughout the meal and never removed or released the lap tray as directed. On 11/19/14, at 6:38 p.m. during the supper meal, the director of nursing (DON) was heard to advise NA-E to remove R72's w/c lap tray for the meal. R72's tray remained off throughout the meal. On 11/20/14, at 10:45 a.m. NA-E verified R72's lap tray was not removed on the evening of 11/17/14. She reported she was unaware his lap tray was to be removed at meal time. On 11/20/14, at 10:50 a.m. registered nurse (RN)-B stated it was her expectation that staff removed R72's lap tray while feeding him. RN-B stated a restraint was to be released whenever R72 was in a supervised setting. The facility's Physical Restraints policy dated 6/5/12, indicated the purpose for a physical restraint was to prevent injury. The policy directed a resident was to be released from a restraint	2 535		

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	00678	A. BUILDING: ______ B. WING ______	11/20/2014

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2 535	Continued From page 4 every two to three hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or policies and procedures related to the use of restraints. Care plans for all residents who require restraints could be reviewed and/or revised as appropriate, with re-educate to staff on the need for release of restraints when appropriate, to ensure the least restrictive use. An auditing system could be developed to ensure on-going compliance, with the results of these audits being reviewed by the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 535		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions for consistent management of maladaptive behaviors, for 1 of 1 resident (R89)	2 560	Corrected	12/20/14

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2 560	Continued From page 5 with a history of inappropriate touching and invasion of personal space. Findings include: R89's care plan dated 7/2/14, identified increased confusion, poor eyesight and a hearing impairment. The plan directed staff to complete accurate mood/ behavior documentation and monitor R89's whereabouts every half hour. The care plan directed staff to keep R89 away from an unidentified female resident, as they had been involved in an "altercation." The care plan also directed diversional activities be provided for R89. The plan did not describe R89's maladaptive behaviors, nor did it direct the staff as to the type of activities that were most appropriate for him, in order to consistently manage and/or proactively address his behavior concerns. R89's Care Area Assessment (CAA) dated 8/20/14, identified he displayed behaviors, with worsening mental status. The behaviors were directed toward both staff members and other residents. The behaviors were to be monitored, but were not to be care planned until "another incident occurs." No further description of R89's behaviors was included in the CAA. Intermittent observations of R89 were conducted during the following: 11/17/14, from 4:00 p.m. to 8:00 p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and; 11/20/14, from 7:00 a.m. to 2:00 p.m. During these observations, R89 ambulated independently throughout the facility, approaching staff, peers and visitors to initiative conversations. R89 routinely invaded the personal space of others when he spoke to them.	2 560		

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2 560	Continued From page 6	2 560		

Review of R89's progress notes from 6/29/14, through 10/24/14, revealed the following:

- R89 had physical altercations with other residents on two occasions.
- Staff members had to intervene to prevent altercations between R89 and other residents on five occasions.
- R89 physically touched staff members on 12 occasions.
- After each incident of maladaptive behavior, R89 was able to be redirected; however, the specific interventions/ techniques used to effectively redirect him were not consistently documented.

On 11/19/14, at 12:00 p.m. the director of nurses (DON) reviewed R89's progress notes. She verified R89 displayed behaviors such as invading others' personal space, attempting to irritate others for his personal enjoyment and inappropriately touching staff members. She stated staff were to redirect R89 when he displayed inappropriate behaviors and conduct monitoring checks every 30 minutes. She confirmed R89's behaviors had not been clearly described and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. At 12:45 p.m., the DON reviewed R89's care plan and confirmed it did not address target behaviors or interventions used to prevent/ deter his behaviors effectively. She confirmed a comprehensive care plan to manage R89's behavior had not been developed.

On 11/19/14, at 12:50 p.m. social worker (SW)-A stated he was not aware of any type of pattern with R89's behaviors. SW-A reported that at the time the CAAs were completed, he understood R89's behaviors to be isolated incidents that did

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2 560	Continued From page 7 not necessitate care planning. He confirmed R89 had since displayed a pattern of behaviors and those behaviors had not been clearly specified and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. The undated Comprehensive Resident Care Plan Policy indicated each resident's care plan was to include measurable objectives and time tables to meet all needs identified in the comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise policies and procedures related to care plan development and provide education to staff to address the importance of developing a comprehensive care plan to meet each resident's needs. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		12/20/14

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2 565	Continued From page 8 Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R31 and R102), received ambulation services in accordance with the care plan. In addition, the facility failed to ensure a secured wheelchair lap tray restraint was removed for 1 of 1 resident (R72) observed during 1 of 2 meal observations with a lap tray which was not removed as directed by the care plan. Findings include: R31's Nursing Rehab plan dated 10/2/14, indicated diagnoses including osteoarthritis, depression and spinal stenosis. The plan directed R31 was to be ambulated, 200 feet with a front wheeled walker and standby assistance from one staff. R31's revised care plan dated 11/20/14, directed one staff assistance for ambulation, using a front wheeled walker, with a caregiver following with his wheelchair. The care plan instructed staff to assist R31 with ambulating to the dining room for all meals. On 11/18/14, at 4:04 p.m. R31 stated, "I am supposed to walk to the [dining room] table three times a day, I don't have a walker to do that and I am supposed to. I have not been walked for two weeks." During observation on 11/19/14, at approximately 8:00 a.m. R31 propelled himself in his wheelchair to the dining room for breakfast. After breakfast, R31 propelled himself in his wheelchair to an activity area. At 11:20 a.m., R31 again propelled himself in his wheelchair to the dining room for lunch. After lunch, R31 propelled himself in his wheelchair out of the dining room. R31 was not observed to be ambulated to/ from meals.	2 565	Corrected	

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2 565	Continued From page 9	2 565		

On 11/19/14, at 9:23 a.m. physical therapist (PT) confirmed recommendations for nursing to walk R31 to meals three times daily. PT continued, "My expectation is that nursing should be doing it [following the recommendation for walking to meals]..." Upon inquiry, PT confirmed R31's walker was not in his room. PT stated the walker must have been left in the therapy room.

On 11/20/14, at 7:11 a.m. registered nurse (RN)-D confirmed R31 had not received the PT recommended ambulation services, but should have. RN-D stated it was her expectation that staff provided ambulation services to residents as directed.

On 11/20/14 at 1:20 p.m. director of nursing (DON) stated, "I agree that we have not been ambulating him [R31] as often as we should."

R102's care plan revised 11/20/14, identified she required assistance from one staff for ambulation. The care plan directed staff to ambulate R102, with a walker and transfer belt, 100 feet twice daily, as tolerated.

Review of NA [nursing assistant] Walking forms from 10/13/14, through 11/19/14, revealed the following:

- From 10/13/14, through 10/31/14, R102 was ambulated 20 out of 38, or 53% of opportunities.
- From 11/1/14, through 11/19/14, R102 was ambulated 16 out of 38, or 42% of opportunities.

On 11/20/14, at 8:05 a.m. DON stated the NA ambulation program was initiated for R102 on 10/13/14, when PT was discontinued. DON verified R102 was not ambulated according to the care plan.

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2 565	Continued From page 10	2 565		

R102 was not assisted with ambulation as directed by the care plan

R102's care plan revised 11/20/14, identified she required assistance from one staff for ambulation. The care plan directed staff to ambulate R102, with a walker and transfer belt, 100 feet twice daily, as tolerated.

Review of NA [nursing assistant] Walking forms from 10/13/14, through 11/19/14, revealed the following:

- From 10/13/14, through 10/31/14, R102 was ambulated 20 out of 38, or 53% of opportunities.
- From 11/1/14, through 11/19/14, R102 was ambulated 16 out of 38, or 42% of opportunities.

On 11/20/14, at 8:05 a.m. DON stated the NA ambulation program was initiated for R102 on 10/13/14, when PT was discontinued. DON verified R102 was not ambulated according to the care plan.

R72's wheelchair lap tray restraint was not removed when supervised as directed by the care plan.

R72's care plan dated 11/14, care plan indicated R72 was at risk for falls, with a tray table on his wheelchair to minimize this risk. The care plan identified R72's lap tray as a restraint and directed staff to remove the tray from the wheelchair when staff were feeding him.

During observation of the evening meal on 11/17/14, from 5:30 p.m. to 6:25 p.m. nursing assistant (NA)-E was observed feeding R72 his

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2 565	Continued From page 11 meal. Throughout the observation R72 was observed with a full lap tray in place and secured by bilateral Velcro straps in which R72 could not reach to independently release. NA-E sat next to R72 throughout the meal and never removed or released the lap tray as directed. On 11/19/14, at 6:38 p.m. during the supper meal, the director of nursing (DON) was heard to advise NA-E to remove R72's wheelchair lap tray for the meal. R72's tray remained off throughout the meal. On 11/20/14, at 10:45 a.m. NA-E verified R72's lap tray was not removed on the evening of 11/17/14. She reported she was unaware his lap tray was to be removed at meal time. On 11/20/14, at 10:50 a.m. registered nurse (RN)-B stated it was her expectation that staff removed R72's lap tray while feeding him as directed by the care plan. RN-B stated a restraint was to be released whenever R72 was in a supervised setting. The facility's Physical Restraints policy dated 6/5/12, indicated the purpose for a physical restraint was to prevent injury. The policy directed a resident was to be released from a restraint every two to three hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and procedures related to care plan implementation and provide education to staff to address the importance of following each resident's care plan. Resident care plans	2 565		

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2 565	Continued From page 12 could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans and monitor for consistent implementation, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised to include the correct dialysis access site for 1 of 1 resident (R80) who received dialysis and had a change in access sites. Findings include: R80's quarterly Minimum Data Set dated 10/23/14, indicated R80 was cognitively intact.	2 570	Corrected	12/20/14

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2 570	Continued From page 13	2 570		

R80's care plan reviewed 10/27/14, indicated R80 was diagnosed with chronic kidney disease and received dialysis, via a right arm fistula (a connection between an artery and vein to receive a dialysis treatment) access site, from an outside service three times week.

R80's Transfer/Discharge Report dated 6/18/14, indicated the right arm dialysis access site had clogged and a chest port was placed.

On 11/18/14, at 3:43 p.m. R80 was observed to have a left sided chest dialysis catheter access site. The access site
was covered with a dressing. At this time, R80 stated the right arm fistula had clotted off and failed about four months ago.

On 11/20/14, at 9:30 a.m. the director of nursing (DON) stated the fistulas had clotted off a few times and therefore the chest port access site was placed on 6/18/14. The DON stated the care plan should be revised.

The undated Comprehensive Resident Care Plan Policy indicated the care plan should be revised as necessary to reflect the resident's current care needs.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could review/ revise policies and procedures related to care plan revision and provide education to staff to address the importance of revising care plans when there has been a change in the resident serviceas. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could

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2 570	Continued From page 14 establish a system to audit care plans to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and establish planned interventions to consistently manage and proactively address maladaptive behaviors for 1 of 1 resident (R89) with dementia and a history of exhibiting behaviors that irritated others, including inappropriate touching and invasion of personal space. Findings include: R89's quarterly Minimum Data Set (MDS) dated 11/5/14, identified diagnoses of dementia and	2 830	Corrected	12/20/14

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2 830	Continued From page 15	2 830		

depression. The assessment indicated R89 displayed cognitive impairment and mood disorders such as feeling down / depressed, feeling hopeless and moving or speaking slowly. The MDS also identified R89 exhibited verbal and physical behaviors toward others.

R89's care plan dated 7/2/14, identified increased confusion, poor eyesight and a hearing impairment. The plan directed the staff to complete accurate mood or behavior documentation and to monitor R89's whereabouts every half hour. The care plan directed staff to keep R89 away from an unidentified female resident, as they had been involved in an "altercation." The plan did not describe the maladaptive behaviors nor did it direct the staff as to the type of activities that were most appropriate for him, in order to consistently manage and/or proactively address R89's behavior concerns.

R89's Care Area Assessment (CAA) dated 8/20/14, identified he displayed behaviors, with worsening mental status. The behaviors were directed toward both staff members and other residents. The behaviors were to be monitored, but were not to be care planned until "another incident occurs." The CAA failed to further specify, describe or evaluate R89's behaviors.

Review of R89's progress notes from 6/29/14, through 10/24/14, revealed the following:

- On 6/29/14, at 9:50 p.m. R89 was found touching an unidentified female resident inappropriately. R89 was redirected and the staff were to "continue to monitor this behavior."
- On 7/6/14, at 5:26 p.m. R89 "got close" to an unidentified female resident. The female resident directed R89 to leave the area, but he then began looking through the female resident's personal

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2 830	Continued From page 16	2 830		

Continued From page 16

belongings. The female resident left the area and the staff members informed R89 he was acting inappropriately. R89 responded by stating "I'm not doing anything."

- On 8/8/14, at 3:30 p.m. R89 was involved in an altercation with another resident. The second resident stated R89 had pushed him, causing him to fall. R89 denied the accusations. He stated, "I didn't touch him." The staff implemented routine checks for R89, which were to be conducted every thirty minutes.
- On 9/3/14, at 3:16 p.m. the staff witnessed R89 "forcefully" pushing another unidentified resident in a wheelchair. The staff members intervened without incident.
- On 9/25/14, at 11:50 p.m. R89 was noted to "taunt" an unidentified female resident from the hallway. The unidentified female resident stated she was going to slap him. Staff members intervened to prevent the two residents from having a physical altercation.
- On 10/11/14, at 10:04 p.m. the staff noted R89 had been redirected several times during the evening shift as he came quite close to another resident's face. The documentation indicated this behavior caused the other residents to feel "uncomfortable."
- On 10/24/14, at 10:22 p.m. R89 was observed before supper to touch an unidentified male resident's thigh. When R89 was redirected, he laughed at the staff and removed his hands.

Further review of the progress notes revealed R89 had a pattern of touching staff in private areas, making inappropriate comments to the staff about female residents / other staff and attempting to physically push staff members while they were walking.

Review of Point of Care Behavior documentation

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for 10/14, to 11/14, indicated R89 displayed sporadic behaviors such as inappropriate touch, verbal abuse, socially inappropriate behaviors and sexually inappropriate remarks. Although the staff identified the type of behavior R89 displayed, the clinical record did not describe the behaviors in sufficient detail to allow for a comprehensive analysis of his maladaptive behaviors and potential environmental factors precipitating the behaviors. The documentation also lacked description of the redirection interventions attempted and whether the interventions were successful or unsuccessful.

On 11/18/14, at 2:05 p.m. R89 was observed by the nurse's station outside of the dining room. R89 was able to ambulate independently without assistive devices. He initiated conversations with staff, peers and visitors without difficulty. However, when R89 approached the person(s) he wished to speak to, he routinely invaded their personal space leaning toward the speaker and asking questions. He was frequently observed to be within a few inches of the other person's face.

On 11/18/14, at 3:00 p.m. R89 approached and initiated a conversation with writer. He stood within inches while conversing, but did not attempt to threaten or touch. Once R89 finished speaking, he left the area without incident.

On 11/18/14, at 3:40 p.m. activity aide (AA)-A confirmed R89 participated in activity programs within the facility. AA-A stated she was aware R89 occasionally displayed behaviors. An example of his behaviors included taking a single puzzle piece from a puzzle that other residents were working on. She stated R89 was easily redirected but would occasionally make snide remarks about having to return the puzzle piece.

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On 11/18/14, at 3:45 p.m. AA-B stated R89 had dementia and was easily redirected. She stated R89 displayed behaviors during activities. An example of his behaviors included throwing the ball (during a ball toss activity) at the other residents, with more force than what the other residents were able to manage. She stated R89 modified his behavior when directed by staff to do so.

On 11/18/14, at 3:50 p.m. registered nurse (RN)-C stated she was in charge during the evening shifts. She was not aware of any concerns with R89.

On 11/18/14, at 4:00 p.m. nursing assistant (NA)-K stated R89 frequently invaded other residents' personal space. She stated R89's invasion of person space made whomever he was speaking to feel uncomfortable.

On 11/18/14, at 4:12 p.m. licensed practical nurse (LPN)-A stated R89 frequently got into the personal space of others. He had incidents in which he had touched both residents and staff inappropriately. LPN-A stated for this reason, R89 received monitoring checks every 30 minutes and was redirected as needed.

On 11/19/14, at 10:20 a.m. LPN-B stated R89 invaded the personal space of others. She described R89's behaviors as "very intimidating" and indicated this behavior not only made the other resident uncomfortable, but put R89 at risk of being hit by other residents. She stated she redirected R89 as needed.

On 11/19/14, at 12:00 p.m. the director of nurses (DON) reviewed R89's progress notes. She

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2 830	Continued From page 19 verified R89 displayed behaviors such as invading others' personal space, attempting to irritate others for his personal enjoyment and inappropriately touching staff members. She stated staff were to redirect R89 when he displayed inappropriate behaviors and conduct monitoring checks every 30 minutes. She confirmed R89's behaviors had not been clearly specified, comprehensively assessed and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. On 11/19/14, at 12:50 p.m. social worker (SW)-A stated he was not aware of any type of pattern with R89's behaviors. SW-A reported that at the time the CAAs were completed, he understood R89's behaviors to be isolated incidents that did not necessitate care planning. He confirmed R89 had since displayed a pattern of behaviors and those behaviors had not been clearly specified, comprehensively assessed and care planned to ensure all staff members intervened consistently, in the most appropriate and effective manner. A policy related to behavioral interventions for the care of persons with dementia was requested, but was not provided. Suggested Method of Correction: The director of nursing or designee could review and revice policy and procedures and provide staff education related to the care of a resident with dementia. The director of nursing or designee could develop an audit tool to ensure appropriate dementia care is provided.	2 830		

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2 830	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R31 and R102) received ambulation services in accordance with their assessed needs. Findings include: R31's quarterly Minimum Data Set (MDS) dated 8/5/14, indicated his cognition was intact. The	2 915	Corrected	12/20/14

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MDS also indicated R31 was independent with transfers and he required extensive assistance of one staff to walk in the corridor. The MDS identified R31 received restorative nursing, range of motion training and skill practice in walking. A Nursing Rehab note dated 10/2/14, indicated R31 had diagnoses including osteoarthritis, depression and spinal stenosis. The nursing rehab plan directed R31 was to be ambulated, 200 feet with a front wheeled walker and standby assistance from one staff. R31's revised care plan dated 11/20/14, directed one staff assistance for ambulation, using a front wheeled walker, with a caregiver following with his wheelchair. The care plan instructed staff to assist R31 with ambulating to the dining room for all meals.

On 11/18/14, at 4:04 p.m. R31 stated, "I am supposed to walk to the [dining room] table three times a day, I don't have a walker to do that and I am supposed to. I have not been walked for two weeks."

During observation on 11/19/14, at approximately 8:00 a.m. R31 propelled himself in his wheelchair to the dining room for breakfast. After breakfast, R31 propelled himself in his wheelchair to an activity area. At 11:20 a.m., R31 again propelled himself in his wheelchair to the dining room for lunch. After lunch, R31 propelled himself in his wheelchair out of the dining room. R31 was not observed to be ambulated to/ from meals.

On 11/19/14, at 9:15 a.m. nursing assistant (NA)-C stated, "We do not walk him [referring to R31]. If he walks, it is with therapy. You would have to ask them how often he walks."

On 11/19/14, at 9:23 a.m. physical therapist (PT) stated, "He [R31] is not to be ambulating on his

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own. He is on a walking program. He walks with therapy three to five times per week and I did put a recommendation in for nursing to be walking him to meals three times a day. It [the recommendation] is in the communication book." PT continued, "My expectation is that nursing should be doing it [following the recommendation for walking to meals] and that it should be on his care plan." The PT then checked R31's room and there was no walker in the room. The PT stated, "It must still be in therapy."

On 11/19/14, at 9:35 a.m. trained medication aide (TMA)-A stated, "I believe he [R31] is on an ambulation program. I would have to check his program. I have never walked him."

On 11/19/14, at 9:44 a.m. NA-J stated, "He [R31] uses his wheelchair to get around. I have not walked him to meals." NA-J verified she had never ambulated R31.

On 11/19/14, at 9:28 a.m. NA-D stated, "He [R31] doesn't walk. He can transfer himself. We do not walk him. He would walk with therapy, but nursing does not walk him."

On 11/20/14, at 7:11 a.m. registered nurse (RN)-D confirmed R31 had not received the PT recommended ambulation services, but should have. RN-D stated it was her expectation that staff provided ambulation services to residents as directed.

On 11/20/14 at 1:20 p.m. director of nursing (DON) stated, "I agree that we have not been ambulating him [R31] as often as we should."

R102's admission MDS dated 9/29/14, revealed her cognition was moderately impaired, with

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diagnoses including dementia and anxiety. The MDS also identified R102 sustained falls prior to admission and required extensive assistance with transfers, locomotion and ambulation in her room. R102's care plan revised 11/20/14, identified she required assistance from one staff for ambulation. The care plan directed staff to ambulate R102, with a walker and transfer belt, 100 feet twice daily, as tolerated.

Review of NA Walking forms from 10/13/14, through 11/19/14, revealed the following:
· From 10/13/14, through 10/31/14, R102 was ambulated 20 out of 38, or 53% of opportunities.
· From 11/1/14, through 11/19/14, R102 was ambulated 16 out of 38, or 42% of opportunities.

On 11/20/14, at 8:05 a.m. DON stated the NA ambulation program was initiated for R102 on 10/13/14, when PT was discontinued. DON verified R102 was not ambulated according to the care plan. DON added she observed staff ambulating R102 and wondered if the staff were not taking credit for ambulating her, including ambulating her to and from the bathroom. DON further added she had been working with the staff on documentation.

On 11/20/14, at 8:42 a.m. NA-A confirmed she did not include ambulation for toileting on the NA Walking form. NA-A stated she documented "0" on the NA Walking form, if/ when R102 did not ambulate a full 100 feet.

The facility's undated Ambulation Policy indicated appropriate documentation for ambulation services was to be on the resident's care plan as well as on therapy and/ or rehab flow sheets. In addition, the policy indicated residents were to receive ambulation services to increase or

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2 915	Continued From page 24 maintain their function. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and procedures related to ambulation services and provide education to staff to address the importance of providing ambulation to residents and documenting the service accurately. The quality assessment and assurance committee could establish a system to audit ambulation records for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		12/20/14

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21426	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 newly admitted residents (R69), received timely tuberculosis (TB) symptom screening and a two-step tuberculin skin test (TST). In addition, the facility failed to ensure 1 of 5 new employees [nursing assistant (NA)-H] received TB symptom screening prior to administration of the two-step TST. Findings include: R69 was admitted to the facility on 5/31/14, with diagnoses including end stage renal failure. The physician's admission orders directed staff not to give R69 a two-step TST, as he "likely will not be living for second step. End stage/terminal with comfort cares at end of life." A progress note dated 6/10/14, (10 days after admission) indicated the nursing staff completed a TB symptom screening and administered a TST to R69. NA-H was hired on 10/24/14. The employee file indicated NA-H received the first-step TST on 10/24/14, with the second-step administered on 11/13/14; however, the employee file lacked evidence of a TB symptom screening for NA-H. On 11/20/14, at 1:35 p.m. registered nurse (RN)-B stated all newly admitted residents were to receive a two-step TST. She stated there must have been a reason for the TST not to be administered on admission for R69. On 11/20/14, at 1:50 p.m. the director of nursing (DON) stated all residents were to receive a TB symptom screening upon admission. The residents were then to either receive a TST or have a chest x-ray or blood test to ensure the newly admitted resident did not have active TB. She stated R69 and his clinical record was	21426	Corrected	

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21426	Continued From page 26 reviewed for a Minimum Data Set (MDS) assessment on 6/10/14. At that time, the nurse involved with the MDS completed a TB screening and administered the TST. The DON also confirmed all employees were to be screened for TB prior to administration of the TSTs. She verified NA-H had not received a symptomology screening prior to the administration of the TST. The undated Tuberculosis Exposure Control Program directed the staff to administer the first step TST following a symptom screening within the first 24 hours of a resident's admission. The policy's Employee Protocol directed all employees were to receive a TB screening prior to receiving a TST. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review facility policies and provide education to staff to address the importance of tuberculosis monitoring for staff and residents. The quality assessment and assurance committee could establish a system to audit tuberculosis screening to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21530		12/20/14

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21530	Continued From page 27 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the licensed pharmacist reported medication irregularities appropriately to the attending physician, and the director of nursing to be acted upon for 1 of 6 residents (R19) reviewed for unnecessary medications.	21530	Corrected	

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Findings include:

R19's Care Are Assessment (CAA) for psychotropic drug use dated 6/24/14, indicated he received Seroquel, 25 mg for agitation and depression. The assessment indicated R19 displayed "behaviors" and he was to be redirected as possible during periods of agitation. The assessment did not specify the type of behaviors R19 displayed, nor did it direct the staff on interventions that were to be used for redirection.

R19's care plan dated 6/24/14, identified he was confabulating stories (fabricating stories without the intent to deceive/ misinterpreted memories) and directed the staff to document his mood/ behaviors, encourage activities and redirect him as needed. The care plan did not describe R19's specific behaviors or provide direction for staff on how to effectively redirect R19 when he exhibited behaviors.

R19's quarterly Minimum Data Set (MDS) dated 9/9/14, identified diagnoses including mild intellectual disabilities and depression. The MDS revealed R19 had mood indicators of feeing down and depressed, but did not display behavioral symptoms. The MDS indicated R19 received antipsychotic medications daily.

R19's current physician orders dated 10/3/14, directed administration of Seroquel, 12.5 milligrams (mg) twice daily, for the treatment of agitation and depression. Further review of the orders revealed R19 had received Seroquel, 25 mg twice daily from 5/12/14, to 9/10/14.

Intermittent observations of R19 were conducted on the following: 11/17/14, from 4:00 p.m. to 8:00

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p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and; 11/20/14, from 7:00 a.m. to 2:00 p.m. During observations, R19 was noted to watch television in his room, eat meals in the main dining room, and interact appropriately with staff, peers and visitors. At no time was R19 observed to display maladaptive behaviors.

Review of the Behavior Documentation from 1/1/14- 9/1/14, indicated R19 had displayed verbal aggression towards others on eight occasions. During each of the incidents, R19 was noted as being directed by others, when he yelled at the staff/ peer and strongly informed them he was his own boss and would do whatever he wished to do. At no time did the documentation indicated R19 was not able to be redirected. Review of R19's Behavior Documentation from 9/1/14, to 11/20/14, revealed no maladaptive behaviors were displayed.

Pharmacy Recommendations dated 6/5/14, indicated R19 had been started on Seroquel, 25 mg twice a day for agitation and depression. The pharmacist noted an antipsychotic medication required an appropriate diagnosis or physician justification to indicate why use of the medication was warranted. The pharmacy consultant recommended R19's Seroquel be reduced. On 6/17/14, the medication was reduced to 12.5 mg, twice daily. On 11/13/14, the consultant pharmacist again recommended the medication to be reduced, but did not request an appropriate indication for the continued use of Seroquel.

On 11/20/14, at 10:20 a.m. registered nurse (RN)-D stated R19 displayed verbal outbursts towards others and made up stories. She stated R19 was easily redirected if he was left alone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00678	A. BUILDING: _____ B. WING _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 30 She confirmed R19 did not have a diagnosis to warrant the use of an antipsychotic medication. On 11/20/14, at 10:40 a.m. the director of nurses (DON) stated R19 displayed verbal aggression toward other residents. She confirmed R19 did not have a diagnosis for the continued use of Seroquel and confirmed the care plan did not direct staff on effective interventions to implement when R19 displayed verbal aggression. On 11/20/14, at 1:30 p.m. licensed practical nurse (LPN)-B stated R19 had a history of being verbally aggressive with others but he did not currently display any type of maladaptive behaviors. On 11/20/14, at 12:50 p.m. the consultant pharmacist was interviewed via telephone. He confirmed R19 did not have appropriate justification for the continued use of Seroquel. He added, since R19 did not have a diagnosis, he recommended the medication be reduced. The consultant pharmacist reported the physician was reducing the medication, so he did not request documented clinical justification. He stated the goal was for R19's Seroquel to be discontinued. The undated Behavior Monitoring policy directed the staff to monitor the behaviors and frequency of maladaptive behaviors and determine appropriate interventions. The policy did not direct the staff to ensure all residents receiving antipsychotic medications to have appropriate diagnosis for the continued use of the medication. The facility's Pharmacy Consultant policy dated 2/97, directed the pharmacist to review each resident's chart on a monthly basis and report irregularities to the DON. The policy did not direct	21530		

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21530	Continued From page 31 the pharmacy consultant to ensure all residents who received antipsychotic medications had a appropriate indications prior to the initiation of the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing could meet with the pharmacist and medical director to review the regulations related to antipsychotic medications. Facility policies and procedures could be reviewed/ revised as appropriate, with re-education provided to pertinent staff on requirements for the use of antipsychotics. Resident medication regimens could be reviewed for compliance with these requirements. The quality assessment and assurance committee could establish a system to audit drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		12/20/14

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21535	Continued From page 32	21535		

Continued From page 32

483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure adequate indications were present to warrant the use of Seroquel (an antipsychotic medication), for 1 of 16 residents (R19) receiving antipsychotic medications.

Corrected

Findings include:

R19's Care Are Assessment (CAA) for psychotropic drug use dated 6/24/14, indicated he received Seroquel, 25 mg for agitation and depression. The assessment indicated R19 displayed "behaviors" and he was to be redirected as possible during periods of agitation. The assessment did not specify the type of behaviors R19 displayed, nor did it direct the staff on interventions that were to be used for redirection.

R19's care plan dated 6/24/14, identified he was confabulating stories (fabricating stories without the intent to deceive/ misinterpreted memories) and directed the staff to document his mood/ behaviors, encourage activities and redirect him as needed. The care plan did not describe R19's specific behaviors or provide direction for staff on

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21535	Continued From page 33 how to effectively redirect him when he exhibited behaviors. R19's quarterly Minimum Data Set (MDS) dated 9/9/14, identified diagnoses including mild intellectual disabilities and depression. The MDS revealed R19 had mood indicators of feeing down and depressed, but did not display behavioral symptoms. The MDS indicated R19 received antipsychotic medications daily. R19's current physician orders dated 10/3/14, directed administration of Seroquel, 12.5 milligrams (mg) twice daily, for the treatment of agitation and depression. Further review of the orders revealed R19 had received Seroquel, 25 mg twice daily from 5/12/14, to 9/10/14. Intermittent observations of R19 were conducted on the following: 11/17/14, from 4:00 p.m. to 8:00 p.m.; 11/18/14, from 8:00 a.m. to 4:30 p.m.; 11/19/14, from 10:00 a.m. to 6:30 p.m., and; 11/20/14, from 7:00 a.m. to 2:00 p.m. During observations, R19 was noted to watch television in his room, eat meals in the main dining room, and interact appropriately with staff, peers and visitors. At no time was R19 observed to display maladaptive behaviors. Review of R19's Behavior Documentation from 1/1/14- 9/1/14, indicated he displayed verbal aggression towards others on eight occasions. During each of the incidents, R19 was noted as being directed by others, when he yelled at the staff/ peer and strongly informed them he was his own boss and would do whatever he wished to do. At no time did the documentation indicated R19 was not redirectable. Review of R19's Behavior Documentation from 9/1/14, to 11/20/14, revealed no maladaptive behaviors were	21535		

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displayed.

Pharmacy Recommendations dated 6/5/14, indicated R19 was started on Seroquel, 25 mg twice a day for agitation and depression. The pharmacist noted an antipsychotic medication required an appropriate diagnosis or physician justification to indicate why use of the medication was warranted. The pharmacy consultant recommended R19's Seroquel be reduced. On 6/17/14, the medication was reduced to 12.5 mg, twice daily. On 11/13/14, the consultant pharmacist again recommended the medication to be reduced, but did not request an appropriate indication for the continued use of Seroquel.

On 11/20/14, at 10:20 a.m. registered nurse (RN)-D stated R19 displayed verbal outbursts towards others and made up stories. She stated R19 was easily redirected if he was left alone. She confirmed R19 did not have a diagnosis to warrant the use of an antipsychotic medication.

On 11/20/14, at 10:40 a.m. the director of nurses (DON) stated R19 displayed verbal aggression toward other residents. She confirmed R19 did not have a diagnosis for the continued use of Seroquel and confirmed the care plan did not direct staff on effective interventions to implement when R19 displayed verbal aggression.

On 11/20/14, at 1:30 p.m. licensed practical nurse (LPN)-B stated R19 had a history of being verbally aggressive with others but he did not currently display any type of maladaptive behaviors.

The undated Behavior Monitoring policy directed the staff to monitor the behaviors and frequency of maladaptive behaviors and determine

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21535	Continued From page 35 appropriate interventions. The policy did not direct the staff to ensure all residents receiving antipsychotic medications had appropriate diagnosis for the continued use of the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing could meet with the pharmacist and medical director to review the regulations related to antipsychotic medications. Facility policies and procedures could be reviewed/ revised as appropriate, with re-education provided to pertinent staff on requirements for the use of antipsychotics. Resident medication regimens could be reviewed for compliance with these requirements. The quality assessment and assurance committee could establish a system to audit drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating	21990		12/20/14

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21990	Continued From page 36 the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential abuse/ neglect to the state agency (SA), for 2 of 6 residents (R89 and R8) reviewed with resident-to-resident altercations. Findings include: Review of a resident-to-resident abuse report dated 6/29/14, indicated R89 (a male resident with dementia) was found touching R8 (a female resident with dementia) inappropriately. The report indicated R89 rubbed his hands over R8's breasts. The allegation of sexual abuse was reported to the SA on 6/30/14. On 11/19/14, at 11:40 a.m. the director of nursing (DON) confirmed the SA was not immediately notified of this allegation. Review of the facility's Neglect/ Abuse Policy dated 12/28/11, instructed staff to notify the administrator and SA of any suspected allegations of abuse or neglect immediately. The policy defined 'immediately' as "within 24 hours." Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy was implemented as written to meet Federal requriements, and then could educate staff. The	21990	Corrected	

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21990	Continued From page 37 DON or designee could also perform audits to ensure reports to the SA occurred in the requried timeframes. Time Period for Correction: Twenty-one (21) days.	21990		