DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	_		-		AND TRANSMITTAL	ID: U84B		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00678		
1. MEDICARE/MEDICAID PROVIDI (L1) 245563	ER NO.	3. NAME AND AL (L3) GREEN PIN			OME	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 475240600	NO.	(L4) 427 MAIN S (L5) MENAHGA		THEAST	(L6) 56464	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 01/0 8. ACCREDITATION STATUS:	07/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :			equirements e Based On:		2. Technical Personnel			
12.Total Facility Beds	65 (L18)	•	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 7. Medical Director JF)8. Patient Room Size 9. Beds/Room 		
13. Total Certified Beds	65 (L17)		ppliance with Progents and/or Appli		* Code: A *	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
65 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION 1	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Lyla Burkman, Supervisor		0	01/13/2015	(L19)	Mark Meeth, Enforcement Specialist 01/29/2015			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBII 1. Facility is Eligible to F			IPLIANCE WITH HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	1				5. Doni of the rook	···		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure 0	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APPI	ROVAL		

DEPARTMENT OF HEALTH AND HUM	AN SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES		
	CARE/MEDICAID CERTIFICATION		ID: U84B		
PART I	- TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00678		
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FACILITY (L3) GREEN PINE ACRES NURSING H	IOME	4. TYPE OF ACTION: <u>7</u> (L8)		
(L1) 245563 2.STATE VENDOR OR MEDICAID NO.	(L4) 427 MAIN STREET NORTHEAST	IOME	1. Initial 2. Recertification		
(L2) 475240600	(L5) MENAHGA, MN	(L6) 56464	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 01/07/2015 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF			
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/II		FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	X A. In Compliance With	And/Or Approved Waivers Of	The Following Requirements:		
To (b):	Program Requirements	2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds 65 (L18)	Compliance Based On: 1. Acceptable POC	3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director F) 8. Patient Room Size		
1 2.100 1 200 03 (210)		5. Life Safety Code	9. Beds/Room		
13. Total Certified Beds (L17)	 B. Not in Compliance with Program Requirements and/or Applied Waivers 	: * Code: A *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
65 (L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELLATION DATE):				
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
Lyla Burkman, Supervisor	01/14/2015 (L19)	Anne Kleppe, Enforcement Specialist 01/16/2015 (L20)			
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)		
1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible		5. Bour of the Above			
(L21)					
22. ORIGINAL DATE 23. LTC AGREE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNIN	IG DATE ENDING DATE	<u>VOLUNTARY</u> <u>00</u>			
06/01/1991		01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination			
	TVE SANCTIONS	04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change		
A. Suspensi	on of Admissions: (L44)		00-Active		
(L27) B. Rescind	Suspension Date:				
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS			
	03001				
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	2. DETERMINATION OF APPROVAL DATE	•			
(L32)	(L33)	DETERMINATION APPR	ROVAL		



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 Weath

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.

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.

Sincerely,

Are Kleepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulations Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> 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 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,

Ane Klegese

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

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 245563	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/7/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
GI	REEN PINE ACRES NURSING HOM	E	427 MAIN STREET NORTHEAS MENAHGA, MN 56464	ST

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	i) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix	F0221	Correction Completed 12/20/2014	ID Prefix	F0225	Correction Completed 12/20/2014	ID Prefix	F0226		Correction Completed 12/20/2014
Reg. # LSC	483.13(a)	-	Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2	2) -	Reg. # LSC	483.13(c)		_
ID Prefix Reg. # LSC	F0279 483.20(d), 483.20(k)(1)	-	ID Prefix Reg. # LSC			ID Prefix Reg. # LSC	483.20(k)(3)(ii)	Correction Completed 12/20/2014
ID Prefix Reg. # LSC	483.25	Correction Completed 12/20/2014			Correction Completed 12/20/2014	ID Prefix Reg. # LSC	_F0329 483.25(l)		Correction Completed 12/30/2014
ID Prefix Reg. # LSC	F0364 483.35(d)(1)-(2)	Correction Completed 12/20/2014	ID Prefix Reg. # LSC		Correction Completed 12/30/2014	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		_	ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			
Reviewed I State Agen			Date: 01/13/20	Signature of Sur	veyor:	28035		Date: 01/07	7/2015
Reviewed I CMS RO	-	d By	Date:	Signature of Sur	veyor:			Date:	
Followup	to Survey Completed o 11/20/2014	n:		Check for any Uncon Uncorrected Defic				YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00678	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/7/2015	
Name of Facility		Street Address, City, State, Zip Code		
GREEN PINE ACRES NURSING HOM	Ē	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	i) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	21990	Correction Completed 12/20/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	MN St. Statute 626.557		Reg. # LSC			Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed 	Reg. #		Correction Completed			
Reg. #			Reg. #		Correction Completed			
ID Prefix Reg. # LSC		_	Reg. #			Pog #		
Reg. #		Correction Completed 	Reg. #		Correction Completed	Reg. #		Correction Completed
Reviewed E State Agent Reviewed E CMS RO	cy LB/AK	,	Date: 01/13/2015 Date:	Signature of Surr Signature of Surr		28035	Date: 01/(Date:	07/2015
Followup t	o Survey Completed o 11/20/2014 M: REVISIT REPORT (C	Check for any Uncor Uncorrected Defic Page 1 of 1				NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245563	(Y2) Multiple Cons A. Building B. Wing	A. Building 01 - MAIN BUILDING 01		(Y3) Date of Revisit 12/29/2014
Name of Facility			Street Address, City, State, Zip Code	
GREEN PINE ACRES NURSING HOME	Ē		427 MAIN STREET NORTHEAS MENAHGA, MN 56464	ЗТ

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	()	′5)	Date
ID Prefix		Correction Completed 12/11/2014	ID Prefix		Correction Completed	ID Prefix			Correction Completed
	NFPA 101		Reg. #			Reg. #			
LSC	K0062		LSC			LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #									
LSC			LSC			LSC			
		Correction			Correction				Correction
ID Drofiv		Completed	ID Drofiv		Completed	ID Drofiv			Completed
			– "						
Reg. # LSC			Reg. # LSC			LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			D.a. #			
LSC			LSC			LSC			_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Dec #			D //			
						LSC			
Reviewed I			Date:	Signature of Sur	veyor:			Date:	
State Agen	cy PS/AK		01/14/2015			27	200	12/2	9/2014
Reviewed E CMS RO	3y Reviewed	Ву	Date:	Signature of Sur	veyor:		1	Date:	
Followup t	o Survey Completed or 11/20/2014	1:	(Check for any Uncor Uncorrected Defic				YES	NO
			1						

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 245563	(Y2) Multiple Con A. Building B. Wing	° 03 - KITCHEN ADDITION		
Name of Facility			Street Address, City, State, Zip Code	
GREEN PINE ACRES NURSING HOMI	Ξ		427 MAIN STREET NORTHEAS MENAHGA, MN 56464	ŝТ

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 12/11/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	NFPA 101		Reg. #			Reg. #		
LSC	K0062		LSC			LSC _		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
LSC						LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
Reg. # LSC			Reg. # LSC			LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
LSC			LSC			LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #			Dec #			D //		
LSC			LSC			LSC		
Reviewed I			Date:	Signature of Sur	veyor:		Date	
State Agen	cy PS/AK		01/14/2015			272	200 12/	/29/2014
Reviewed I CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Completed or 11/20/2014	:	(Check for any Uncor Uncorrected Defic				6 NO
	11/20/2014							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			ND TRANSMITTAL E SURVEY AGENCY	ID: U84B Facility ID: 00678				
1. MEDICARE/MEDICAID PROVIDER N (L1) 245563 2.STATE VENDOR OR MEDICAID NO. (L2) 475240600	0.	 NAME AND ADE (L3) GREEN PINE (L4) 427 MAIN ST (L5) MENAHGA, ¹ 	E ACRES NURSIN TREET NORTHE	NG HOM	E (L6) 56464	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 ADA 2 AOA 1 Other 	/2014 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65 (L37) (L38)	 65 (L18) 65 (L17) 19 SNF (L39) 	X B. Not in Comp Requiremen ICF (L42)	ce With quirements Based On: cceptable POC bliance with Program nts and/or Applied W IID (L43)	aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director		
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S		ATION DATE):					
17. SURVEYOR SIGNATURE	EII	Date : 1	2/15/2014		18. STATE SURVEY AGENCY AP			
(L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY (L20)								
		BE COMPLETEI		(L19) GIONAI				
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible	PART II - TO	20. COM		GIONAI	21. 1. Statement of Finance	(L20) E AGENCY		
1. Facility is Eligible to Part	PART II - TO	20. COM RIGH ENT 24	D BY HCFA RE	GIONAI VIL	21. 1. Statement of Financ 2. Ownership/Control 1 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY</u> 01 01-Merger, Closure	(L20) E AGENCY ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety		
1. Facility is Eligible to Part 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	PART II - TO , ticipate (L21) 23. LTC AGREEMI	20. COMI RIGH ENT 24 DATE E SANCTIONS	D BY HCFA REO PLIANCE WITH CIV TS ACT: 4. LTC AGREEMEN ENDING DATE (L25)	GIONAI VIL	21. 1. Statement of Financ 2. Ownership/Control 1 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00	(L20) E AGENCY ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety		
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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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 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

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

5563s15licltr

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FO	RM APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	IO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245563	B. WING _			11/20/2014	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	PINE ACRES NURSIN	C HOME		42	7 MAIN STREET NORTHEAST		
GREEN	PINE ACRES NORSIN	GHOME		М	ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	S	F 00	00			
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
F 221 SS=D	on-site revisit of you validate that substa		F 22	21		12/20/14	
	physical restraints i	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.					
	by: Based on observat review, the facility fa (R72) with a wheeld was released from during 1 of 2 meal of	NT is not met as evidenced ion, interview and document ailed to ensure 1 of 1 resident chair (w/c) lap tray restraint, the restraint while supervised observations in order to estrictive device for the least			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 reviewe Q 6 months by primary RN. Care plan h been reviewed and corrected to remove lap tray at meals and times of 1:1 supervision and staff has been educate on protocol for restraints. There are no	as d	
	R72's quarterly Min 8/14/14, indicated h	imum Data Set (MDS) dated is cognition was severely quired extensive assistance			other residents utilizing restraints. There are no other residents utilizing restraints in faci at this time, but continued monitoring w be in place as observation for following policy by DON should another resident	lity II	
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE	(X6) DATE	
	ically Signed	LIVOUT LIET NET NEOLNIATIVE O SIGI	WH ONE		THE STREET	12/12/2014	

Electronically Signed

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.

PRINTED: 12/17/2014

STATEMEN	FOF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245563	B. WING _		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
GREEN	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 221	The 11/14, care pla falls, with a tray tak risk. The care plan restraint and direct from the w/c when During observation 11/17/14, from 5:30 assistant (NA)-E w meal. Throughout to observed with a ful by bilateral Velcro s reach to independe R72 throughout the released the lap tra On 11/19/14, at 6:3 the director of nurs NA-E to remove R R72's tray remaine On 11/20/14, at 10 lap tray was not rep 11/17/14. She repo tray was to be rem On 11/20/14, at 10 (RN)-B stated it wa removed R72's lap stated a restraint w R72 was in a supe The facility's Physie 6/5/12, indicated th restraint was to pres	daily living (ADLs). an indicated R72 was at risk for ble on his w/c to minimize this identified R72's lap tray as a ed staff to remove the tray staff were feeding him. of the evening meal on 0 p.m. to 6:25 p.m. nursing as observed feeding R72 his the observation R72 was I lap tray in place and secured straps in which R72 could not ently release. NA-E sat next to e meal and never removed or ay as directed. 88 p.m. during the supper meal, ing (DON) was heard to advise 72's w/c lap tray for the meal. d off throughout the meal. :45 a.m. NA-E verified R72's moved on the evening of orted she was unaware his lap oved at meal time. :50 a.m. registered nurse as her expectation that staff tray while feeding him. RN-B vas to be released whenever rvised setting. cal Restraints policy dated he purpose for a physical event injury. The policy directed be released from a restraint	F 22	utilize a restraint in the future Policy indicates that a restrai released at least every two h any time resident is under di supervision including during mealtime. Staff educated on care plan reviewed again at next staff 12/16/14 and continued mon completed by DON with supe x/week x 1 month, then weel months at different meal time monthly there after. Promptin residents EMAR for cart nurs ensure lap tray was removed periods of 1:1 supervision in time. This has been reviewed meeting on 12/9/14.	int should be lours and at rect activities and and will be meetings litoring will be ervision 3 kly x 3 es, and ng placed in se to sign to d during cluding meal	

If continuation sheet Page 2 of 32

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED
		245563	B. WING			11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
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F 225 SS=D	483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating resident had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thorou prevent further pote investigation is in pu The results of all inv to the administrator representative and with State law (inclu certification agency	(c)(2) - (4) PORT DIVIDUALS t employ individuals who have abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment uppropriation of their property; vledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency). ve evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 2	25			12/20/14

If continuation sheet Page 3 of 32

		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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GREEN	PINE ACRES NURSIN	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	by: Based on interview facility failed to imm potential abuse/ new for 2 of 6 residents resident-to-resident Findings include: Review of a resider dated 6/29/14, indic with dementia) was resident with dementia) was resident with dementia breasts. The allega reported to the SA of On 11/19/14, at 11:4 (DON) confirmed the notified of this allega Review of the facilitit dated 12/28/11, insi administrator and S allegations of abuse	NT is not met as evidenced y and document review, the hediately report allegations of glect to the state agency (SA), (R89 and R8) reviewed with t altercations. ht-to-resident abuse report cated R89 (a male resident found touching R8 (a female ntia) inappropriately. The 9 rubbed his hands over R8's ation of sexual abuse was on 6/30/14. 40 a.m. the director of nursing the SA was not immediately	F	225	It is the policy of Green Pine Acress report suspicion of Vulnerable Adul immediately, without delay, to OHF Common Entry Point as well as administrator. Incidents that occur the hours the DON is in the building initial report will be immediately sub by DON with administrator notified. DON is not in the building the the administrator and DON will be notif phone immediately and the report of submitted by either the RN unit ma or LPN that is working. Both RNs a LPNs have been educated on subr of the electronic document to OHF Common Entry Point reporting alor updated policy. After initial report a investigation occurs and is complet submitted within 5 days by DON or designee. A Vulnerable Adult Reporting form been created for in hours monitorin will be required to be filled out with reporting of each case. The form w returned to the Director of Nursing completion with a printed copy of th submitted report. The new form that been created includes the docume of time and date the administrator of notified in addition to the time nursis made aware of the situation. The Vulnerable Adult Policy has been u with current standards. The nursing department will be edu on new form, updated policy, and additional training in Vulnerable Adult on new form, updated policy, and	t cases C and during g the omitted If ied via will be nager nd nission C and ng with n ced and has ng and the iill be upon ne at has ntation was ng was pdated	

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		AND HUMAN SERVICES			F	ORM	12/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE	E SURVEY PLETED
		245563	B. WING			11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 225 F 226 SS=D	ABUSE/NEGLECT The facility must de policies and proced	P/IMPLMENT , ETC POLICIES evelop and implement written	F 2		reporting requirements at next staff meetings no later than December 20th Compliance will be monitored by Direc of Nursing or designee with each incid Failure to have report completed will prompt re-education of nurse filling ou report. Investigations will be complete Director of Nursing or designee. This been reviewed at QA meeting 12/09/2	ctor dent. ut ed by has 2114.	12/20/14
	and misappropriation This REQUIREMENT by: Based on interview facility's abuse pro- immediate reporting and state agency (S abuse/ neglect, res 2 of 6 residents (R8 resident-to-resident Findings include: Review of the facilit dated 12/28/11, ins administrator and S allegations of abuse policy defined 'imm	NT is not met as evidenced v and document review, the hibition policies failed to direct g to the facility administrator SA) for allegations of potential ulting in delayed reporting for 39 and R8) reviewed for			Policy has been updated with current recommendations by the Department Health. Updates completed prior to Department of Health exit. Policy that in place indicated that the reporting of Vulnerable Adult cases would occur immediately (within 24 hours), verbiag was changed to Immediately, without delay also the order in which departm heads were notified was rearranged of the policy to read Administer to be not first and immediately. Immediate repor to OHFC, Common Entry Point, and Administrator were already in practice time of survey but policy now does ref this order appropriately. Current practice is for DON to submit	of was f ge hent on tified orting e at flect	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	СОМ	PLETED
		245563	B. WING		11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226	Continued From pa	age 5	F 226	6		
F 279 SS=D	with dementia) was resident with deme report indicated R8 breasts. The allege reported to the SA On 11/19/14, at 11: (DON) confirmed th notified of this allege stated it was the fa notify the administr concerns related to reported 'immediat and as soon as the She stated allegativ be reported within a the staff were not to the SA and administ the facility's policy of reporting requirement abuse/ neglect. 483.20(d), 483.20(I COMPREHENSIVE A facility must use to develop, review comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment.	40 a.m. the director of nursing he SA was not immediately jation. At 12:30 p.m. the DON cility's practice to immediately ator and the SA of any o abuse and neglect. She ely' meant as soon as possible involved residents were safe. ons of abuse/ neglect were to a few hours of the incident and o wait up to 24 hours to notify strator. The DON confirmed was not consistent with the ents for incidents of potential k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's in of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's ind mental and psychosocial ntified in the comprehensive	F 279	incident immediately when DON i house. If DON is not in facility the manager or LPN are to submit immediately. The RN unit manage LPN will immediately call adminis DON, submit electronic report, an Common Entry Point. Staff has be educated on electronic form, notif common entry point, and policy up new form has been created to ind time and date nurse was made av incident and when all parties were notified. The new form will be revi DON after each incident. Monitori occur for compliance by DON or of with each incident with re-educati indicated. This was reviewed at C meeting 12/09/2014.	RN unit er or trator, d notify een ying odate. A icate the vare of ewed by ng will designee on as	12/20/14

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED <u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME			27 MAIN STREET NORTHEAST //ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	psychosocial well-k §483.25; and any s be required under s due to the resident §483.10, including under §483.10(b)(4 This REQUIREME by: Based on observa review, the facility f interventions for co- maladaptive behav with a history of ina invasion of persona Findings include: R89's care plan da confusion, poor eye impairment. The pl accurate mood/ be monitor R89's whe care plan directed s unidentified female involved in an "alte directed diversiona The plan did not de behaviors, nor did i of activities that we order to consistent address his behavi R89's Care Area As 8/20/14, identified f	physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment 4). NT is not met as evidenced tion, interview and document failed to develop care plan onsistent management of fors, for 1 of 1 resident (R89) appropriate touching and al space. ted 7/2/14, identified increased esight and a hearing an directed staff to complete havior documentation and reabouts every half hour. The staff to keep R89 away from an e resident, as they had been rcation." The care plan also I activities be provided for R89. escribe R89's maladaptive it direct the staff as to the type are most appropriate for him, in ly manage and/or proactively		279	The care plan of R 89 has been reand corrected to indicate target behas well as specific interventions. The Plans of all residents with behaviors been reviewed and updated with tar behaviors and interventions. Staff here educated on care planning for behaviors and interventions. All rescare plans with behaviors will be reand monitored by DON or designed weekly for 3 months until compliance assured then will be reviewed mont behavior committee with DON mon Staff will continue to be educated or behavior care planning and will be reviewed again at next RN meeting 12/17/14 This has been reviewed at QA mee 12/09/2014	aviors le Care s have rget las r target ident viewed ce is hly by itoring. n on	

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		AND HUMAN SERVICES				FORM	: 12/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245563	B. WING	i		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	residents. The beha but were not to be of incident occurs." No behaviors was inclu- Intermittent observa during the following 8:00 p.m.; 11/18/14 11/19/14, from 10:0 11/20/14, from 7:00 these observations, independently throus staff, peers and visi conversations. R89 personal space of of or next to others whe Review of R89's pro- through 10/24/14, ri- R89 had physic residents on two oc- Staff members altercations betwee five occasions. R89 physically occasions. After each incio R89 was able to be specific intervention effectively redirect h documented. On 11/19/14, at 12: (DON) reviewed R89 verified R89 display invading others' per irritate others for his inappropriately touc	aviors were to be monitored, care planned until "another o further description of R89's uded in the CAA. ations of R89 were conducted p: 11/17/14, from 4:00 p.m. to from 8:00 a.m. to 4:30 p.m.; 0 a.m. to 6:30 p.m., and; a.m. to 2:00 p.m. During R89 ambulated ughout the facility, approaching itors in order to initiate oroutinely invaded the others by putting his face near nen he spoke to them.	F	279			

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245563	B. WING		·····	11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279 F 280 SS=D	displayed inappropri monitoring checks of confirmed R89's be described and care members intervene appropriate and effet the DON reviewed li it did not address ta interventions used to effectively. She com- plan to manage R8 developed. On 11/19/14, at 12:: stated he was not a with R89's behavior time the CAAs were R89's behaviors to not necessitate care had since displayed those behaviors had and care planned to intervened consiste and effective mannet The undated Comp Policy indicated ead include measurable meet all needs iden assessment. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has th incompetent or othe incapacitated under	riate behaviors and conduct every 30 minutes. She ehaviors had not been clearly planned to ensure all staff ed consistently, in the most ective manner. At 12:45 p.m., R89's care plan and confirmed arget behaviors or to prevent/ deter his behaviors firmed a comprehensive care 9's behavior had not been 50 p.m. social worker (SW)-A aware of any type of pattern rs. SW-A reported that at the e completed, he understood be isolated incidents that did e planning. He confirmed R89 d a pattern of behaviors and d not been clearly specified o ensure all staff members ently, in the most appropriate er. orehensive Resident Care Plan ch resident's care plan was to e objectives and time tables to ntified in the comprehensive 0(k)(2) RIGHT TO NNING CARE-REVISE CP he right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or		279			12/20/14

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245563	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		427 MAIN STREET NORTHEAST		
				MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 9	F 28	0		
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after				
	by: Based on observat review, the facility fa was revised to inclu site for 1 of 1 reside dialysis and had a c Findings include: R80's quarterly Min 10/23/14, indicated R80's care plan rev was diagnosed with received dialysis, vi connection betweer a dialysis treatment service three times R80's Transfer/Disc	NT is not met as evidenced ion, interview and document ailed to ensure the care plan ide the correct dialysis access ent (R80) who received change in access sites. imum Data Set dated R80 was cognitively intact. iewed 10/27/14, indicated R80 o chronic kidney disease and a a right arm fistula (a n an artery and vein to receive) access site, from an outside week. charge Report dated 6/18/14, arm dialysis access site had		R 80 did not have dialysis access s updated in care plan appropriately a of survey. Care plan has been revie and updated with ETAR updated as to ensure staff aware of dialysis acc site. DON has reviewed the Care P all dialysis residents and ensured accuracy. RNs have been educated care planning importance of approp dialysis access sites. The care plan 80 did read to not do blood pressur right arm d/t fistula site; this site is r being used but should still not be us blood pressure monitoring. Care plans will be monitored by DC all new dialysis patients or upon cha dialysis site to ensure care plan has updated from here forward. This wa reviewed at QA meeting on 12/09/2	at time ewed s well cess lans of d on oriate o of R es on not sed for DN with ange of s been as	

Facility ID: 00678

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		AND HUMAN SERVICES			FORM	12/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245563	B. WING _		11/	20/2014
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	clogged and a chess On 11/18/14, at 3:4 have a left sided ch site. The access sit was covered with a stated the right arm failed about four m On 11/20/14, at 9:3 (DON) stated the fis times and therefore was placed on 6/18 plan should be revis The undated Comp Policy indicated the as necessary to ref needs. 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility f (R31 and R102), ref	 at port was placed. 3 p.m. R80 was observed to lest dialysis catheter access e dressing. At this time, R80 fistula had clotted off and onths ago. 0 a.m. the director of nursing stulas had clotted off a few the chest port access site v14. The DON stated the care sed. arehensive Resident Care Plan care plan should be revised lect the resident's current care RVICES BY QUALIFIED 	F 28		dicated in cated on	12/20/14

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/17/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245563	B. WING			11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 11	F 2	282			
	by the care plan.				appropriately r/t ambulation of resid NAR meeting 12/16/14. Documenta	ation	
	Findings include:				review will be done weekly by DON designee with weekly walking list ch		
	by the care plan.	ed with ambulation as directed			R 31 had been instructed by PT to ambulate TID which was not reflect	ed in	
	one staff assistance wheeled walker, with his wheelchair. The	plan dated 11/20/14, directed of or ambulation, using a front tha caregiver following with care plan instructed staff to bulating to the dining room for			care plan as therapy staff had not n primary RN aware. PT has been ed on policy r/t communication with nu PT has been observed to be in compliance as evidenced by proper documentation being utilized. This w monitored weekly by DON or design	nade lucated rsing. , will be	
	supposed to walk to times a day, I don't	4 p.m. R31 stated, "I am o the [dining room] table three have a walker to do that and I have not been walked for two			Medicare meetings via communicative with therapy. R 72 is the only resident of our facil utilizing a restraint at this time. R 72 utilizes lap tray and documentation	tion ity	
	8:00 a.m. R31 prop to the dining room f R31 propelled hims activity area. At 11:2 himself in his whee lunch. After lunch, F wheelchair out of th observed to be amb On 11/20/14, at 7:1 (RN)-D confirmed F ambulation assistar plan and stated it w	on 11/19/14, at approximately elled himself in his wheelchair or breakfast. After breakfast, telf in his wheelchair to an 20 a.m., R31 again propelled lchair to the dining room for R31 propelled himself in his the dining room. R31 was not bulated to/ from meals. 1 a.m. registered nurse R31 had not received nce as directed by the care as her expectation that staff in services to the residents as			place for restraint protocol to be rev Q 6 months by primary RN. Care pl been reviewed and corrected to ren lap tray at meals and times of 1:1 supervision and staff has been edu on protocol for restraints. There are other residents utilizing restraints in at this time, but continued monitorin be in place as observation for follow policy by DON should another reside utilize a restraint in the future. Policy indicates that a restraint shour released at least every two hours a any time resident is under direct supervision including during activities mealtime.	viewed an has nove cated e no facility ng will ving of lent uld be nd at es and	
) p.m. director of nursing ree that we have not been			Staff educated on care plan and will reviewed again at next staff meeting 12/16/14 and continued monitoring	gs	

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	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION		<u>0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	PLETED
		245563	B. WING		11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	ambulating him [R3 R102 was not assist directed by the card R102's care plan for required assistance The care plan direct with a walker and t daily, as tolerated. Review of NA [nurs from 10/13/14, thro following: • From 10/13/14, thro following: • From 11/11/14, ambulated 20 out of • From 11/11/14, ambulated 16 out of On 11/20/14, at 8:0 ambulation program 10/13/14, when PT verified R102 was care plan. R72's wheelchair I removed when sup plan. R72's care plan da R72 was at risk for wheelchair to minin identified R72's lap directed staff to rer wheelchair when si During observation 11/17/14, from 5:30	31] as often as we should." sted with ambulation as	F 28	 completed by DON with supervisis x/week x 1 month, then weekly x 3 months at different meal times, ar monthly there after. Prompting plaresidents EMAR for cart nurse to ensure lap tray was removed duri periods of 1:1 supervision includir time. F tag 0282 has been reviewed a 0 meeting on 12/9/14. 	3 aced in sign to ng ng meal	

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245563	B. WING			11/20/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	observed with a full by bilateral Velcro s reach to independe R72 throughout the released the lap tra On 11/19/14, at 6:33 the director of nursi NA-E to remove R7 meal. R72's tray rer meal. On 11/20/14, at 10:- lap tray was not ren 11/17/14. She repor tray was to be remove On 11/20/14, at 10:- (RN)-B stated it was removed R72's lap directed by the care was to be released supervised setting. The facility's Physic 6/5/12, indicated the restraint was to be every two to three h 483.25 PROVIDE C	 lap tray in place and secured straps in which R72 could not intly release. NA-E sat next to meal and never removed or by as directed. 8 p.m. during the supper meal, ing (DON) was heard to advise 72's wheelchair lap tray for the mained off throughout the 45 a.m. NA-E verified R72's noved on the evening of rted she was unaware his lap oved at meal time. 50 a.m. registered nurse s her expectation that staff tray while feeding him as e plan. RN-B stated a restraint whenever R72 was in a cal Restraints policy dated e purpose for a physical vent injury. The policy directed e released from a restraint nours. CARE/SERVICES FOR 		282			12/20/14
55=D	Each resident must provide the necessa or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED				
245563		245563	B. WING		11/2	20/2014		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GREEN	PINE ACRES NURSIN	G 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	HOULD BE COMPLETION			
F 309	Continued From pa	ge 14	F 30	9				
	 9 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. 			The care plan of R 89 has been read and corrected to indicate target behas well as specific interventions. The Plans of all residents with behaviors been reviewed and updated with tar behaviors and interventions. Staff has been educated on care planning for behaviors and interventions. All ress care plans with behaviors will be re- and monitored by DON or designed weekly for 3 months until compliance assured then will be reviewed mont behavior committee with DON mon Staff will continue to be educated o behavior care planning and will be reviewed again at next RN meeting 12/17/14 This has been reviewed at QA meet 12/09/2014	naviors ne Care s have rget nas r target ident viewed e ce is thly by itoring. n			

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	•••••••••••••••••••••••••••••••••••••••	AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/20/2014	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	PINE ACRES NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 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 is behavior." On 7/6/14, at 5:26 p.m. R89 mas 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 9/25/14, at 11:50 p.m. R89 was noted to "taunt" an unidentified female resident from the hallway. The unidentified female resident from the		F	309			

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245563	B. WING	i		11/20/2014			
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
GREEN	PINE ACRES NURSIN	G HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 309	having a physical a • On 10/11/14, at R89 had been redir evening shift as he resident's face. The behavior caused th "uncomfortable." • On 10/24/14, at observed before su male resident's thig he laughed at the s Further review of th R89 had a pattern of areas, making inap staff about female r attempting to physic they were walking. Review of Point of of for 10/14, to 11/14, sporadic behaviors verbal abuse, socia and sexually inappr staff identified the t the clinical record of in sufficient detail to analysis of his mala potential environme behaviors. The doc description of the re attempted and whe successful or unsue On 11/18/14, at 2:0 the nurse's station of R89 was able to an assistive devices. H	Itercation. t 10:04 p.m. the staff noted rected several times during the came quite close to another e documentation indicated this e other residents to feel t 10:22 p.m. R89 was pper to touch an unidentified th. When R89 was redirected, taff and removed his hands. The progress notes revealed of touching staff in private propriate comments to the residents / other staff and cally push staff members while Care Behavior documentation indicated R89 displayed such as inappropriate behaviors ropriate remarks. Although the ype of behavior R89 displayed, lid not describe the behaviors o allow for a comprehensive adaptive behaviors and ental factors precipitating the umentation also lacked edirection interventions ther the interventions were	F	309					

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245563	B. WING			11/20/2014	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	However, when R83 he wished to speak personal space lear asking questions. H be within a few inch On 11/18/14, at 3:0 initiated a conversa within inches while attempt to threaten speaking, he left the On 11/18/14, at 3:4 confirmed R89 part within the facility. A R89 occasionally di example of his behaving on 11/18/14, at 3:4 dementia and was R89 displayed behaving example of his behaving On 11/18/14, at 3:4 dementia and was R89 displayed behaving example of his behaving on 11/18/14, at 3:5 (RN)-C stated she were evening shifts. She concerns with R89. On 11/18/14, at 4:0	 ⁹ approached the person(s) ⁹ to, he routinely invaded their ning toward the speaker and le was frequently observed to hes of the other person's face. ⁰ p.m. R89 approached and ation with writer. He stood conversing, but did not or touch. Once R89 finished e area without incident. ⁰ p.m. activity aide (AA)-A ticipated in activity programs A-A stated she was aware isplayed behaviors. An aviors included taking a single a puzzle that other residents he stated R89 was easily d occasionally make snide ing to return the puzzle piece. ⁵ p.m. AA-B stated R89 had easily redirected. She stated aviors during activities. An aviors included throwing the bas activity) at the other e force than what the other e force than what the other e to manage. She stated R89 ior when directed by staff to do ⁰ p.m. registered nurse was in charge during the was not aware of any 	F3	309			

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		AND HUMAN SERVICES			FORM	: 12/17/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING		11/:	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME		27 MAIN STREET NORTHEAST //ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	residents' personal invasion of person a was speaking to fee On 11/18/14, at 4:1 (LPN)-A stated R89 personal space of c which he had touch inappropriately. LPI received monitoring was redirected as r On 11/19/14, at 10: invaded the person described R89's be and indicated this b other resident unco of being hit by othe redirected R89 as r On 11/19/14, at 12: (DON) reviewed R8 verified R89 display invading others' per irritate others for his inappropriately touc stated staff were to displayed inappropri monitoring checks of confirmed R89's be specified, compreh planned to ensure a consistently, in the manner. On 11/19/14, at 12: stated he was not a with R89's behavior	 space. She stated R89's space made whomever he el uncomfortable. 2 p.m. licensed practical nurse a frequently got into the others. He had incidents in hed both residents and staff N-A stated for this reason, R89 g checks every 30 minutes and heeded. 20 a.m. LPN-B stated R89 hal space of others. She shaviors as "very intimidating" behavior not only made the omfortable, but put R89 at risk r residents. She stated she 	F 309			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
				IG		
		245563	B. WING _		11/2	20/2014
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 309 F 311 SS=D	R89's behaviors to not necessitate car- had since displayed those behaviors ha comprehensively as ensure all staff mer in the most appropriation A policy related to b care of persons wit was not provided. 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given to services to maintain	be isolated incidents that did e planning. He confirmed R89 d a pattern of behaviors and d not been clearly specified, ssessed and care planned to nbers intervened consistently, riate and effective manner. behavioral interventions for the h dementia was requested, but	F 30			12/20/14
	by: Based on observative review, the facility finds of the facility for the facility of th	NT is not met as evidenced tion, interview and document ailed to ensure 2 of 3 residents ceived ambulation services in eir assessed needs. ed ambulation assistance as e plan. imum Data Set (MDS) dated s cognition was intact. The I R31 was independent with quired extensive assistance of the corridor. The MDS ved restorative nursing, range nd skill practice in walking. A e dated 10/2/14, indicated R31		R 31 and R102 ambulation was documented correctly and as ind care plan. NARs have been educ appropriate documentation and o program adjusted to prevent the documentation of 0 for walking w to select an appropriate response will be educated again on docum appropriately r/t ambulation of re NAR meeting 12/16/14. Docume review will be done weekly by DC designee with weekly walking list Residents observation checks wi completed on a weekly basis to e that all residents on list are in fac as indicated by the individualized plan. Monitoring will be complete	icated in cated on computer with need e. NARs entation sidents at ntation DN or checks. Il be ensure t walking care	

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		AND HUMAN SERVICES & MEDICAID SERVICES			0		APPROVEI 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	rehab plan directed 200 feet with a from assistance from one plan dated 11/20/14 for ambulation, usin a caregiver followin care plan instructed ambulating to the d On 11/18/14, at 4:00 supposed to walk to times a day, I don't am supposed to walk to times a day, I don't am supposed to. If weeks." During observation 8:00 a.m. R31 prop to the dining room f R31 propelled hims activity area. At 11:2 himself in his wheel lunch. After lunch, F wheelchair out of th observed to be amb On 11/19/14, at 9:11 (NA)-C stated, "We R31]. If he walks, it have to ask them he On 11/19/14, at 9:22 stated, "He [R31] is own. He is on a wal therapy three to five a recommendation him to meals three	 Juding osteoarthritis, anal stenosis. The nursing R31 was to be ambulated, twheeled walker and standby e staff. R31's revised care 4, directed one staff assistance and a front wheeled walker, with g with his wheelchair. The d staff to assist R31 with ining room for all meals. 4 p.m. R31 stated, "I am the [dining room] table three have a walker to do that and I have not been walked for two on 11/19/14, at approximately elled himself in his wheelchair to an 20 a.m., R31 again propelled lichair to the dining room for R31 propelled himself in his edining room. R31 was not boulated to/ from meals. 5 a.m. nursing assistant do not walk him [referring to is with therapy. You would ow often he walks." 3 a.m. physical therapist (PT) not to be ambulating on his king program. He walks with a times per week and I did put in for nursing to be walking 	F 3	311	DON or designee. R 31 had been instructed by PT to ambulate TID which was not reflec care plan as therapy staff had not r primary RN aware. PT has been ed on policy r/t communication with nu PT has been observed to be in compliance as evidenced by prope documentation being utilized. This monitored weekly by DON or desig Medicare meetings via communication with therapy. Tag F 0311 has been reviewed at C meeting 12/09/2014	nade ducated irsing. r will be nee at tion	

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245563	B. WING			11/:	20/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	PT continued, "My of should be doing it [1 for walking to meals care plan." The PT there was no walke "It must still be in th On 11/19/14, at 9:3 (TMA)-A stated, "I ta ambulation program program. I have new On 11/19/14, at 9:4 uses his wheelchait walked him to meal never ambulated R On 11/19/14, at 9:2 doesn't walk. He ca walk him. He would does not walk him.' On 11/20/14, at 7:1 (RN)-D confirmed F recommended amb have. RN-D stated staff provided ambu directed. On 11/20/14 at 1:20 (DON) stated, "I ag ambulating him [R3 R102 was not provi directed by the care R102's admission M her cognition was m diagnoses including	 expectation is that nursing following the recommendation s] and that it should be on his then checked R31's room and it in the room. The PT stated, herapy." 5 a.m. trained medication aide believe he [R31] is on an in. I would have to check his ver walked him." 4 a.m. NA-J stated, "He [R31] it to get around. I have not ls." NA-J verified she had 31. 8 a.m. NA-D stated, "He [R31] in transfer himself. We do not I walk with therapy, but nursing ' 1 a.m. registered nurse R31 had not received the PT pulation services, but should it was her expectation that ulation services to residents as 0 p.m. director of nursing ree that we have not been 81] as often as we should." 	F3	311			

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		FORM	: 12/17/2014 APPROVED
(X2) MUL		(X3) DAT	E SURVEY
B. WING		11/	20/2014
	STREET ADDRESS, CITY, STATE, ZIP CODE		
	427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
ID PREFI) TAG	X (EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETION DATE
with pom. she ation. 2, was es. as es. as es. o the ere DN staff e did ro" ot ated n as In	311		
	A. BUILD B. WING ID PREFI TAG	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Yes STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464 PREFIX CACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) with com. She ation. 2, Assist ies. Assist ies. Assist ies. Assist ies. And Data Previous F 311	Kale of the left of the l

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245563	B. WING	i		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOME			127 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 SS=D	UNNECÉSSARY D Each resident's dru	g regimen must be free from	F:	329			12/30/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any					
	resident, the facility who have not used given these drugs u therapy is necessa as diagnosed and o record; and resider drugs receive grad behavioral interven	ehensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on observa review, the facility f justification for the antipsychotic media (R19) reviewed for Findings include:	NT is not met as evidenced tion, interview and document ailed to provide medical continued use Seroquel (an cation), for 1 of 6 residents unnecessary medications.			R 19 received Seroquel with dx of agitation and depression with pharn consultant reviewing monthly and medication reviewed by MD Q 6 mo for reduction. Medication has been reviewed and reduced on 11/25/14 request of MD to change dx on medication to aggression as approp for resident. Staff has been educate	onths with oriate	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	of CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG _		COlvir	FLETED
		245563	B. WING _			11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 27 MAIN STREET NORTHEAST		
GREEN I	PINE ACRES NURSIN	IG HOME		42 M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 329	Continued From pa	age 24	F 32	29			
	received Seroquel, depression. The as displayed "behavio redirected as poss The assessment d behaviors R19 disp on interventions the redirection. R19's care plan da confabulating storie the intent to deceiv and directed the st behaviors, encoura as needed. The ca specific behaviors	use dated 6/24/14, indicated he 25 mg for agitation and ssessment indicated R19 rs" and he was to be ible during periods of agitation. id not specify the type of blayed, nor did it direct the staff at were to be used for ted 6/24/14, identified he was es (fabricating stories without re/ misinterpreted memories) aff to document his mood/ age activities and redirect him are plan did not describe R19's or provide direction for staff on edirect him when he exhibited			diagnosis r/t psychotropic medication plan to have pharmacy consultant complete an in-service for staff incl RNs, DON, and invitation to medicat director, on 01/08/14 to continue education. Psychotropic medication continue to be monitored monthly b pharmacy consultant. DON will mon Psychotropic medications weekly for month until in compliance then mor behavior meetings after compliance met. This has been reviewed at QA mee 12/09/2014.	uding al ns will y nitor or 1 nthly at e is	
	9/9/14, identified di disabilities and dep R19 had mood ind depressed, but did symptoms. The M antipsychotic medi R19's current phys directed administra milligrams (mg) tw	ician orders dated 10/3/14, ation of Seroquel, 12.5 ice daily, for the treatment of					
	orders revealed R1 mg twice daily from Intermittent observ on the following: 1	ession. Further review of the 19 had received Seroquel, 25 n 5/12/14, to 9/10/14. rations of R19 were conducted 1/17/14, from 4:00 p.m. to 8:00 m 8:00 a.m. to 4:30 p.m.;					

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		AND HUMAN SERVICES				FORM	: 12/17/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245563	B. WING			11/3	20/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREEN	PINE ACRES NURSIN	G HOME			127 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	 11/20/14, from 7:00 observations, R19 v in his room, eat me and interact approprivisitors. At no time maladaptive behavior Review of R19's Be 1/1/14- 9/1/14, indic aggression towards During each of the being directed by or staff/ peer and strono own boss and woul do. At no time did to R19 was not redirect Behavior Documen revealed no malada displayed. Pharmacy Recommindicated R19 was twice a day for agita pharmacist noted a required an approp justification to indication was warranted. The recommended R19 6/17/14, the medication twice daily. On 11/1 pharmacist again re to be reduced, but of indication for the co On 11/20/14, at 10: (RN)-D stated R19 towards others and R19 was easily red 	a.m. to 2:00 p.m. During was noted to watch television eals in the main dining room, priately with staff, peers and was R19 observed to display	F	329			

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		& MEDICAID SERVICES	0.0		IO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY
		245563	B. WING _		11/20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GREEN I	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From pa warrant the use of	age 26 an antipsychotic medication.	F 32	29	
	(DON) stated R19 toward other reside not have a diagnos Seroquel and confi direct staff on effect when R19 displaye On 11/20/14, at 1:3 (LPN)-B stated R19 verbally aggressive	 40 a.m. the director of nurses displayed verbal aggression ents. She confirmed R19 did is for the continued use of rmed the care plan did not stive interventions to implement d verbal aggression. 60 p.m. licensed practical nurse 9 had a history of being e with others but he did not not ny type of maladaptive 			
F 364 SS=E	the staff to monitor of maladaptive beh appropriate interve direct the staff to er antipsychotic media diagnosis for the co 483.35(d)(1)-(2) NL PALATABLE/PREF Each resident rece food prepared by m value, flavor, and a	vior Monitoring policy directed the behaviors and frequency aviors and determine ntions. The policy did not nsure all residents receiving cations had appropriate ontinued use of the medication. JTRITIVE VALUE/APPEAR, ER TEMP ives and the facility provides nethods that conserve nutritive ppearance; and food that is e, and at the proper	F 36	54	12/20/14
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview and document failed to serve food at the of or 4 of 4 residents (R9, R54,		NARs had served residents food that required assistance eating, but did not s down immediately as they should have	

Facility ID: 00678

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/17/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	R43, R65) for 1 of 2 main dining room. Findings include: On 11/17/14, during the main dining roo until 6:50 p.m. the f -At 6:00 p.m., cogn R9, R54, R43 and but were noted as a assistance. At 6:12 nursing assistants R54, R43 and R9 w was observed to as meal of waffles and was asked to check food. NA-F brough where the cook check waffles and sausag degrees Fahrenheid degrees F. The co checked for all food The cook confirme meal on 11/17/14, w The cook placed R microwave was als dining room which was available for st cold. On 11/20/14, at 111 (DON) stated any r	2 meal observations in the 2 meal observations in the g continuous observations of om supper meal from 5:35 p.m. following was observed: itively impaired tablemate's R65 were served their meals, unable to eat without staff 2 p.m., 12 minutes later, three (NAs) began assisting R65, with eating their meals. NA-F ssist R43 with eating a pureed d sausage. At that time, NA-F k the temperature of R43's at the plate to the kitchen the plate to the kitchen ecked the temperature of the ge. The waffles were 102 t (F) and the sausage was 86 ok stated temperatures were ds before meal service began. d temperatures for the evening were adequate prior to service. 43's plate of food in the ve the plate back to NA-F. A o observed stationed in the when asked, NA-F stated it taff to use to warm food if it got 30 a.m. the director of nursing esident who required staff hould received assistance as	F	364	assist the residents to eat. NARs habeen educated on sitting down righ to help those that need help eat and be re-educated on 12/17/14. LPNs been instructed to monitor dinning a activity with one nurse to stay near room during meal time. Observation monitoring will occur by DON or de- during various meal times 3x/week month then weekly x 2 months and periodically thereafter. DON and Di will weekly x 3 months then periodic after compliance is met ask resider are cognitively intact if they felt ther was warm enough during the last m service. This was reviewed at Q A meeting 12/09/14.	t away d will have room dinning nal signee x 1 etary cally nts that re food	

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		(X3) DATE		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMF	PLETED	
		245563	B. WING		11/2	0/2014	
NAME OF F	PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN I	PINE ACRES NURSI	NG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 364	Continued From p	age 28	F 364	4			
	all residents were environment for m possible.	Policy dated 12/19/12, directed to be provided a home-like eals to the greatest extent					
F 428 SS=D	483.60(c) DRUG I IRREGULAR, AC	REGIMEN REVIEW, REPORT Γ ON	F 428	3		12/30/14	
		of each resident must be once a month by a licensed					
	the attending phys	ust report any irregularities to ician, and the director of reports must be acted upon.					
	This REQUIREME	NT is not met as evidenced					
	Based on observa review, the facility pharmacist reporte appropriately to th director of nursing	ation, interview and document failed to ensure the licensed ed medication irregularities e attending physician and the to be acted upon for 1 of 6 viewed for unnecessary		R 19 received Seroquel with dx of agitation and depression with pharm consultant reviewing monthly and medication reviewed by MD Q 6 mo for reduction. Medication has been reviewed and reduced on 11/25/201 request of MD to change dx on medication to aggression as approp	nths 4 with		
	Findings include:			for resident. Staff has been educate diagnosis r/t psychotropic medicatio	d on		
	psychotropic drug received Seroquel depression. The a displayed "behavio	sessment (CAA) for use dated 6/24/14, indicated he , 25 mg for agitation and ssessment indicated R19 ors" and he was to be sible during periods of agitation.		plan to have pharmacy consultant complete an in-service for staff inclu RNs, DON, and invitation to medica director, on 01/08/14 to continue education. Psychotropic medications continue to be monitored monthly by	l s will		

Event ID:U84B11

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		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN				27 MAIN STREET NORTHEAST		
				N	IENAHGA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	Continued From pa	age 29	F	128			
	The assessment di behaviors R19 disp on interventions that redirection. R19's care plan dat confabulating stories the intent to deceiv and directed the stat behaviors, encoura as needed. The car specific behaviors of how to effectively re- behaviors. R19's quarterly Min 9/9/14, identified di intellectual disabilitit revealed R19 had re- and depressed, but symptoms. The MI antipsychotic medic R19's current physi- directed administra milligrams (mg) twi agitation and depre- orders revealed R1 mg twice daily from	d not specify the type of blayed, nor did it direct the staff at were to be used for ted 6/24/14, identified he was es (fabricating stories without e/ misinterpreted memories) aff to document his mood/ age activities and redirect him re plan did not describe R19's or provide direction for staff on edirect R19 when he exhibited himum Data Set (MDS) dated agnoses including mild ies and depression. The MDS mood indicators of feeing down t did not display behavioral DS indicated R19 received		720	pharmacy consultant. DON will mor Psychotropic medications weekly for month until in compliance then mor behavior meetings after compliance met. This has been reviewed at QA mee 12/09/2014.	or 1 hthly at e is	
	on the following: 11 p.m.; 11/18/14, from 11/19/14, from 10:0 11/20/14, from 7:00 observations, R19 in his room, eat me and interact approp	Allon's of R19 were conducted /17/14, from 4:00 p.m. to 8:00 n 8:00 a.m. to 4:30 p.m.; 00 a.m. to 6:30 p.m., and; 0 a.m. to 2:00 p.m. During was noted to watch television eals in the main dining room, priately with staff, peers and was R19 observed to display					

Facility ID: 00678

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PRINTED: 12/17/2014 FORM APPROVED

		AND HUMAN SERVICES				FORM	12/17/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245563	B. WING			11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 428	Continued From para maladaptive behavior Review of the Beha 1/1/14- 9/1/14, indice verbal aggression to occasions. During end noted as being direct at the staff/ peer and was his own boss a wished to do. At no indicated R19 was Review of R19's Be 9/1/14, to 11/20/14, behaviors were disp Pharmacy Recommended R19 had be mg twice a day for a pharmacist noted and required an approp justification to indice was warranted. The recommended R19 6/17/14, the mediced twice daily. On 11/1 pharmacist again re to be reduced, but of indication for the com-	ge 30 fors. Noior Documentation from cated R19 had displayed owards others on eight each of the incidents, R19 was cted by others, when he yelled ad strongly informed them he time did the documentation not able to be redirected. The did the documentation revealed no maladaptive olayed. The nendations dated 6/5/14, been started on Seroquel, 25 agitation and depression. The n antipsychotic medication riate diagnosis or physician ate why use of the medication the pharmacy consultant 's Seroquel be reduced. On ation was reduced to 12.5 mg, 3/14, the consultant ecommended the medication did not request an appropriate ontinued use of Seroquel.	1	128			
	(RN)-D stated R19 towards others and R19 was easily red She confirmed R19 warrant the use of a	20 a.m. registered nurse displayed verbal outbursts made up stories. She stated irected if he was left alone. did not have a diagnosis to an antipsychotic medication. 40 a.m. the director of nurses					
	(DON) stated R19 (displayed verbal aggression nts. She confirmed R19 did					

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CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL	TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
245563 B. WING	
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 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	X PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
F 428Continued From page 31 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 	28

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		AND HUMAN SERVICES	75ª	563024		PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			T	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COMP	LETED
		245563	B. WING		11/2	0/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	PINE ACRES NURSIN	GHOME		427 MAIN STREET NORTHEAST		
OREENT				MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 000	ס		
	FIRE SAFETY					
	Minnesota Departm Fire Marshal Divisio Green Pine Acres M substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapt THE FACILITY'S P	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Nursing Home was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection 9 Standard 101, Life Safety er 19 Existing Health Care. OC WILL SERVE AS YOUR				
	DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.	-			
	DEFICIENCIES (K-	R THE FIRE SAFETY TAGS) TO:		EPOC		
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	GHAL DIVISION STREET, SUITE 145				
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245563	B. WING	_		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSING	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre The facility has bee Green Pine Acres N in five different year 1-story building with 1964 and was deter construction. In 199 basement was adde building and was de construction. In 199 and connecting link southeast corner of 1-story building with determined to be of 1999 a 1-story build was added to the ne building that was de construction. In 200 basement was adde was determined to be	RECTION FOR EACH TINCLUDE ALL OF THE PRMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to nce of the deficiency. n inspected as two buildings: lursing Home was constructed s. The original building is a partial basement build in mined to be of Type II(111) 59 a 1-story building without ed to the west of the original etermined to be of Type II(111) 96 the administration addition was constructed to the the original build that is a nout basement that was Type V(111) construction. In ling without basement addition orthwest of the original etermined to be of II(111) 04 a 1-story addition without et to the original building and be of Type II(111) construction.	K	000			
	The entire facility is sprinkler system.	protected by a complete fire ne facility has a complete fire					

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES			OMB NC	APPROVE 0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245563	B. WING		11	/20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
GREEN F	PINE ACRES NURSIN	G HOME			ENAHGA, MN 56464	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000	Continued From pa	-	КO	00		
	corridors and space	smoke detection in the es open to the corridor that is natic fire department				
	The facility has a lic and had a census c	censed capacity of 65 beds of 62 at the time of the survey.				
K 062 SS=F	NOT MET as evide	42 CFR Subpart 483.70(a) is nced by: FETY CODE STANDARD	КO	62		12/11/14
33-F	continuously mainta condition and are in	c sprinkler systems are ained in reliable operating ispected and tested .6, 4.6.12, NFPA 13, NFPA 25,				<
	Based on documen with staff, the facility and maintain the au accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, T Water Based Fire F deficient practice do sprinkler system is fully operational in t	s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation is (99), and NFPA 25 Standard Festing and Maintenance of Protection Systems, (98). This bes not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.			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 Superviso to assure compliance in the future.	
	Findings include:		e			
	On facility tour betw	veen 10:30 AM and 1:30 PM				

Facility ID: 00678

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 12/19/201 FORM APPROVE OMB NO. 0938-039		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245563	B. WING		11/20/2014		
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
K 062	on 11/19/2014, a re interview with the F revealed the facility quarterly fire sprink NFPA 13(99) and N	view of documentation and acility Administrator (CE), failed to conduct 2 of 4 ler flow tests required by FPA 25(98).	K 062				

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		AND HUMAN SERVICES	FS	52	30716	FORM	12/19/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - KITCHEN ADDITION		E SURVEY PLETED
		245563	B. WING			11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST		
					IENAHGA, MN 56464		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	ĸ	000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Divisio Green Pine Acres N substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nat Association (NFPA)	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Nursing Home was found not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety ter 19 Existing Health Care.			>		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		-			
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				1	
	DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO:			EPOC		
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	ically 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - KITCHEN ADDITION			E SURVEY PLETED
		245563	B. WING			11/20/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	PINE ACRES NURSIN	G HOME					
				1	MENAHGA, MN 56464		0(0)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa By e-mail to: Marian.Whitney@s		κo	000			
		RRECTION FOR EACH T INCLUDE ALL OF THE RMATION:					
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person ection and monitoring to nce of the deficiency.					
	Green Pine Acres N in five different year 1-story building with 1964 and was deter construction. In 199 basement was adde building and was de construction. In 199 and connecting link southeast corner of 1-story building with determined to be of 1999 a 1-story build was added to the no building that was de construction. In 200 basement was adde was determined to be	n inspected as two buildings: lursing Home was constructed is. The original building is a a partial basement build in rmined to be of Type II(111) 59 a 1-story building without ed to the west of the original etermined to be of Type II(111) 96 the administration addition was constructed to the the original build that is a nout basement that was Type V(111) construction. In ling without basement addition orthwest of the original etermined to be of II(111) 04 a 1-story addition without ed to the original building and be of Type II(111) construction. protected by a complete fire					
	The entire facility is sprinkler system. The system of th	protected by a complete fire ne facility has a complete fire					t Dago 2 of 4

Facility ID: 00678

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		AND HUMAN SERVICES		0	FORM A	PPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245563	B. WING 11/20/			
	PROVIDER OR SUPPLIER	GHOME		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 000 K 062 SS=F	alarm system with s corridors and space monitored for autor notification. The facility has a lid and had a census of The requirement at NOT MET as evide NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	smoke detection in the es open to the corridor that is matic fire department censed capacity of 65 beds of 62 at the time of the survey.	K 000		1	12/11/14
	Based on documer with staff, the facilit and maintain the au accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice do sprinkler system is fully operational in the negatively affect rest Findings include:	s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), I 4.6.12, NFPA 13 Installation ns (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.		Simplex Grinnell was notified that the contract was out of compliance, in the required quarterly flow tests and que maintenance was not conducted with the timeframes required in that comount they came and did the required word 11-19-2014, and have assured us they will meet the required timeframe requirements going forward. This we monitored by the Maintenance Sup to assure compliance in the future.	that the arterly thin tract. ork on hat ne vill be	

Facility ID: 00678

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/19/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - KITCHEN ADDITION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING			11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	on 11/19/2014, a re interview with the F revealed the facility quarterly fire sprink NFPA 13(99) and N	view of documentation and acility Administrator (CE), failed to conduct 2 of 4 ler flow tests required by IFPA 25(98). ice was verified by the Facility	K	062			
	×	ε.					

Event ID: U84B21

Facility ID: 00678

If continuation sheet Page 4 of 4

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00678	B. WING		11/2	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	STREET NC A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/12/14

Electronically Signed

6899

If continuation sheet 1 of 38

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11//	20/2014
IAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	IG HOME	IN STREET NOI IGA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 000		-	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correctio ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the ment of Health.	n or			
su at or elu re th M th fe as	surveyors of this De above provider and orders are issued. electronic plan of c	/14, 11/19/14, and 11/20/14, epartment's staff, visited the I the following correction Please indicate in your orrection that you have lers, and identify the date whe ted.	en			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for	3			
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column Fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.	3			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (;	X3) DATE SURVEY COMPLETED
		00678	B. WING		11/20/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
REEN F	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 5646		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 000	Continued From pa	ige 2	2 000		
	THIS WILL APPEA	R ON EACH PAGE.			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 535	MN Rule 4658.030 Restraints	0 Subp. 5 A-D Use of	2 535		12/20/14
	resident placed in a home must also: A. develop a sy restrained resident specified in the writ B. assist the re- for the resident's sa elimination needs; C. provide an o exercise, and elimin minutes during eac restraint is employed	esident from the restraint as	1		
	by: Based on observat review, the facility f (R72) with a wheele was released from during 1 of 2 meal of	ent is not met as evidenced ion, interview and document ailed to ensure 1 of 1 resident chair (w/c) lap tray restraint, the restraint while supervised observations in order to restrictive device for the least		Corrected	
	Findings include:				
	R72's quarterly Min	imum Data Set (MDS) dated			

U84B11

If continuation sheet 3 of 38

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			-			
		00678	B. WING		11 /2	20/2014
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GREEN I	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 56464	-		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 535	Continued From pa	age 3	2 535			
	impaired and he re	his cognition was severely quired extensive assistance daily living (ADLs).				
	falls, with a tray tak risk. The care plan restraint and direct	an indicated R72 was at risk for ole on his w/c to minimize this identified R72's lap tray as a ed staff to remove the tray staff were feeding him.	r			
	11/17/14, from 5:30 assistant (NA)-E w meal. Throughout to observed with a ful by bilateral Velcros reach to independe	of the evening meal on 0 p.m. to 6:25 p.m. nursing as observed feeding R72 his the observation R72 was I lap tray in place and secured straps in which R72 could not ently release. NA-E sat next to e meal and never removed or ay as directed.				
	the director of nurs NA-E to remove R	88 p.m. during the supper meal ing (DON) was heard to advise 72's w/c lap tray for the meal. d off throughout the meal.				
	lap tray was not re	:45 a.m. NA-E verified R72's moved on the evening of orted she was unaware his lap oved at meal time.				
	(RN)-B stated it wa removed R72's lap	50 a.m. registered nurse as her expectation that staff tray while feeding him. RN-B vas to be released whenever rvised setting.				
	6/5/12, indicated th restraint was to pre-	cal Restraints policy dated le purpose for a physical event injury. The policy directed le released from a restraint	ł			

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00678	B. WING		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	GHOME	I STREET NO A, MN 5646			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLETE DATE
2 535	Continued From pa	ige 4	2 535			
	every two to three h	nours.				
	The director of nurs and/or policies and of restraints. Care require restraints cor revised as appropriat the need for release appropriate, to ensu An auditing system on-going compliance audits being review Assessment & Asse	THOD OF CORRECTION: sing or designee could review procedures related to the use plans for all residents who ould be reviewed and/or rate, with re-educate to staff on e of restraints when ure the least restrictive use. could be developed to ensure be, with the results of these red by the facility's Quality urance committee. R CORRECTION: Fourteen				
2 560	Plan of Care; Contents Subp. 2. Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The of must include the inor required by Minnes subdivision 14, para	of plan of care. The n of care must list measurable stables to meet the resident's n goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560			12/20/14
	by: Based on observati review, the facility f interventions for co	ion, interview and document ailed to develop care plan nsistent management of iors, for 1 of 1 resident (R89)		Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11//	20/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN P	PINE ACRES NURSIN	GHOME	N STREET NO A, MN 56464	-		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ige 5	2 560			
	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.					
	8/20/14, identified h worsening mental s directed toward bot residents. The beha but were not to be o	essessment (CAA) dated the displayed behaviors, with status. The behaviors were th staff members and other aviors were to be monitored, care planned until "another o further description of R89's uded in the CAA.				
	during the following 8:00 p.m.; 11/18/14 11/19/14, from 10:0 11/20/14, from 7:00 these observations independently throu staff, peers and vis	ughout the facility, approaching itors to initiative conversations. ed the personal space of				

U84B11

If continuation sheet 6 of 38

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/20/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
GREEN F	PINE ACRES NURSIN	IG HOME	N STREET NO	RTHEAST		
(X4) ID	SUMMARY ST		GA, MN 56464	PROVIDER'S PLAN OF	COBRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	COMPLET
2 560	Continued From pa	age 6	2 560			
	 through 10/24/14, r R89 had physic residents on two or Staff members altercations betwee five occasions. R89 physically occasions. After each incid R89 was able to be specific intervention effectively redirect documented. 	rogress notes from 6/29/14, revealed the following: cal altercations with other ccasions. had to intervene to prevent en R89 and other residents on touched staff members on 12 dent of maladaptive behavior, e redirected; however, the ns/ techniques used to him were not consistently :00 p.m. the director of nurses				
	(DON) reviewed R8 verified R89 display invading others' pe irritate others for hi inappropriately toug stated staff were to displayed inapprop monitoring checks confirmed R89's be described and care members intervent appropriate and eff the DON reviewed it did not address ta interventions used effectively. She cor	89's progress notes. She yed behaviors such as rsonal space, attempting to is personal enjoyment and ching staff members. She predirect R89 when he riate behaviors and conduct every 30 minutes. She ehaviors had not been clearly e planned to ensure all staff ed consistently, in the most fective manner. At 12:45 p.m., R89's care plan and confirmed	d			
	stated he was not a with R89's behavio time the CAAs wer	:50 p.m. social worker (SW)-A aware of any type of pattern rs. SW-A reported that at the e completed, he understood be isolated incidents that did				

	IT OF DEFICIENCIES OF CORRECTION	CALL CALL CALL CALL CALL CALL CALL CALL		CONSTRUCTION		E SURVEY PLETED
		00070	B. WING		11/20/2014	
		00678			 11 /2	20/2014
	PROVIDER OR SUPPLIER	427 MAII	DDRESS, CITY, S ⁻ N STREET NO			
REEN F	PINE ACRES NURSIN	IG HOME	GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 560	Continued From pa	age 7	2 560			
	had since displayed those behaviors ha and care planned to intervened consiste and effective mann The undated Comp Policy indicated ea- include measurable meet all needs ider assessment. SUGGESTED MET The director of nurs	orehensive Resident Care Plan ch resident's care plan was to e objectives and time tables to ntified in the comprehensive THOD OF CORRECTION: sing or designee could review/				
	plan development a to address the import comprehensive car needs. Resident car revised for complia and assurance com					
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/20/1
		omprehensive plan of care I personnel involved in the t.				
	This MN Requirem by:	ent is not met as evidenced				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00678	B. WING		11/2	11/20/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GREEN	PINE ACRES NURSIN	GHOME	STREET NO A, MN 5646				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Based on observati review, the facility fa (R31 and R102), re accordance with the facility failed to ensu- tray restraint was re (R72) observed dur with a lap tray which by the care plan. Findings include: R31's Nursing Reha- indicated diagnoses depression and spin R31 was to be amb wheeled walker and staff. R31's revised directed one staff a using a front wheeled following with his w instructed staff to a the dining room for On 11/18/14, at 4:0 supposed to walk to times a day, I don't am supposed to. I f weeks." During observation 8:00 a.m. R31 prop to the dining room f R31 propelled hims activity area. At 11:2 himself in his whee lunch. After lunch, F wheelchair out of th	on, interview and document ailed to ensure 2 of 3 residents ceived ambulation services in e care plan. In addition, the ure a secured wheelchair lap emoved for 1 of 1 resident ring 1 of 2 meal observations h was not removed as directed ab plan dated 10/2/14, s including osteoarthritis, nal stenosis. The plan directed pulated, 200 feet with a front d standby assistance from one care plan dated 11/20/14, ssistance for ambulation, ed walker, with a caregiver heelchair. The care plan ssist R31 with ambulating to		Corrected			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME	NSTREET NOF A, MN 56464	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	On 11/19/14, at 9:2 confirmed recomme R31 to meals three "My expectation is f [following the recom- meals]" Upon inq walker was not in h must have been lef On 11/20/14, at 7:1 (RN)-D confirmed F recommended amb have. RN-D stated staff provided amb directed. On 11/20/14 at 1:20 (DON) stated, "I ag ambulating him [R3 R102's care plan direct with a walker and th daily, as tolerated. Review of NA [nurs from 10/13/14, thro following: From 10/13/14, thro following: From 11/1/14, t ambulated 20 out of From 11/1/14, at 8:0 ambulation program 10/13/14, when PT	age 9 3 a.m. physical therapist (PT) endations for nursing to walk times daily. PT continued, that nursing should be doing it nmendation for walking to uiry, PT confirmed R31's is room. PT stated the walker it in the therapy room. 1 a.m. registered nurse R31 had not received the PT pulation services, but should it was her expectation that ulation services to residents as 0 p.m. director of nursing ree that we have not been B1] as often as we should." evised 11/20/14, identified she e from one staff for ambulation. eted staff to ambulate R102, ransfer belt, 100 feet twice sing assistant] Walking forms rugh 11/19/14, revealed the , through 10/31/14, R102 was of 38, or 53% of opportunities. through 11/19/14, R102 was of 38, or 42% of opportunities.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00678	B. WING		11/20/2014		
	PROVIDER OR SUPPLIER		TADDRESS, CITY, STATE, ZIP CODE				
GREEN I	PINE ACRES NURSIN	AG HOME 427 MAII	N STREET NO GA, MN 56464	RTHEAST			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 10	2 565				
	R102 was not assist directed by the car	sted with ambulation as e plan					
	required assistance The care plan direc	evised 11/20/14, identified she e from one staff for ambulation cted staff to ambulate R102, ransfer belt, 100 feet twice					
	from 10/13/14, thro following: • From 10/13/14 ambulated 20 out o • From 11/1/14,	sing assistant] Walking forms ough 11/19/14, revealed the , through 10/31/14, R102 was of 38, or 53% of opportunities. through 11/19/14, R102 was of 38, or 42% of opportunities.					
	ambulation program 10/13/14, when PT	05 a.m. DON stated the NA m was initiated for R102 on was discontinued. DON not ambulated according to the	2				
		ap tray restraint was not pervised as directed by the care)				
	R72 was at risk for wheelchair to minir identified R72's lap directed staff to rer	ted 11/14, care plan indicated falls, with a tray table on his nize this risk. The care plan tray as a restraint and move the tray from the taff were feeding him.					
	11/17/14, from 5:30	of the evening meal on 0 p.m. to 6:25 p.m. nursing as observed feeding R72 his					

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2014	
		00678	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
REEN	PINE ACRES NURSIN	GHOME	N STREET NOF GA, MN 56464	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 11	2 565			
	observed with a full by bilateral Velcro s reach to independe R72 throughout the released the lap tra On 11/19/14, at 6:3 the director of nurs NA-E to remove R7 meal. R72's tray re meal. On 11/20/14, at 10: lap tray was not rer 11/17/14. She repo tray was to be remove On 11/20/14, at 10: (RN)-B stated it wa removed R72's lap directed by the care was to be released supervised setting. The facility's Physic 6/5/12, indicated th restraint was to pre	 8 p.m. during the supper mealing (DON) was heard to advise 72's wheelchair lap tray for the mained off throughout the 45 a.m. NA-E verified R72's noved on the evening of rted she was unaware his lap oved at meal time. 50 a.m. registered nurse s her expectation that staff tray while feeding him as e plan. RN-B stated a restraint whenever R72 was in a 				
	The director of nurs revise facility policie care plan implemento staff to address to	HOD OF CORRECTION: sing or designee could review/ es and procedures related to ntation and provide education he importance of following e plan. Resident care plans				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME	MAIN STREET NO AHGA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	quality assessment could establish a s	R CORRECTION:	e .nd			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			12/20/14
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	. A comprehensive plan of wed and revised by an am that includes the attendi- ered nurse with responsibili d other appropriate staff in mined by the resident's ne practicable, with the resident, the resident's leg nepresentative at least n seven days of the revision resident assessment requision subpart 3, item B.	ing ty eds, gal			
	by: Based on observat review, the facility f was revised to inclusite for 1 of 1 reside	ent is not met as evidence ion, interview and documer ailed to ensure the care pla ude the correct dialysis acc ent (R80) who received change in access sites.	nt an	Corrected		
	Findings include:					
		nimum Data Set dated R80 was cognitively intact				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00678	B. WING		11//	11/20/2014	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
REEN	PINE ACRES NURSIN	IG HOME	A, MN 56464	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 570	Continued From pa	age 13	2 570				
	was diagnosed with received dialysis, v connection betwee a dialysis treatmen service three times R80's Transfer/Dise	charge Report dated 6/18/14, arm dialysis access site had					
	have a left sided ch site. The access sit was covered with a	t dressing. At this time, R80 n fistula had clotted off and					
	(DON) stated the fi times and therefore	30 a.m. the director of nursing stulas had clotted off a few the chest port access site 3/14. The DON stated the care sed.					
	Policy indicated the	prehensive Resident Care Plan e care plan should be revised flect the resident's current care					
	The director of nurs revise policies and plan revision and p address the import when there has bee serviceas. Residen reviewed/ revised f	THOD OF CORRECTION: sing or designee could review/ procedures related to care rovide education to staff to ance of revising care plans en a change in the resident it care plans could be or compliance. The quality ssurance committee could					

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00678	B. WING	B. WING		20/2014
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME	MAIN STREET NO IAHGA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From pa	age 14	2 570			
	establish a system compliance.	to audit care plans to ensu	ıre			
	TIME PERIOD FO Twenty-one (21) da					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			12/20/14
	receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal supervision based on ad preferences as identified resident assessment and scribed in parts 4658.0400 ing home resident must be possible unless there is a the attending physician that ain in bed or the resident bed.	d in and e out			
	by: Based on observat review, the facility f planned interventio proactively address of 1 resident (R89) exhibiting behavior	ent is not met as evidence ion, interview and docume ailed to assess and establ ins to consistently manage is maladaptive behaviors fo with dementia and a histo is that irritated others, inclu- ning and invasion of persor	nt ish and r 1 ry of ding	Corrected		
	R89's quarterly Mir	nimum Data Set (MDS) dat diagnoses of dementia and				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED	
		00678	B. WING	B. WING		11/20/2014	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		20/2014	
	PINE ACRES NURSIN	427 MAI	N STREET NO				
	PINE ACRES NURSIN	MENAH	GA, MN 56464				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 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 slow The MDS also identified R89 exhibited verbal physical behaviors toward others. R89's care plan dated 7/2/14, identified increat confusion, poor eyesight and a hearing impairment. The plan directed the staff to complete accurate mood or behavior documentation and to monitor R89's whereab 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 stat to the type of activities that were most approp for him, in order to consistently manage and/c proactively address R89's behavior concerns. 		t s s				
	8/20/14, identified I worsening mental s directed toward bot residents. The beh but were not to be incident occurs." The specify, describe o	ssessment (CAA) dated he displayed behaviors, with status. The behaviors were th staff members and other aviors were to be monitored, care planned until "another he CAA failed to further r evaluate R89's behaviors.					
	through 10/24/14, r On 6/29/14, at touching an uniden inappropriately. R8 were to "continue to On 7/6/14, at 5 unidentified female	ogress notes from 6/29/14, revealed the following: 9:50 p.m. R89 was found tified female resident 9 was redirected and the staff o monitor this behavior." 5:26 p.m. R89 "got close" to an resident. The female resident we the area, but he then began					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00678	B. WING		11/20/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME	N STREET NO A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	the staff members inappropriately. R8 doing anything." • On 8/8/14, at 3 an altercation with resident stated R85 to fall. R89 denied didn't touch him." T checks for R89, wh every thirty minutes • On 9/3/14, at 3 R89 "forcefully" pus resident in a wheel intervened without • On 9/25/14, at "taunt" an unidentif hallway. The unider she was going to sl intervened to preven having a physical a • On 10/11/14, at R89 had been redir evening shift as he resident's face. The behavior caused th "uncomfortable." • On 10/24/14, at befave a physical at the laughed at the st Further review of th R89 had a pattern areas, making inap staff about female	16 p.m. the staff witnessed shing another unidentified chair. The staff members incident. 11:50 p.m. R89 was noted to ied female resident from the ntified female resident stated lap him. Staff members ent the two residents from				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00678	- B. WING	B. WING		11/20/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		20/2014	
		427 MAIN	STREET NOI				
GREENI	PINE ACRES NURSIN	IG HOME MENAHO	A, MN 56464				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 17	2 830				
	sporadic behaviors verbal abuse, socia and sexually inappr staff identified the t the clinical record c in sufficient detail to analysis of his mala potential environme behaviors. The door description of the re attempted and whe successful or unsur On 11/18/14, at 2:0 the nurse's station	5 p.m. R89 was observed by outside of the dining room.					
	assistive devices. H staff, peers and vis However, when R8 he wished to speak personal space lea asking questions. H be within a few inch	nbulate independently without He initiated conversations with itors without difficulty. 9 approached the person(s) to, he routinely invaded their ning toward the speaker and He was frequently observed to nes of the other person's face.					
	initiated a conversa within inches while attempt to threaten	0 p.m. R89 approached and ation with writer. He stood conversing, but did not or touch. Once R89 finished e area without incident.					
	confirmed R89 part within the facility. A R89 occasionally d example of his beh puzzle piece from a were working on. S redirected but woul	0 p.m. activity aide (AA)-A ticipated in activity programs A-A stated she was aware isplayed behaviors. An aviors included taking a single a puzzle that other residents the stated R89 was easily d occasionally make snide ing to return the puzzle piece.					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/20/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	PINE ACRES NURSIN	IC HOME 427 MAI	N STREET NO	RTHEAST		
	PINE ACRES NORSIN	MENAHO	GA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	dementia and was R89 displayed beh example of his beh ball (during a ball to residents, with mor residents were able	5 p.m. AA-B stated R89 had easily redirected. She stated aviors during activities. An naviors included throwing the oss activity) at the other re force than what the other e to manage. She stated R89 rior when directed by staff to do)			
	(RN)-C stated she	50 p.m. registered nurse was in charge during the was not aware of any				
	(NA)-K stated R89 residents' personal	00 p.m. nursing assistant frequently invaded other I space. She stated R89's space made whomever he el uncomfortable.				
	(LPN)-A stated R88 personal space of which he had touch inappropriately. LP	2 p.m. licensed practical nurse 9 frequently got into the others. He had incidents in ned both residents and staff N-A stated for this reason, R89 g checks every 30 minutes and needed.)			
	invaded the person described R89's be and indicated this k other resident unco	20 a.m. LPN-B stated R89 hal space of others. She ehaviors as "very intimidating" behavior not only made the omfortable, but put R89 at risk er residents. She stated she needed.				
		:00 p.m. the director of nurses 89's progress notes. She				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00678	B. WING		11/20/2014	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
REEN	PINE ACRES NURSIN	GHOME	STREET NOI A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	verified R89 display invading others' per irritate others for his inappropriately touc stated staff were to displayed inappropri- monitoring checks confirmed R89's be- specified, compreh- planned to ensure a consistently, in the manner. On 11/19/14, at 12: stated he was not a with R89's behavior time the CAAs were R89's behaviors to not necessitate car had since displayed those behaviors ha comprehensively as ensure all staff mer in the most appropri- A policy related to b care of persons wit was not provided. Suggested Method nursing or designed policy and procedur related to the care of The director of nurs	ige 19 yed behaviors such as rsonal space, attempting to s personal enjoyment and ching staff members. She redirect R89 when he riate behaviors and conduct every 30 minutes. She shaviors had not been clearly ensively assessed and care all staff members intervened most appropriate and effective 50 p.m. social worker (SW)-A aware of any type of pattern rs. SW-A reported that at the e completed, he understood be isolated incidents that did e planning. He confirmed R89 d a pattern of behaviors and d not been clearly specified, ssessed and care planned to mbers intervened consistently, riate and effective manner. behavioral interventions for the h dementia was requested, but of Correction: The director of e could review and revice res and provide staff education of a resident with dementia. sing or designee could develop ure appropriate dementia care				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/20/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	IG HOME	STREET NO			
(X4) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	TION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	age 20	2 830			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			12/20/1
	comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a ne the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speec	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the ss, and groom; ad ambulate;				
	by: Based on observat review, the facility f (R31 and R102) re- accordance with th Findings include:	ent is not met as evidenced ion, interview and document failed to ensure 2 of 3 residents ceived ambulation services in eir assessed needs.		Corrected		
		nimum Data Set (MDS) dated s cognition was intact. The				

STATE FORM

U84B11

If continuation sheet 21 of 38

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00678	B. WING		11/20/2014	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		11/2	.0/2014
		427 MAII	N STREET NO			
iREEN H	PINE ACRES NURSIN	IG HOME MENAHO	GA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 21	2 915			
	transfers and he re one staff to walk in identified R31 rece of motion training a Nursing Rehab not had diagnoses incl depression and spi rehab plan directed 200 feet with a from assistance from on plan dated 11/20/14 for ambulation, usin a caregiver followin care plan instructed ambulating to the c On 11/18/14, at 4:0 supposed to walk t times a day, I don't	d R31 was independent with equired extensive assistance of the corridor. The MDS ived restorative nursing, range and skill practice in walking. A e dated 10/2/14, indicated R31 uding osteoarthritis, inal stenosis. The nursing d R31 was to be ambulated, it wheeled walker and standby ie staff. R31's revised care 4, directed one staff assistance ing a front wheeled walker, with ng with his wheelchair. The d staff to assist R31 with lining room for all meals.				
	8:00 a.m. R31 prop to the dining room R31 propelled hims activity area. At 11: himself in his whee lunch. After lunch, wheelchair out of th observed to be am On 11/19/14, at 9:1	on 11/19/14, at approximately belled himself in his wheelchair for breakfast. After breakfast, self in his wheelchair to an 20 a.m., R31 again propelled lichair to the dining room for R31 propelled himself in his he dining room. R31 was not bulated to/ from meals. 5 a.m. nursing assistant				
	(NA)-C stated, "We R31]. If he walks, it	e do not walk him [referring to t is with therapy. You would now often he walks."				
		23 a.m. physical therapist (PT) s not to be ambulating on his				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/20/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
REEN F	PINE ACRES NURSIN		N STREET NOF GA, MN 56464	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 22	2 915			
	own. He is on a way therapy three to fiv a recommendation him to meals three recommendation] i PT continued, "My should be doing it [for walking to meal care plan." The PT there was no walke "It must still be in th On 11/19/14, at 9:3 (TMA)-A stated, "I ambulation program program. I have ne On 11/19/14, at 9:4 uses his wheelchat walked him to meal never ambulated F On 11/19/14, at 9:2 doesn't walk. He cat walk him. He would does not walk him. On 11/20/14, at 7:1 (RN)-D confirmed recommended amb have. RN-D stated staff provided amb directed. On 11/20/14 at 1:2 (DON) stated, "I ag	alking program. He walks with e times per week and I did put in for nursing to be walking times a day. It [the s in the communication book." expectation is that nursing [following the recommendation Is] and that it should be on his then checked R31's room and er in the room. The PT stated, herapy." 35 a.m. trained medication aide believe he [R31] is on an m. I would have to check his ever walked him." 44 a.m. NA-J stated, "He [R31] ir to get around. I have not als." NA-J verified she had R31. 28 a.m. NA-D stated, "He [R31] an transfer himself. We do not d walk with therapy, but nursing				
	R102's admission	MDS dated 9/29/14, revealed				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/20/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
REEN I	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	age 23	2 915			
	MDS also identified admission and requiransfers, locomotion R102's care plan re required assistance The care plan direct	g dementia and anxiety. The d R102 sustained falls prior to uired extensive assistance with on and ambulation in her room evised 11/20/14, identified she e from one staff for ambulation cted staff to ambulate R102, ransfer belt, 100 feet twice				
	through 11/19/14, r From 10/13/14 ambulated 20 out c From 11/1/14,	king forms from 10/13/14, revealed the following: , through 10/31/14, R102 was of 38, or 53% of opportunities. through 11/19/14, R102 was of 38, or 42% of opportunities.				
	ambulation program 10/13/14, when PT verified R102 was care plan. DON ad ambulating R102 a not taking credit for ambulating her to a	05 a.m. DON stated the NA m was initiated for R102 on was discontinued. DON not ambulated according to the ded she observed staff and wondered if the staff were r ambulating her, including and from the bathroom. DON had been working with the staff				
	not include ambula Walking form. NA-	2 a.m. NA-A confirmed she did tion for toileting on the NA A stated she documented "0" form, if/ when R102 did not) feet.	k			
	appropriate docum services was to be well as on therapy addition, the policy	ed Ambulation Policy indicated entation for ambulation on the resident's care plan as and/ or rehab flow sheets. In indicated residents were to services to increase or				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00678	B. WING		11/	11/20/2014	
PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
PINE ACRES NURSIN	IG HOME		-			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE	(X5) COMPLET DATE	
	-	2 915				
maintain their funct	ion.					
The director of nurs revise facility policie ambulation service staff to address the ambulation to resid service accurately. assurance committ	sing or designee could review/ es and procedures related to s and provide education to e importance of providing lents and documenting the The quality assessment and see could establish a system to					
		21426			12/20/14	
maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	hensive tuberculosis ogram according to the most s infection control guidelines of States Centers for Disease nation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance					
	PROVIDER OR SUPPLIER PINE ACRES NURSIN SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa maintain their funct SUGGESTED MET The director of nurs revise facility policid ambulation service staff to address the ambulation to resid service accurately. assurance committ audit ambulation re TIME PERIOD FOI Twenty-one (21) da MN St. Statute 144 Prevention And Co (a) A nursing home maintain a comprefine infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme (b) Written complia	OF CORRECTION IDENTIFICATION NUMBER: 00678 00678 PROVIDER OR SUPPLIER STREET AU PINE ACRES NURSING HOME 427 MAIN MENANCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00678 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S' PINE ACRES NURSING HOME 427 MAIN STREET NOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 24 2 915 maintain their function. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and provide education to staff to address the importance of providing ambulation services and provide education to staff to address the importance of providing ambulation records for compliance. 21426 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21426 (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 page and 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00678 B. WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 'NNE ACRES NURSING HOME 427 MAIN STREET NORTHEAST MENAHGA, MN 56464 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREPTX PROVIDER'S PLAN OF (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG Continued From page 24 2 915 Continued From page 24 2 915 maintain their function. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and provide education to staff to address the importance of providing ambulation services and provide education to staff to address the importance of providing ambulation resorders for compliance. 21426 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21426 MN St. Statute 144A.04 Subd. 4 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 plant ta covers all paid and unpaid employees, contractors, students, residents, and vounteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 11/ NOVDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 11/ INE ACRES NURSING HOME 427 MAIN STREET NORTHEAST MENAPICA, MN 56464 11/ SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH OPERCED TO THE APPROPRIATE DEFICIENCY) Continued From page 24 maintain their function. 2 915 CROSS REFERCED TO THE APPROPRIATE DEFICIENCY) 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 residents and documenting the service accurately. The quality assessment and assurance committee could establish a system to audit ambulation records for compliance. 21426 IIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21426 MN St. Statute 144A.04 Subd. 4 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 plath tat 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	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING		11/20/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY,	STATE, ZIP CODE	•	
GREEN F	PINE ACRES NURSIN	IG HOME	IN STREET N			
		MENAH	GA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET	
21426	Continued From pa	age 25	21426			
		ent is not met as evidenced				
	facility failed to ens residents (R69), re- symptom screening skin test (TST). In a ensure 1 of 5 new of (NA)-H] received T administration of the Findings include: R69 was admitted diagnoses including	to the facility on 5/31/14, with g end stage renal failure. The	,	Corrected		
	give R69 a two-ste living for second st comfort cares at er A progress note da admission) indicate a TB symptom scre to R69.	ted 6/10/14, (10 days after ed the nursing staff completed eening and administered a TS				
	indicated NA-H rec 10/24/14, with the s 11/13/14; however, evidence of a TB s On 11/20/14, at 1:3 (RN)-B stated all ne	10/24/14. The employee file evident the first-step TST on second-step administered on the employee file lacked ymptom screening for NA-H. 5 p.m. registered nurse ewly admitted residents were				
	have been a reason administered on ac On 11/20/14, at 1:5 (DON) stated all re symptom screening	ep TST. She stated there mus n for the TST not to be Imission for R69. 50 p.m. the director of nursing sidents were to receive a TB g upon admission. The n to either receive a TST or	t			
unesota D	have a chest x-ray newly admitted res	or blood test to ensure the ident did not have active TB. d his clinical record was				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/	20/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
GREEN I	PINE ACRES NURSIN	GHOME	I STREET NO A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
21426	reviewed for a Mini assessment on 6/1 involved with the M and administered th confirmed all emplo TB prior to adminis verified NA-H had r screening prior to th The undated Tuber Program directed th step TST following the first 24 hours of policy's Employee F were to receive a T a TST. SUGGESTED MET The director of nurs facility policies and address the importa monitoring for staff assessment and as establish a system to ensure complian	mum Data Set (MDS) 0/14. At that time, the nurse DS completed a TB screening ne TST. The DON also byees were to be screened for tration of the TSTs. She not received a symptomology ne administration of the TST. culosis Exposure Control ne staff to administer the first a symptom screening within f a resident's admission. The Protocol directed all employees B screening prior to receiving THOD OF CORRECTION: sing or designee could review provide education to staff to ance of tuberculosis and residents. The quality ssurance committee could to audit tuberculosis screening				
21530		0 A.B.C Drug Regimen Review en of each resident must be	21530			12/20/14
	reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedure Requirements in Lo the Department of Health Care Finance	onthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING		11/2	20/2014
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
REEN	PINE ACRES NURSIN	IG HOME	NSTREET NC A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	available through the system. It is not sue B. The pharma irregularities to the and the attending p must be acted upor physician visit, or se pharmacist. For pu- upon" means the ad- report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the med- the attending physic justification for the ophysician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter assessment and as by part 4658.0070. This MN Requirement by: Based on observation review, the facility for pharmacist reporter appropriately to the director of nursing to the director of nursing to the director of nursing to	nge 27 ne Minitex interlibrary loan abject to frequent change. acist must report any director of nursing services shysician, and these reports n by the time of the next coner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. Ing physician does not concur t's recommendation, or does the justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality asurance committee required If the attending physician is or, the consulting pharmacist er directly to the quality asurance committee.		Corrected	ΥΥ) 	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	JG HOME	N STREET NO GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 28	21530			
	Findings include:					
	psychotropic drug u received Seroquel, depression. The as displayed "behavio redirected as possi The assessment d behaviors R19 disp	sessment (CAA) for use dated 6/24/14, indicated he 25 mg for agitation and ssessment indicated R19 rs" and he was to be ible during periods of agitation. id not specify the type of blayed, nor did it direct the staf at were to be used for				
	confabulating storie the intent to deceiv and directed the st behaviors, encoura as needed. The ca specific behaviors	ted 6/24/14, identified he was es (fabricating stories without ve/ misinterpreted memories) aff to document his mood/ age activities and redirect him re plan did not describe R19's or provide direction for staff on edirect R19 when he exhibited				
	9/9/14, identified di intellectual disabilit revealed R19 had and depressed, bu	nimum Data Set (MDS) dated iagnoses including mild ies and depression. The MDS mood indicators of feeing down t did not display behavioral DS indicated R19 received cations daily.	ו			
	directed administra milligrams (mg) twi agitation and depre orders revealed R1	ician orders dated 10/3/14, ation of Seroquel, 12.5 ice daily, for the treatment of ession. Further review of the 19 had received Seroquel, 25 n 5/12/14, to 9/10/14.				
		ations of R19 were conducted I/17/14, from 4:00 p.m. to 8:00				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00678	B. WING		11/	20/2014
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		20/2011
BREEN I	PINE ACRES NURSIN	IG HOME	N STREET NOI	-		
		MENAHO	GA, MN 56464		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 29	21530			
	11/19/14, from 10:0 11/20/14, from 7:00 observations, R19 in his room, eat me and interact approp visitors. At no time maladaptive behav Review of the Beha 1/1/14- 9/1/14, indiv verbal aggression to occasions. During noted as being dire at the staff/ peer ar was his own boss a wished to do. At no indicated R19 was Review of R19's Be	avior Documentation from cated R19 had displayed towards others on eight each of the incidents, R19 was ected by others, when he yelled nd strongly informed them he and would do whatever he o time did the documentation not able to be redirected. ehavior Documentation from , revealed no maladaptive				
	Pharmacy Recommindicated R19 had mg twice a day for pharmacist noted a required an approp justification to indic was warranted. The recommended R19 6/17/14, the medicat twice daily. On 11/1 pharmacist again re to be reduced, but indication for the co	nendations dated 6/5/14, been started on Seroquel, 25 agitation and depression. The an antipsychotic medication oriate diagnosis or physician cate why use of the medication e pharmacy consultant 0's Seroquel be reduced. On ation was reduced to 12.5 mg, 13/14, the consultant ecommended the medication did not request an appropriate ontinued use of Seroquel. :20 a.m. registered nurse				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING			00/0014
						20/2014
	PROVIDER OR SUPPLIER	427 MAII	DDRESS, CITY, ST N STREET NOI			
GREEN	PINE ACRES NURSIN	IG HOME	GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 30	21530			
		did not have a diagnosis to an antipsychotic medication.				
	(DON) stated R19 toward other reside not have a diagnos Seroquel and confi direct staff on effect	40 a.m. the director of nurses displayed verbal aggression ents. She confirmed R19 did sis for the continued use of rmed the care plan did not stive interventions to implemen of verbal aggression.	t			
	(LPN)-B stated R19 verbally aggressive	0 p.m. licensed practical nurse 9 had a history of being 9 with others but he did not 10 type of maladaptive	•			
	pharmacist was int confirmed R19 did justification for the added, since R19 c recommended the consultant pharma reducing the medic documented clinica	50 p.m. the consultant erviewed via telephone. He not have appropriate continued use of Seroquel. He did not have a diagnosis, he medication be reduced. The cist reported the physician was cation, so he did not request al justification. He stated the Seroquel to be discontinued.				
	the staff to monitor of maladaptive beh appropriate interve the staff to ensure antipsychotic media	vior Monitoring policy directed the behaviors and frequency aviors and determine ntions. The policy did not direc all residents receiving cations to have appropriate ontinued use of the medication				
	2/97, directed the p resident's chart on	nacy Consultant policy dated pharmacist to review each a monthly basis and report DON. The policy did not direct				

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	STREET NOI A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 31	21530			
	who received antipa	ultant to ensure all residents sychotic medications had a ons prior to the initiation of the				
	The director of nurs pharmacist and me regulations related Facility policies and reviewed/ revised a re-education provid requirements for th Resident medicatio for compliance with quality assessment	ed to pertinent staff on e use of antipsychotics. n regimens could be reviewed these requirements. The and assurance committee ystem to audit drug regimens				
21535	TIME PERIOD FOF Twenty-one (21) da		21535			12/20/14
	Drug Usage; Genera Subpart 1. Genera must be free from u unnecessary drug i A. in excessive therapy; B. for excessiv C. without adea D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th	ral al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 32	21535			
	Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th	Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observat review, the facility f indications were pr Seroquel (an antips	ient is not met as evidenced ion, interview and document failed to ensure adequate esent to warrant the use of sychotic medication), for 1 of receiving antipsychotic		Corrected		
	Findings include:					
	psychotropic drug u received Seroquel, depression. The as displayed "behavio redirected as poss The assessment d behaviors R19 disp	sessment (CAA) for use dated 6/24/14, indicated he 25 mg for agitation and sessment indicated R19 rs" and he was to be ible during periods of agitation. id not specify the type of played, nor did it direct the staff at were to be used for				
	confabulating storie the intent to deceiv and directed the st behaviors, encoura as needed. The ca	ted 6/24/14, identified he was es (fabricating stories without re/ misinterpreted memories) aff to document his mood/ age activities and redirect him are plan did not describe R19's or provide direction for staff on				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING		11/	20/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ODEEN		427 MAIN	STREET NOP	RTHEAST		
GREEN	PINE ACRES NURSIN	MENAHG	A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	ige 33	21535			
	how to effectively rebehaviors.	edirect him when he exhibited				
	9/9/14, identified di intellectual disabiliti revealed R19 had r and depressed, but	imum Data Set (MDS) dated agnoses including mild ies and depression. The MDS nood indicators of feeing down t did not display behavioral DS indicated R19 received cations daily.				
	directed administra milligrams (mg) twi agitation and depre orders revealed R1	tician orders dated 10/3/14, tion of Seroquel, 12.5 ce daily, for the treatment of ession. Further review of the 9 had received Seroquel, 25 5/12/14, to 9/10/14.				
	on the following: 1 p.m.; 11/18/14, from 11/19/14, from 10:0 11/20/14, from 7:00 observations, R19 in his room, eat me and interact approp	ations of R19 were conducted 1/17/14, from 4:00 p.m. to 8:00 n 8:00 a.m. to 4:30 p.m.; 00 a.m. to 6:30 p.m., and; 0 a.m. to 2:00 p.m. During was noted to watch television eals in the main dining room, oriately with staff, peers and was R19 observed to display iors.				
	1/1/14- 9/1/14, india aggression towards During each of the being directed by o staff/ peer and stro own boss and woul do. At no time did R19 was not redire	ehavior Documentation from cated he displayed verbal s others on eight occasions. incidents, R19 was noted as thers, when he yelled at the ngly informed them he was his d do whatever he wished to the documentation indicated ctable. Review of R19's tation from 9/1/14, to 11/20/14,				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00678	B. WING		11/	20/2014
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
REEN I	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 56464			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 34	21535			
	displayed.					
	indicated R19 was twice a day for agits pharmacist noted a required an approp justification to indic was warranted. Th recommended R19 6/17/14, the medica twice daily. On 11/ pharmacist again re to be reduced, but	nendations dated 6/5/14, started on Seroquel, 25 mg ation and depression. The in antipsychotic medication riate diagnosis or physician ate why use of the medication be pharmacy consultant 0's Seroquel be reduced. On ation was reduced to 12.5 mg, 13/14, the consultant ecommended the medication did not request an appropriate ontinued use of Seroquel.				
	(RN)-D stated R19 towards others and R19 was easily red She confirmed R19	20 a.m. registered nurse displayed verbal outbursts made up stories. She stated irected if he was left alone. did not have a diagnosis to an antipsychotic medication.				
	(DON) stated R19 (toward other reside not have a diagnos Seroquel and confi direct staff on effect	40 a.m. the director of nurses displayed verbal aggression ents. She confirmed R19 did is for the continued use of rmed the care plan did not tive interventions to implemen d verbal aggression.	t			
	(LPN)-B stated R19 verbally aggressive	0 p.m. licensed practical nurse 9 had a history of being 9 with others but he did not 19 type of maladaptive				
	the staff to monitor	vior Monitoring policy directed the behaviors and frequency aviors and determine				

Minneso	ota Department of He	alth				1 APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		11/	20/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	N STREET NO 3A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	appropriate interver direct the staff to er antipsychotic medic diagnosis for the co SUGGESTED MET The director of nurs pharmacist and me regulations related Facility policies and reviewed/ revised a re-education provid requirements for th Resident medicatio for compliance with quality assessment	Antions. The policy did not asure all residents receiving cations had appropriate ontinued use of the medication THOD OF CORRECTION: sing could meet with the dical director to review the to antipsychotic medications. I procedures could be s appropriate, with ed to pertinent staff on e use of antipsychotics. In regimens could be reviewed these requirements. The and assurance committee restem to audit drug regimens ce.				
21990	Maltreatment of Vu Subd. 4. Reportin immediately make entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify the caregiver, the nature maltreatment, any of maltreatment, the r reporter, the time, of incident, and any of	.557 Subd. 4 Reporting -	21990			12/20/14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00678	B. WING		11/2	20/2014
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
BEEN I	PINE ACRES NURSIN	IG HOME	N STREET N			
		MENAHO	GA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From pa	age 36	21990			
	reporter may disclo in section 13.02, ar	treatment. A mandated ose not public data, as defined and medical records under the extent necessary to bdivision.				
	by: Based on interview facility failed to imn potential abuse/ ne	ent is not met as evidenced and document review, the nediately report allegations of eglect to the state agency (SA), (R89 and R8) reviewed with t altercations.	,	Corrected		
	Findings include:					
	dated 6/29/14, india with dementia) was resident with deme report indicated R8	nt-to-resident abuse report cated R89 (a male resident s found touching R8 (a female entia) inappropriately. The 89 rubbed his hands over R8's ation of sexual abuse was on 6/30/14.				
		40 a.m. the director of nursing he SA was not immediately gation.				
	dated 12/28/11, ins administrator and S allegations of abus	ty's Neglect/ Abuse Policy structed staff to notify the SA of any suspected e or neglect immediately. The nediately' as "within 24 hours."	,			
	nursing (DON) cou to ensure the abus implemented as wr	l of Correction: The director of Id work with the administrator e prohibiton policy was ritten to meet Federal then could educate staff. The				

(EACH DEFICIENCY REGULATORY OR L ontinued From pa DN or designee c sure reports to th heframes.	IG HOME 427 MAIN MENAHG ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING	TATE, ZIP CODE RTHEAST	11/20/2014 (X5) COMPLE DATE
E ACRES NURSIN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI ontinued From pa DN or designee c sure reports to the heframes.	STREET AD 427 MAIN MENAHG MENAHG MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 37 could also perform audits to the SA occurred in the requried	DRESS, CITY, S STREET NO A, MN 56464 ID PREFIX TAG	BTATE, ZIP CODE PRTHEAST PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLE
E ACRES NURSIN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI ontinued From pa DN or designee c sure reports to the heframes.	AG HOME 427 MAIN MENAHG ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 37 could also perform audits to ne SA occurred in the requried	STREET NO A, MN 56464 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa DN or designee c sure reports to th heframes.	MENAHG ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 37 could also perform audits to the SA occurred in the requried	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
(EACH DEFICIENCY REGULATORY OR L ontinued From pa DN or designee c sure reports to the heframes.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 37 could also perform audits to be SA occurred in the requried	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
DN or designee c sure reports to th neframes. ne Period for Con	could also perform audits to the SA occurred in the requried	21990		
sure reports to the frames. ne Period for Col	ne SA occurred in the requried			
	rrection: Twenty-one (21)			
t	ment of Health	ment of Health		ment of Health