DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COM						ID: UVMU Facility ID: 00474
1. MEDICARE/MEDICAID PROVIDER 1 (L1) 245402 2.STATE VENDOR OR MEDICAID NO. (L2) 938342500	NO.	3. NAME AND ADD (L3) GLENW (L4) 719 SOU (L5) GLENW	OOD VILLA THEAST 2N	GE CA	EET (L6)	R 56334	 TYPE OF ACT Initial Termination Validation On-Site Visit 	TION: <u>7</u> 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey At	fter Complaint
6. DATE OF SURVEY 1/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2014 (L34) (L10)	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 EN 09/30	DING DATE: (L35)
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	64 (L18) 64 (L17)	X B. Not in Com	ce With equirements	/aivers:	2. Techi 3. 24 H	nical Personnel our RN y RN (Rural SNF)	Following Requiremen 6. Scope of 7. Medical 8. Patient R 9. Beds/Ro (L12)	^r Services Limit Director Room Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY ME		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)			oor (j) (1).		
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY AP	PROVAL	Date:
Sarah Grebenc, U	1	Dr BE COMPLETE	1/17/2014	(L19)			rcement Spec	<u>ialist</u> 3/14/2014 (L20)
19. DETERMINATION OF ELIGIBILIT _X1. Facility is Eligible to Pa 2. Facility is not Eligible	Y	20. COM	IPLIANCE WITH CI		21. 1. S 2. O	tatement of Financi	al Solvency (HCFA-257 nterest Disclosure Stmt (
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINAT	ION ACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	DATE	ENDING DATE		VOLUNTARY 01-Merger, Closur		05-Fai	LUNTARY l to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involum			il to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV A. Suspension				04-Other Reason fo			ovider Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)				00-Ac	tive
		•	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	Poste	d 3/31/20	014 ML	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	Е				
	(L32)	02/12/2014		(L33)	DETERMINA	TION APPRO	VAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

STATE AGENCY REMARKS

ID: UVMU Facility ID: 00474

C&T REMARKS - CMS 1539 FORM

Page 2 Provider Number: 24-5402 Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page. Effective January 7, 2014, the facility is certified for 64 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245402

March 14, 2014

Ms. Mary Krueger, Administrator Glenwood Village Care Center 719 Southeast 2nd Street Glenwood, Minnesota 56334

Dear Ms. Krueger:

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

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

Effective January 7, 2014, the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Inston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 10, 2014

Ms. Mary Krueger, Administrator Glenwood Village Care Center 719 Southeast 2nd Street Glenwood, MN 56334

RE: Project Number s542024

Dear Ms. Krueger:

On December 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, effective January 17, 2014 and therefore remedies outlined in our letter to you dated December 18, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K0067 at the time of the December 5, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Feel free to contact me if you have questions.

Sincerely,

Santo Drebenc

Sarah Grebenc, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure cc: Licensing and Certification File Department of Health and Human Services Centers for Medicare & Medicaid Services

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 245402	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/17/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
Gl	ENWOOD VILLAGE CARE CENTE	R	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	Г

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	F0156		Correction Completed 01/17/2014	ID Prefix	F0282		Correction Completed 01/17/2014		ID Prefix	F0318		Correction Completed 01/17/2014
Reg. # LSC	483.10(b)(5)	- (10), 483.	10(k	Reg. # LSC	483.20(k)(3)(ii)					483.25(e)(2)		
ID Prefix Reg. # LSC	F0356 483.30(e)		Correction Completed 01/17/2014	ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)		Correction Completed 01/17/2014		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC	-			Reg. #								
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	су	Reviewed / 0ට් Reviewed	<i>د</i> ک	Date: 2//0// Date:	Signature o イ ノクラレン Signature o	-					Date: 2//0 Date:	9/14
Followup t	o Survey Co 12/5	mpleted on /2013	:		Check for any L Uncorrected						YES	NO

DEPARTMENT OF HEALTH A	ND HUMAN SE	RVICES			CENTERS FOI	R MEDICARE & MEDICAID SERVICES
	MED	ICARE/MEDICA	AID CERTIFIC	ATION A	AND TRANSMITTAL	ID: UVMU
	PART	I - TO BE COM	PLETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00474
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245402).		OOD VILLAO	GE CAR		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 938342500		(L4) 719 SOUT (L5) GLENW() STREE	^(L6) 5633	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 12/04 8. ACCREDITATION STATUS:	5/2013 (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 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:		
From (a):		A. In Compliar	nce With		And/Or Approved Waivers Of T	The Following Requirements:
To (b) :		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	64 (L18)	-	Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	64 ^(L17)		pliance with Program ents and/or Applied		* Code: B5 *	9. Beds/Room (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)
64						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE	SHOW LTC CANCEL	LATION DATE):			
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Christine Bodick-Nor	d, HFE NE	II	01/06/2014	(L19)	Kate JohnsTon, En	forcement Specialist 02/03/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	L OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C HTS ACT:	CIVIL		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
 Facility is Eligible to Partic 	cipate	Kiti	ins Act.		3. Both of the Above	
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ		00 <u>INVOLUNTARY</u>
12/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimbursen	05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	
25. LTC EXTENSION DATE:	27. ALTERNATIV				04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
	A. Suspension of	of Admissions:	(L44)			00-Active
(L27)	B. Rescind Sus	pension Date:	(211)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DA	ATE		

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUM	IAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES				
	MEDICARE/MEDICAID CERTIFICATION AND TRANS	SMITTAL	ID: UVMU			
	PART I - TO BE COMPLETED BY THE STATE SURVEY	AGENCY	Facility ID: 00474			
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS					

CCN-245402

-

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7012 3050 0001 9094 7109

December 18, 2013

Ms. Mary Krueger, Administrator Glenwood Village Care Center 719 Southeast 2nd Street Glenwood, Minnesota 56334

RE: Project Number S5402024

Dear Ms. Krueger:

On December 5, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301

Telephone: (320) 223-7365 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
 - Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Glenwood Village Care Center December 18, 2013 Page 4

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 5, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Glenwood Village Care Center December 18, 2013 Page 5

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

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

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

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

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

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

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Ane Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		DISTRUCTION DEC 3 1 2013		E SURVEY
		245402	B. WING _			12	05/2013
AME OF F	PROVIDER OR SUPPLIER	I		STREE	MN Dept of Health	1 100	00/2010
		OFNITED			OUTHEAST 2ND STREET		
	OOD VILLAGE CARE	CENTER		GLEN	NWOOD, MN 56334		
(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) COMPLETI DATE
F 000	INITIAL COMMEN	ſS , ·	F 00	00			
	WILL SERVE AS Y COMPLIANCE UPO ACCEPTANCE. YC				F: 156		
F 156 SS=E	ONSITE REVISIT C CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re- any amendments to writing. The facility must inf entitled to Medicaid of admission to the resident becomes e- items and services facility services und	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in the nursing facility or, when the eligible for Medicaid of the that are included in nursing er the State plan and for may not be charged; those	F 15	56	It is the policy of the Glenwood Village Care Center to inform residents both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay at the facility. is also the policy of the Glenwood Village Care Center to provide the resident with the proper liability required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services informing them of their rights to appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services.	lt ,	
JRATORY		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	1	TITLE	a	(X6) DATE
Y.	Mary Kine			Ú	dministratov nay be excused from correcting providing		1-13

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245402	B. WING	· · · · · · · · · · · · · · · · · · ·	12/05/2013
AME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET	
LENWO	DOD VILLAGE CARE	CENTER		GLENWOOD, MN 56334	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
F 156	Continued From pa		F 15	6	
1 100	•	vices that the facility offers		Policy will be updated to	
	and for which the re	esident may be charged, and		include guidance as to the	•
		ges for those services; and nt when changes are made to		timing of the denial letter bei	ng ·
	the items and servi	ces specified in paragraphs (5)		issued and to include a denial	
	(i)(A) and (B) of this	s section.		letter be issued when a reside	nt
	at the time of admis the resident's stay, facility and of charg including any charg	form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate.		is discharged to home. Education will be provided to the MDS coordinator and RN clinical managers on updated	
	The facility must fu legal rights which ir A description of the	rnish a written description of		policy by 1/7/14. Audits will be done on all den letters issued x 2 months.	ial
	for establishing elig the right to request 1924(c) which dete	requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's		Audits will be brought to the quality assurance for compliance and review.	
	spouse an equitabl cannot be consider	ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's		Responsible Person: Director Nursing	of
	medical care in his down to Medicaid e	or her process of spending eligibility levels.		Completion Date: 1/7/2014	
	numbers of all pert groups such as the agency, the State I ombudsman progra advocacy network,	s, addresses, and telephone inent State client advocacy State survey and certification icensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a			

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		AND HUMAN SERVICES			· · ·	FORM	: 12/18/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245402	B. WING	G		· 12/	05/2013
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO	OOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	· ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 156	agency concerning misappropriation of facility, and non-cor directives requiremed The facility must inf name, specialty, an physician responsib The facility must pro- written information, applicants for admis information about h Medicare and Medic receive refunds for such benefits. This REQUIREMEN by: Based on interview facility failed to ensu- R27, R21, R31) rev received the require Non-Coverage Cen- Medicaid Services (them of their rights review of their Medi- to discontinuation of Finding include: R15 did not receive prior to the end of sl R15 was admitted to	State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance ents. orm each resident of the d way of contacting the ble for his or her care. ominently display in the facility and provide to residents and asion oral and written ow to apply for and use caid benefits, and how to previous payments covered by IT is not met as evidenced and document review, the ure 4 of 5 residents (R15, iewed for liability notices, ed Notice of Medicare ters for Medicare and CMS) Form 10123, informing to an appeal and expedited care coverage, 48 hours prior f skilled services. the required 48 hour notice killed services.	F	156			
		abilitation procedures.			ility ID: 00474 If continua	,	Page 3 of 31

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/18/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245402	B. WING			12/	05/2013
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE 19 SOUTHEAST 2ND STREET		
GLENWO	DOD VILLAGE CARE	CENTER			GLENWOOD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 156	Continued From pa	ge 3	F '	156			
	services occupatior therapy (PT) wound notice was signed b hours before the er	CMS Form 10123 for skilled hal therapy (OT) and physical care ending 11/21/13. The by the resident on 11/20/13, 24 id of skilled services. The to home on 11/22/13, per the ress notes.		··· ·			
• •	R27 was not provid to the end of skilled	ed with 48 hours notice prior services.					
	skilled coverage en notice on 11/16/13, coverage. R27 disc	0123 indicated a date of ding 11/15/13. R27 signed the after the ending of skilled charged from the facility on ursing progress notes.	•				
	registered nurse (R a two day notice wh ending. When ask incidences with R2	on 12/4/13, at 1:15 p.m. N)-A stated she gives at least nen Medicare services are ed about the specific 7 and R15, she indicated the					• .
	there was not a two had found out late t end. RN-A confirm issued 48 hours pri	"Isolated incidents," in which b-day notice provided, as she hat therapies were going to ed the denial letters were not or to the end of skilled ther stated the denial letters					
		sing secretary (NS)-M in the					•
		e an CMS Form 10123 48 ntinuation of skilled services.		,			
		o the facility on a skilled stay R21 discharged from the					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: UVMU	<u> </u> 1	Fa	ility ID: 00474 If conti	nuation shee	t Page 4 of 31

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				TE SURVEY MPLETED
		245402	B. WING	;		12	/05/2013
AME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP COD	Ξ	
LENWO	OOD VILLAGE CARE	CENTER			SOUTHEAST 2ND STREET ENWOOD, MN 56334		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 156		ge 4 I an CMS form 10123 48 ntinuation of skilled services.	F	156			
	R31 was admitted t beginning 10/17/13 facility on 10/25/13.	o the facility on a skilled stay . R31 discharged from the					
	When interviewed of stated a CMS Form to R21 or R31 at all discharged directly						· .
	RN-A stated she the need the letter if the stated she goes by policy for when to is thought R31 and R	on 12/5/13, at 11:19 a.m. ought the residents did not ey were going home. RN-A a spreadsheet with the facility ssue the denial letters. She 21 discharged to home as they their therapy services.					
	Notices Initiative] N [skilled nursing faci residents going hor skilled services sho notice, Centers for -Services (CMS) Fo guidance as to the issued and if the fa	policy entitled BNI [Beneficiary on-Coverage Notices for SNF lity] Residents, included ne after the end of Medicare buld be issued the generic Medicare and Medicaid rm 10123. The policy lacked timing of the denial letter being cility needed to provide the discharged to home.			•		
F 282 SS=E	483.20(k)(3)(ii) SEI PERSONS/PER C/ The services provided b	RVICES BY QUALIFIED	F	282		,	

ATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
id plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		IPLETED
		245402	B. WING		12	/05/2013
IAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENW	OOD VILLAGE CARE	CENTER		719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From p	age 5	F 2	82		
		NT is not met as evidenced		F:282		
	by: Based on observa review, the facility nursing programs directed by the car	ation, interview, and document failed to ensure restorative were being provided as re plan for 4 of 4 residents nd R35), reviewed for		It is the policy of the Glenwo Village Care Center that services provided or arrange	d	
	Findings include:	programs.		must be provided by qualifie persons in accordance with each resident's written plan care.		
	frequency, or of ea directed. R17's care plan, da the restorative plan When interviewed	e range of motion services in ach body area as the care plan ated 10/9/13, indicated to see n for the restorative program. on 12/4/13, at 11:00 a.m. RN)-B stated the restorative		R17 Referral was made to and OT to assess ROM ir extremities, trunk and neck further recommendati Recommendations from PT OT will be followed.	i all for ons.	
;	care plan is the Re Intervention, in the access this to do t computer, and the are included.	estorative Nursing Assistant electronic record. The aides heir documentation on the directions for each resident		R66 referral was made to and OT for recommendat for ROM to all extremi Recommendations from PT	ions ties.	
	in the electronic re October, November directed staff to ap shoulders for 15 m PROM to both upp shoulder flexion ar times a week. No	Nursing Assistant Intervention, cord, for the months of er, and December 2013, uply hot backs to neck and ninutes prior to ROM, and ber and lower extremities, nd abduction to 90 degrees, six directions were given for ons or specific joints for ROM.		OT will be followed. R12 referral was made to and OT for recommendat for ROM to all extremi Recommendations from PT OT will be followed.	ions ties.	

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DEPARTMENT OF HEALTH				FORM	: 12/18/2013 TAPPROVED
CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	1	IPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY MPLETED
	245402	B. WING		12/	/05/2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
rock-n-go wheel cl wedge pillows on ther head and shoul assistant (NA)-B h R17's neck. This w Then NA-B attemp R17's neck only m was stiff. NA-B the shoulder, less than 10 times. No further (active assist ROM) When interviewed stated this is how s ROM. She had ne elbows, wrists, har extremities. A phy her how to perform started recently. N directions on the e assist with ROM o what all joints to per When interviewed stated she was in o nursing programs. ROM as directed in physical therapy at on how to perform knew they were ha each unit manager programs were be taken further action program was being	room. She was seated in a hair, leaning to the left, had he left side of the chair, and ilders were forward. Nursing ad applied a warm blanket to was left in place for 15 minutes. ted PROM to R17's neck, oved slightly, NA-B stated she en lifted R17's arms up, at the 0.45 degrees and repeated this er ROM, PROM, or AAROM I) had been performed. on 12/4/13, at 9:55 a.m. NA-B she normally assists R17 with over performed ROM on R17's hds, fingers, or lower sical therapy aide had shown n ROM for R17 when she IA-B was not aware the lectronic record instructed to n R17's lower extremities, or erform ROM on. on 12/4/13, at 2:00 p.m. RN-B charge of the restorative R17 should have received n the electronic record. The de (PTA) educates new staff ROM for each resident. RN-B wing difficulty, and had directed to ensure restorative ing accomplished. She had not n to ensure each residents g provided as ordered.	F 28	 R35 referral was made to F and OT for recommendation for restorative program Recommendations from PT an OT will be followed. All other residents who an currently receiving a nursim restorative program will be reassessed by RN clinical manager and referred to PT an OT as needed. Restorative nursing program policy was reviewed an updated. Audits will be conducted weeklex 3 weeks on all residents while receive a ROM program that ROM has been completed a planned. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director of Nursing Completion Date: 1/7/2014 	or n. id re al d d n d y o n t s e or	

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BYATE MARKING OF DEPICIENCIES AND PLAN IF OF CONTRECTION AND PLAN IF OF CONTRECTION A BUILDING CP3 MULTIFIE CONSTRUCTION A BUILDING CP3 MULTIFIE CONSTRUCTION CROSS REFERENCE TO THE ATHORNOUS AND THE PERCEDEND TAG CP3 MULTIFIE CONSTRUCTION CROSS REFERENCE TO THE ATHORNOUS AND THE PERCEDEND TAG CP3 MULTIFIE CONSTRUCTION CROSS REFERENCE TO THE ATHORNOUS AND THE PERCEDENT ACTION BROUD BE CROSS REFERENCE TO THE ATHORNOUS AND THE PERCEDENT TAG CP3 MULTIFIE CONSTRUCTION TAG CP3 MULTIFIE CON			AND HUMAN SERVICES				FORM	: 12/18/2013 APPROVED . 0938-0391
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE TY 3 SUTHARY STATEMENT OF DEFICIENCES CACH DEPICINGN WUST BE PRECEDED BY FULL (EACH DEPICINGN WUST BE PRECED BY FULL (EACH DEPICINGN WUST BE PRECED BY FULL (EACH DEPICINGN WUST BE PRECED BY FULL (EACH DEPICING WUST BE PRECED BY FULL (EACH DEPICING WUST BY PRECED BY FULL (EACH DEPICED TO THE APPROPRIATE (EACH DEPICING WUST BY PRECED BY FULL (EACH DEPICED TO THE APPROPRIATE (EACH DEPICED	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
Tri 9 SOUTHEAST 2ND STREET GLENWOOD, WILLAGE CARE CENTER CMUD PREFIX TAG Image: Colspan="2">SUMMARY STATEMENT OF DEFICIENCIES (READ ADDRY OR LS DENTIFYING INFORMATION) F282 Continued From page 7 F282 F282 Continued From page 7 F282 R66's care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care. F282 R66's electronic Restorative Nursing Care plan for October, November, and December 2013, directed staff: Sated exercises, gente AAPROM to knees 10 and ankles 10 times as tolerated. Gentue stretching to both heel chords and hamstrings, hold 30 seconds, repeat livice. Staff was directed to do this six times a week. R66's restorative nursing program was documented as being completed only four times in October 2013, 11 times in November 2013, and had not been completed in December as of December 5, 2013. When interviewed on 12/4/13, at 2:16 p.m. NA-B state shee nables to complete R66's restorative nursing program. She will do ROM on upper and lower extremilies, but has never done upper and lower extremilies, but has never done the hamstring or heel cord stretches. The ROM has to be done in bed, and she doesn't always catch. R66 in sedon ta 12/5/13, at 10:10 a.m. NA-D stated if the restorative as day orifi, the bat ald will usually do the restorative nursing programs. When interviewed on 12/5/13, at 10:10 a.m. NA-D stated if the restorative adde has a day off, the bat ald ewill usually do the restorative nursing programs. When interviewed on 12/5/13, at 10:17 a.m. NA-D stated if the adsormetimes			245402	B. WING	i		12/	/05/2013
GLENWOOD VILLAGE CARE CENTER GLENWOOD, MN 56334 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PREVIDENCIES I) (FROM DEFICIENCY MIST BE PREVIDEND BY DILL REGULATORY OR USC DENTIFYING INFORMATION) ID PREVIDENCIES ACTION SHOULD BE CROSSREFFERENCES TO THE APPROPRIATE DEFICIENCY Continued From should be crossreferences action should be crossreferences action of the APPROPRIATE DEFICIENCY Continued From page 7 F 282 F 282 Continued From page 7 F 282 F 282 R66's care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care. F 282 R66's electronic Restorative Nursing Care plan for October, November 2013, directed staff: Seated exercises, gentle APPROM to knees 10 and ankles 10 times as tolerated. Gentle stretching to both heel chords and harmstrings, hold 30 seconds, repeat twice. Staff was directed to 60 this six times a week. F R66's restorative nursing program was documented as being completed only four times in October 2013, 11 times in November 2013, and had not been completed in December, as of December 6, 2013. When interviewed on 12/4/13, at 215 p.m. NA-B stated she was not has never done the harmstring or heel cord stretches. The ROM has to be doe in order to do it. She had not been able to do any ROM for R66 this month so far. When interviewed on 12/5/13, at 10:10 a.m. NA-D stated if the restorative aide has a day off, the bat aid will usually do the restorative nursing programs. When interviewed on 12/5/13, at 10:17 a.m. NA-D stated is in a bath aide and sormetimes Her Nather State APPROFE <	NAME OF F	PROVIDER OR SUPPLIER						
Methods reactive nursing program. She ville PREFix TAG (texth considering active action should be considered as the program. She villed as the program. She villed as the program. She villed and the restorative care plan dated 7/3/13, indicated the restorative care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care. F 282 Continued From page 7 F 282 R66's care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care. F 282	GLENWO	OOD VILLAGE CARE	CENTER			•		
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NA-D stated she is a bath aide and sometimes		NA-D stated if the r the bath aide will us nursing program fo assistants working could do it. She ha	restorative aide has a day off, sually do the restorative r residents, or the nursing with the resident that day and never assisted either R17 or	×				
		When interviewed NA-D stated she is	on 12/5/13, at 10:17 a.m. a bath aide and sometimes					

		AND HUMAN SERVICES & MEDICAID SERVICES				FO	RM	12/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3)	DATE	E SURVEY PLETED
•	· ·	245402	B. WING	i			12/0	5/2013
	PROVIDER OR SUPPLIER	CENTER	,	7	STREET ADDRESS, CITY, STATE, ZIP COD 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	Ε.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
F 282	if there is no restoration is the residents who	ge 8 restorative nursing programs, ative aide that day. She had a o she would assist with their r, R17 and R66 were not on	F 2	282	2	· · · ·		
	When interviewed of verified the restorat completed as direc changed from assis	on 12/4/13, at 2:00 p.m. RN-B live program had not been ted for R66. R66 was recently at of two to transfer to a full ecline in ability to transfer.						
	director of nursing (nursing programs v correctly or in the fr R66. It could be be assistant is new. S to be completed as	on 12/5/13, at 9:15 a.m. the (DON) verified restorative vere not being completed requency ordered for R17 and ecause the restorative nursing the would expect the programs directed. If the restorative he proper way to do assist with						
	the restorative prog charge nurse.	rams, she should ask the						
	R12 did not receive directed by the care	e range of motion services as e plan.						
	restorative plan of	ted 6/13/13, indicated a care for range of motion er to the restorative plan.						
	for , November and staff to perform PR include hip abduction	Care Intervention/Task sheets, I December 2013, instructed OM to the lower extremities to on, knee extensions and tretches, 10-15 repetitions						
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: UVMU	11	Fa	facility ID: 00474 If co	ontinuation s	sheet	Page 9 of 31

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		AND HUMAN SERVICES				FORM	: 12/18/2013 I APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
	· .	245402	B. WING	≩		12	/05/2013
NAME OF I	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
		OFNITED		17	719 SOUTHEAST 2ND STREET		
GLENW	OOD VILLAGE CARE	CENTER		(GLENWOOD, MN 56334		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000		•		000			
F 282	Continued From pa			282	<u>,</u>		
	(reps) five times pe extremities 10 reps	r week. PROM to the upper to shoulders, elbows, wrists					
	and fingers as toler	ated and passive range of					
	motion to the neck,	side to side stretches for 10			· ·		
	reps and flexion/ex	tension to neck for 10 reps.					
	had restorative nur	Task sheet's showed R12 only sing twice between 11/23/13					
,	12/5/13.	not at all between 12/1/13 and					
	stated the normal p	on 12/5/13, at 9:09 a.m. NA-C procedure for restorative there is usually a restorative				;	
	aide that completed was the restorative responsibility was a	d the exercises, however, this aide's usual day off and the assumed by the aides working					
	on the unit.						,
	R12's ROM progra	m was observed with R12 lying at 9:31 a.m. NA-C began					
	range of motion se	rvices with the R12's fingers tremity, completing five reps					
	each of finger exte	nsion, wrist flexion, elbow on and shoulder abduction and					
		nstructed R12 to loosen and					
	relax the joints as s	she completed the range of					
	motion activities. N	NA-C proceeded to move to the			· · ·		
	right upper extremi	ty and completed the same					
	exercises and reps	as for the left upper extremity.					
	I NA-C then perform	ed range of motion on the completing five reps of right				•	
	foot flexion downwa	ard and upward and five reps					
	of knee flexion and	lextension. NA-C then					ļ
	performed the sam	e exercises on the left lower					
	extremity, increasing	ng the reps of knee flexion and			•		
	perform ROM on F	for the left side. NA-C did not (12's neck, and only did five ther than the ten as ordered.					
L	567(02-99) Previous Version		<u> </u>		acility ID: 00474 ' If continua	tion phoof	Page 10 of 31

		AND HUMAN SERVICES & MEDICAID SERVICES			jeć w wie in de	FORM	12/18/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245402	B. WING			12/0)5/2013
NAME OF I	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO	OOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET SLENWOOD, MN 56334		
. (X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 10 hes had been done.	F2	282			
	stated she was finis exercises she woul	on 12/5/13, at 9:37 a.m. NA-C shed with the restorative d normally do for R12.					
	restorative nursing would determine will stated "I usually jus know where to loca for their restorative not know R12 was	boout the facility's procedure for programs and how NA-C hich joints to exercise. NA-C t do all of them." NA-C did not te each resident's instructions nursing programs. NA-C did suppose to have 10 reps each r heel cord stretches.					
	Restorative nursing for R35 as directed	services were not provided by the care plan.					•
	R35's care plan dat involve R35 in resto current ROM.	ted 7/4/13, directed staff to prative services to maintain					
· · · · · · · · · · · · · · · · · · ·	for September, Oct included: arm bike active ROM, which slides, quad sets, a abduction and amb	Care Intervention/Task sheets ober, and November 2013, , pulleys with weights and included 20 repetitions of heel ankle pumps and hip pulation. This was to occur five 35 was also to ambulate every					
	exercise program f R35 had refused th times, and had not lower body exercise	cumentation of the restorative or September 2013, showed le arm bike and pulleys nine been offered six times. The es of the heel slides, quad and hip abduction had not			cility ID: 00474 lf continuat		Page 11 of 3'

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		AND HUMAN SERVICES				FORM	12/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245402	B. WING			12/	05/2013
	PROVIDER OR SUPPLIER	CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	been done at all. R 18 of the 30 days.	35 had refused to ambulate	F2	282			
	program for Octobe 12 of 31 days to do on 6 of 31 days, the not offered. Lower	cumentation of the restorative er, 2013, revealed R35 refused the arm bike and pulleys and ese restorative services were body exercises were not days. The resident refused to			· · · · · ·		
	ambulate 13 of 31 of R35's electronic do program for Novem arm bike and pulley						
	exercises were refu were not offered on refused to ambulate When interviewed of stated restorative s	used 7 times, and services 13 days. The resident e 5 of 30 days. on 12/5/13, at 11:21 a.m. RN-B ervices were not available for					
	She indicated that s managers the staff this until a new staf also reported she w	ne restorative staff resigned. she informed the nurse would need to supplement f was hired and trained. She vas not aware of the frequency nts were currently being services.	-				· · ·
	Nursing Program, 3 1. Nursing personr nursing	nel are trained in restorative					
	resident needs. 4each resident rehab potential by t assistance by nursi	sing is provided daily per will be evaluated for his /her he attending physician, with ing staff e seen at least quarterly by					
FORM ONE OF	Restorative Nurse.	rom above rounds or	11	Fa	acility ID: 00474 If continuat	ion sheet	Page 12 of 31

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION .		E SURVEY
		245402	B. WING		12	05/2013
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	*****	
GLENWO	DOD VILLAGE CARE	CENTER		9 SOUTHEAST 2ND STREET LENWOOD, MN 56334		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 282 F 318 SS=E	"Therapy Recomme 9. Restorative Nurs on appropriate reside decline 10-20 degre reassessed by ther 12. Maintenance ac will be described or 14. Occupational th restorative therapy recommendation re 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility with a limited range	Il be on the back of the endations". e will measure degree of ROM dents at least quarterly. If ees is noted resident will be apy. ctivity of daily living programs n resident care plan erapy, physical therapy and will be consulted for egarding a restorative program. EASE/PREVENT DECREASE	F 282 F 318		•	
	range of motion an decrease in range of	d/or to prevent further		F 318:		
·	by: Based on observation revirestorative therapy R66, R12, and 35) assessed as requir Findings include: R17 did not receive frequency or of her	NT is not met as evidenced tion, interview, and ew the facility failed to provide for 4 of 4 residents (R17, reviewed, who had been ing restorative therapy. e range of motion services in arms and lower extremities to or to maintain her range of		It is the policy of the Glenw Village Care Center based o the comprehensive assessm of a resident; the facility me ensure that a resident with limited range of motion receives appropriate treatm and series to increase range motion and/or to prevent further decrease in range o motion.	n nent ust a nent e of	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245402	B. WING		12/	05/2013
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	R17's annual Minir 4/16/13, included a disease, required to assist for most activ not have any function	num Data Set (MDS) dated diagnosis of Alzheimer's otal staff assistance of one vities of daily living (ADL's), did onal limits in ROM, did not ad received passive range of	F 3	R17 Referral was made to and OT to assess ROM in extremities, trunk and neck further recommendati Recommendations from PT OT will be followed.	all for ons. and	-
	R17 had declined to most ADL's, and ha in range of motion of MDS indicated R17	S dated 10/3/13, indicated o requiring two staff assist for ad developed functional limits of both upper extremities. The did not reject cares, and had e times in the assessment	•	R66 referral was made to and OT for recommendat for ROM to all extremi Recommendations from PT OT will be followed.	ions ties. and	
	the restorative plan When interviewed o (RN)-B stated the r Restorative Nursing	ted 10/9/13, indicated to see for the restorative program. on 12/4/13, registered nurse estorative care plan is the g Assistant Intervention, in the The aides access this to do		R12 referral was made to and OT for recommendat for ROM to all extremi Recommendations from PT OT will be followed.	ions ties. and	
	their documentation directions are there R17's Restorative N in the electronic rec October, Novembe directed staff to ap shoulders for 15 m PROM to both upper shoulder flexion an	n on the computer, and the	•	R35 referral was made to and OT for recommendation restorative progr Recommendations from PT OT will be followed.	for am.	
	number of repetitio R17's Physical The	rapy Restorative Care 28/12, directed staff to apply				

		AND HUMAN SERVICES & MEDICAID SERVICES			n na hanna an	FORM	12/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION		E SURVEY PLETED
		245402	B. WING			12/	05/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO	DOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	hot packs to R17's minutes, then assis of motion (AAROM extremities, and low week. R17's PT Progress staff to assist R17 v followed by cervical trunk ROM, and up ROM either in supir R17's Occupation T nursing dated 4/5/1 range of motion (Pf decreased respons to occur three times fingers, extension p and abduction 15-2 apply a warm blank neck, and gentle he right. During observation was in the therapy of rock-n-go wheel ch wedge pillows on th her head and shoul assistant (NA)-B ha R17's neck. This w Then NA-B attempt R17's neck only mo was stiff. NA-B the shoulder, less than 10 times. No furthe had been performe When interviewed of stated this is how s	neck and shoulders for 15 t R17 with active assist range b) to neck, trunk, upper ver extremities six times per Notes dated 1/2/13, directed with hot Packs for 15 minutes, ROM in sitting position. Also per and lower extremities ne or sitting position. Therapy Recommendations to 3, included, "Gentle passive ROM), secondary to e and verbalization." This was s per week to elbows, wrists, orimarily, and shoulder flexion 0 repetitions. Staff were to the prior to ROM and PROM of ead extension turning left and on 12/4/13, at 9:35 a.m. R17 room. She was seated in a air, leaning to the left, had he left side of the chair, and ders were forward. Nursing ad applied a warm blanket to vas left in place for 15 minutes. Hed PROM to R17's neck, hoved slightly, NA-B stated she n lifted R17's arms up, at the 45 degrees and repeated this r ROM, PROM, or AAROM d.		318	All other residents who ar currently receiving a nursin restorative program will be reassessed by RN clinical manager and referred to PT an OT as needed. Restorative nursing program policy was reviewed an updated. Audits will be conducted week x 3 weeks on all residents wh receive a ROM program that ROM has been completed at planned. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director or Nursing Completion Date: 1/7/2014	ng al nd d y o it s r f	Page 15 of 31
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: UVMU1	1	Fac	cility ID: 00474 If continuatio	n sheet	Page 15 of 31

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ALTION DOT MULTICE CONSTRUCTION (X1) PROVINCENDERUPLIENCUE INSPIRATION OF CORRECTION (X2) PROVINCENDERUPLIENCUE INSPIRATION NUMBER (X2) PROVINCENDERUPLIENCUE INSPIRATION OF CORRECTION (X2) PROVINCENDERUPLIENCUE INSPIRATION NUMBER (X2) PROVINCENDERUPLIENCUE INSPIRATION (X2) PROVINCENDERUPLIENCUE INSPIRATION (X2) PROVINCENDERUPLIENCUE IN			AND HUMAN SERVICES & MEDICAID SERVICES	•			FORM	12/18/2013 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE. ZIP GODE GLENWOOD VILLAGE CARE CENTER If a southeast zwo street Available SUMMARY STATEMENT OF DEPICIENCIES BACH DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES Preferx SUMMARY STATEMENT OF DEPICIENCIES F318 Continued From page 15 ROM. She had never performed ROM on R17's elbows, wrists, hands, fingers, or lower extremities. A physical Interay suide had shown her how to perform ROM for R17 when she started recently. NA-B was not extremities, or what all joints to perform ROM on. R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follower December 1, 2013, ROM had been completed to total of three times only. 15 minutes each time. November 2013, ROM had been completed to total of three times only. 15 minutes each time. November 2013, ROM had been completed to the other three times on the electronic record instructed to assist with ROM on encompleted to the other of the restorative 2013, ROM had been completed to the other of three times only. 15 minutes each time. November 2013, ROM had been completed to the other of three times only. 15 minutes each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative programs were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapy aid (F1). A stated it would be difficult to determine f1 R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/2/7/2, goal was to maintain the ability to sit in	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		E CONSTRUCTION	(X3) DATE	E SURVEY
CLENWOOD VILLAGE CARE CENTER T19 SOUTHEAST 2ND STREET GLENWOOD, MN 58334 SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVA CARE CENTER) D PREFIX REQUATORY OR LIG DEMTIFYING INFORMATION) PREFIX REQUESTION (CONSERPTING) COMPLETION (CONSERPTING) CONSERPTING) CONSERPTING) CONSERPTING) CONSERPTING) CO	-		245402	B. WING			12/	05/2013
GLENWOOD VILLAGE CARE CENTER CM1D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EAD) DEFICIENCY MIST BE PRECIDED BY FULL REGULATORY OR USE DENTIFYING INFORMATION) D PREVIDER PLAN OF CORRECTIVE ACTION ACULD BE CROSS REPERED TO A CONTROL THE APPROPRIATE DEFICIENCY Continued From page 15 F 318 Continued From page 16 F 318 ROM. She had never performed ROM on R17's elbows, wrists, hands, fingers, or lower extremites. A physical therapy alde had shown her how to perform ROM for R17 when she started recently. NA-B was not ware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. F 318 R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follow upleted a total of three times only. 16 minutes each time, November 2013, ROM had been completed 11 times, 5 minutes each time. December 2013, ROM had only been completed 101 files, 6 minutes each time. Becember 2013, ROM had only been completed 101 files, 6 minutes each time, ab 6 minutes. In November and December 2013, ROM had only been completed 11 should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed nestident. RN-B knew they were having difficulty, and had directed each unit manage or obsure restorative program was being accomplished. She had not taken further action to ensure each resident. Provatisch decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/27/12, geal was to maintain the ability to sit in	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(A) D PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTING ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LS DENTIFYING INFORMATION) IP OF ORRECTING ACTION SHOULD BE REGULATORY OR LS DENTIFYING INFORMATION) IP OF ORRECTING ACTION SHOULD BE REGULATORY OR LS DENTIFYING INFORMATION) F 318 Continued From page 15 ROM. She had never performed ROM on R17's elibows, wrists, hands, fingers, or lower extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on 0. F 318 R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follow up Reports dated 10/13, 1113, and 12/13 indicated: October 2013, ROM had been completed 1 times, 5 minutes each time. December 2013, ROM had been completed 1 times, 5 minutes each time. December 2013, RT should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B stated she was ing or goorden. RN-B stated she was an otherape of the restorative programs were being accomplished. She had not taken further action to ensure each resident. Provident manager to ensure restorative programs were being accomplished. She had not taken further action to advare diversed ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/27/12, geal was to maintain the ability to sit in			CENTER					
PHERM REGULATORY OR LSC DENTIFYING INFORMATION TAG CROSS-REPERENCED TO THE APPROPRIATE DATE F 318 Continued From page 15 F F S18	OLENW		· · · · · · · · · · · · · · · · · · ·		G			
 ROM. She had never performed ROM on R17's elbows, wrists, hands, fingers, or lower extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follow up Reports dated 1013, 11/13, and 12/13 indicated: October 2013, ROM had been completed a total of three times only, 15 minutes each time. November 2013, ROM had been completed 11 times, 5 minutes each time. November 2013, and December 2013, ROM had been completed 11 times, 5 minutes each time. November 2013 and December 4, 2013, each 5 minutes. In November and December 2013, RT should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were having difficulty, and had directed each unit manager to ensure restorative programs were being accomplished. She had not taken further action to ensure restorative program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapist (PT)-A stated the ROM as directed it would be difficult to determine if R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11 times action to ensure each residents program was being provided as ordered. 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
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elbows, wrists, hands, fingers, or lower extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follow up Reports dated 10/13, 11/13, and 12/13 indicated: October 2013, ROM had been completed a total of three times only, 15 minutes each time. November 2013, ROM had been completed a total of three times only the minutes each time. November 2013, ROM had been completed a total of three times only in the comber 2013, ROM had only been completed twice between December 1, 2013 and December 4, 2013, each 5 minutes. In November and December 2013, RT7 should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were having difficulty, and had directed each unit manager to ensure restorative programs were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapist (PT)-A stated it would be difficult to determine if R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/27/12, goal was to maintain the ability to sit in	F 310		-		010			
extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. R17's Restorative Follow up Reports dated 10/13, 11/13, and 12/13 indicated: October 2013, ROM had been completed a total of three times only, 15 minutes each time. November 2013, ROM had been completed 11 times, 5 minutes each time. December 2013, ROM had only been completed threes, 5 minutes each time. December 2013, ROM had only been completed twice between December 1, 2013 and December 4, 2013, each 5 minutes. In November and December 2013, R17 should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapist (PT)-A stated it would be difficult to determine if R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/27/12, goal was to maintain the ability to sit in								•
started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17s lower extremities, or what all joints to perform ROM on. R17's Restorative Follow up Reports dated 10/13, 11/13, and 12/13 indicated: October 2013, ROM had been completed a total of three times only, 15 minutes each time. November 2013, ROM had been completed 11 times, 5 minutes each time. December 2013, ROM had only been completed 11 times, 6 minutes each time. December 1, 2013 and December 4, 2013, each 5 minutes. In November and December 2013, RT should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were having difficulty, and had directed each unit manager to ensure restorative programs were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapy tift (PT-A) stated it would be difficult to determine if R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM asessment dated 11/27/12, goal was to maintain the ability to sit in		extremities. A phys	sical therapy aide had shown					
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				<u> </u>	Ea	sility ID: 00474	tion sheet	Page 16 of 31

	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245402	B. WING			12	/05/2013
NAME OF I	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO	OOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET LENWOOD, MN 56334		
(X4) ID PREFIX . TAG	(EACH DEFICIENC)	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 318	Continued From pa	ae 16	F	318			
1 010	a wheel chair with o five degree for neul and would have the	cervical spine positioned within tral, side bent for five minutes a ability to lie supine with ioned within five degree of					
	neutral for five minu assessment of R17 time. PT-A stated h her goal area. PT-	utes. There had been no 's actual ability of ROM at the ne felt R17 had maintained in a then attempted to perform					
		ck and could move it about houlders he could move 25-45			,		
	program as had be	e the restorative nursing en assessed as needed.					
	diagnosis of Alzhein cognitive impairme assistance from sta cares, had a function extremities on one	S dated 9/17/13, included a mer's disease, severe nt, required extensive aff for all ADL's, did not reject onal limitation in ROM of upper side, and received PROM			· · ·		
		ted 7/3/13, indicated the n was on the restorative plan					
	goal was to tolerate stretching 4 to 5 da flexibility, and to tra	ent dated 7/3/13, indicated the e lower extremities ROM and tys a week, to increase insfer with assist of two staff.					
	restorative nursing to nursing staff.	otes dated 7/17/13, indicated training had been completed					
	for October, Noven	Nursing Assistant Intervention nber, and December 2013, ted exercises, gentle AAPROM					

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE	0938-039 E SURVEY PLETED
		045400	B. WING				
		245402				12/0	05/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GLENWO	DOD VILLAGE CARE	CENTER		719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334			
(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 I	BE	(X5) COMPLETIO DATE
F 318	Gentle stretching to hamstrings, hold 3	age 17 Ikles 10 times as tolerated. 5 both heel chords and 0 seconds, repeat twice. Staff this six times a week.	'F 31	8			
	R66's restorative n documented as be in October 2013, 1	ursing program was ing completed only four times 1 times in November 2013, and pleted in December, as of	1				
	stated she was not restorative nursing upper and lower ex the hamstring or he has to be done in b catch R66 in bed in	on 12/4/13, at 2:15 p.m. NA-B always able to complete R66's program. She will do ROM on ctremities, but has never done eel cord stretches. The ROM bed and she doesn't always n order to do it. She had not y ROM for R66 this month so	5	· · · · · · · · · · · · · · · · · · ·			•
	NA-D stated if the us the bath aide will us nursing program fo assistants working	on 12/5/13, at 10:10 a.m. restorative aide has a day off, sually do the restorative r residents, or the nursing with the resident that day ad never assisted either R17 or rams.					
	NA-D stated she is will need to the res there is no restorat list of residents who	on 12/5/13, at 10:17 a.m. a bath aide and sometimes torative nursing programs if ive aide that day. She has a o she would have to assist with wever, R17 and R66 were not					
		on 12/4/13, at 2:00 p.m. RN-B tive program had not been					

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION				E SURVEY IPLETED
		245402	B. WING					12/	05/2013
NAME OF F	PROVIDER OR SUPPLIER		I	STRE	EET ADDRESS, CI	TY, STATE,	ZIP CODE		00/2010
GLENWO	OOD VILLAGE CARE	CENTER			SOUTHEAST 2N				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDEI (EACH CORI CROSS-REFEF		TION SHOU	ILD BE	(X5) COMPLETIO DATE
F 318	completed as direc	age 18 ted for R66. R66 was recently st of two to transfer to a full ecline in ability to transfer.	F 31	8	· · · ·		· .		•
	director of nursing nursing programs of correctly or in the f R66. It could be be assistant is new. S to be completed as aide did not know f	on 12/5/13, at 9:15 a.m. the (DON) verified restorative were not being completed requency ordered for R17 and ecause the restorative nursing She would expect the programs a directed. If the restorative the proper way to do assist with grams, she should ask the			•				
							. •		
	R12 did not receive prevent further dec	e range of motion services to cline in range of motion.							
	12/5/13, included t	er the Diagnosis Listing, dated orticollis (a condition of neck position), Alzheimer's mal posture.						· .	
	functional loss of F required extensive	DS dated 11/19/13, included a ROM both upper extremities, assistance with all ADL's, and estorative nursing program.							
	restorative plan of	ated 6/13/13, indicated a care for range of motion er to the restorative plan.							
	for November and	Nursing Assistant Intervention I December 2013, instructed ROM to the lower extremities to	-						

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		AND HUMAN SERVICES	·		·		FORM	12/18/2013 APPROVED 0938-0391
			MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
245402		. B. W	ING _			12/05/2013		
NAME OF I	PROVIDER OR SUPPLIER	<u>to an </u>	•••••••••••••••		STREET ADDRESS, CITY, STAT	E, ZIP CODE		
GLENWO	OOD VILLAGE CARE	CENTER			719 SOUTHEAST 2ND STRE GLENWOOD, MN 56334	ET		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES			PROVIDER'S PLAN (EACH CORRECTIVE			(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED DEFICI	TO THE APPROPE		DATE
F 318	Continued From pa	ae 19		F 31	8			
	include hip abductio	on, knee extensions and tretches, 10-15 repetitions						
	(reps) five times pe	r week. PROM to the upper to shoulders, elbows, wrists			· · · · · · · · · · · · · · · · · · ·			
	and fingers as toler motion to the neck,	ated and passive range of side to side stretches for 10						
	-	tension to neck for 10 reps.				,		· ,
	had restorative nurs	Task sheet's showed R12 or sing twice between 11/23/13 not at all between 12/1/13 ar						
	R12 was observed her hands and finge	on 12/2/13, at 7:41 p.m. wit ers in a curled position.	h					
	R12 was observed the fingers and han lap in a curled and	on 12/5/13, at 8:35 a.m. wit ds on both sides resting in h closed position.	h Ier					
	stated R12 was ab	on 12/5/13, at 8:31 a.m. NA le to straighten all fingers o. NA-C stated R12 typically al position.						
	stated the normal p programs was that aide that completed was the restorative	on 12/5/13, at 9:09 a.m. NA- procedure for restorative there is usually a restorative d the exercises, however this aide's usual day off and the assumed by the aides workir	5					
	range of motion pro bed. NA-C began/i the R12's fingers of completing five rep wrist flexion, elbow	a,m., NA-C performed R12 ogram while R12 was lying ir range of motion services wit n the left upper extremity, s each of finger extension, flexion and extension and	1 1				1	
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: UV	/MU11	I	Facility ID: 00474	If continuati	on sheet I	Page 20 of 31

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245402		B. WING_		12/05/2013	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LENW	OOD VILLAGE CARE	CENTER		719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 318	shoulder abduction instructed R12 to lo she completed the NA-C proceeded to extremity and com reps as for the left performed range o extremities, comple flexion downward a knee flexion and ex performed the sam extremity, increasin extension to seven perform ROM on F reps each area, ra	age 20 and adduction. NA-C bosen and relax the joints as range of motion activities. To move to the right upper pleted the same exercises and upper extremity. NA-C then f motion on the lower eting five reps of right foot and upward and five reps of ktension. NA-C then the exercises on the left lower of the reps of knee flexion and for the left side. NA-C did not R12's neck, and only did five ther than the ten as ordered. thes had been done.	F 3 [,]	18	
	finished with the re- normally do for R1 would be back to of she is tightening uf facility's procedure programs and how joints to exercise. all of them." NA-C the restorative nur- resident were loca NA-C did not know reps each area, ne stretches. When interviewed DON stated that h restorative nursing aide to ask the cha	7 a.m., NA-C stated she was storative exercises she would 2. NA-C further stated she lo more later, "If she looks like o." NA-C was asked about the for restorative nursing NA-C would determine which NA-C stated "I usually just do was unable to verbalize where sing instructions for each ted at the time of the interview. A R12 was suppose to have 10 ack ROM, or heel cord on 12/5/13, at 10:58 a.m. the her expectation with regard to a programs would be for the arge nurse for help if they were ative program for a resident.			

		AND HUMAN SERVICES					PRINTED FORM OMB NO	APPR	OVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DÀTE SURVEY COMPLETED		
		245402	B. WING	•		•	12	/05/201	13
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE			
				7	19 SOUTHEAST 2ND STRE	ET			
GLENWO	DOD VILLAGE CARE	CENTER		G	LENWOOD, MN 56334	1			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN	OF CORREC	FION	(X COMPL	5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE CROSS-REFERENCED			COMPL	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			IENCY)	UPRIATE		
					· · · · · · · · · · · · · · · · · · ·	,			
F 318	O times of France in a		F 3	dà					
F 310	Continued From pa		<u>г</u> . э	10					
	for R35 as had bee	en assessed as needed.	•					1	
	D2510 guartariu MD	Added 6/19/12 included a							
		S dated 6/18/13, included a and lung failure, he was	-						
		id not reject cares, required	•						
	extensive assistant	ce for most ADL's, did not have			· · · · ·				
		A problems, and was receiving							
		herapy) and PT (physical							
	therapy) services.								
·		S dated 9/17/13, showed R35				•			
	continued to require	e extensive assistance with							
	ADL's, but had dec	lined to having bilateral upper ROM. The MDS indicated					•		
	B35 was again rea	eiving PT and OT services.						-	• •
	NSS was ayain rec	enting i i and of services.				·			
	R35's care plan da	ted 7/4/13, directed staff to							
	involve R35 in rest	orative services to maintain							•
	current ROM.							1	
	R35's Physical The	erapy Progress Notes dated							•••
	9/13/13, Instructed	staff for a restorative nursing sto ambulate with the use of a							
	four wheeled walke	er with assistance of two staff,				•••		1	
	who were to follow	the resident with a wheelchair.							
		er extremity range of motion							
	independently in be	ed. In addition, restorative was							
	to work with the res	sident three times per week to							
	maintain or increas	se his lower extremity strength.							
		o do knee extensions and hip							
		und weights for 20 repetitions						ļ	
		mstring and hip abductions.							•
1		mber 2013, the resident had							
		participate in the arm bike,							
	pullevs with weight	s and active ROM (which							
		ions of heel slides, quad sets,			ι .				
	ankle pumps and	hip abduction) R35 refused			•				
	the arm bike and p	ulleys with weights nine times			•				
EODM CMS 2	567(02-99) Previous Versions	s Obsolete Event ID: UVMU	11	Fac	cility ID: 00474	If contin	uation sheet	Page 2	2 of 31

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1				E	. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD					E SURVEY IPLETED
		245402	B. WING			•	12/	05/2013
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CI		DDE	
GLENWO	OOD VILLAGE CARE	CENTER			SOUTHEAST 2N ENWOOD, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORI	R'S PLAN OF COR RECTIVE ACTION S RENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
					u .	- <u></u>		
F 318	Continued From pa	ge 22	F3	318				
		rative services were not						-
	offered. Restorativ	e Nursing services (which			·			
	included 20 repetiti	ons of heel slides, quad sets,						
		ip abduction) were not offered						
	refused to ambulate	f 25 days. The resident						
•	The electronic docu	imentation of the restorative						
	program for Octobe	er 2013, revealed R35 refused						
•	12 of 31 days to do	the arm bike and pulleys and						
	on 6 of 31 days, the	ese restorative services were						
	not offered. Resto	rative Nursing services (which						
	included 20 repetiti	ons of heel slides, quad sets, ip abduction) were not offered						
		he resident refused to						
	ambulate 13 of 31							
	The electronic docu	mentation of the restorative						
	program for Novem	ber 2013, R35 had 26						
	opportunities to par	ticipate in the arm bike,						·
	pulleys with weight	s and active ROM (which		·		•		
	included 20 repetiti	ons of heel slides, quad sets,						
	ankle pumps and i	nip abduction) R35 refused ulleys with weights 11 time		.		•		
	and ten times resto	prative services were not						
	offered Restorativ	e Nursing services (which						
	included 20 repetiti	ons of heel slides, quad sets,					•	
	ankle pumps and h	ip abduction) R35 refused 7						
	opportunities and s	ervices were not offered on 13						
		t refused to ambulate 5 of 30						
	days.	on 12/5/12 of 11:00 o m the						
	DT. A physical there	on 12/5/13, at 11:00 a.m. the apist stated she was not						
	currently working w	with the resident and had not						
	evaluated his curre	ent functional status. She also						
	reported no referra	I at the present time had been						1
	initiated by nursing	staff or the resident's						
	physician. Once th	e resident is discharged from						
		ne nursing department					,	
	oversees their prog When interviewed	jiess.						

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			IPLE CONSTRUCTION	(X3) DA	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245402	B. WING_		12	12/05/2013		
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 318	stated restorative s October 2013 as th She indicated that s managers the staff this until a new staff also reported she w of which the resider offered restorative s	ervices were not available for e restorative staff resigned. she informed the nurse would need to supplement f was hired and trained. She vas not aware of the frequency nts were currently being services.	F 31	18				
	Nursing Program, 3 1. Nursing personr nursing 3. Restorative nursi resident needs. 4each resident rehab potential by t assistance by nursi 7. Residents will be Restorative Nurse. 8. Documentation f	nel are trained in restorative sing is provided daily per will be evaluated for his /her he attending physician, with ng staff seen at least quarterly by rom above rounds or						
	"Therapy Recomme 9. Restorative Nurs on appropriate resident decline 10-20 degre reassessed by ther 12. Maintenance active will be described on 14. Occupational therapy	e will measure degree of ROM dents at least quarterly. If ees is noted resident will be						
F 356 SS=C	483.30(e) POSTEE INFORMATION	ost the following information on	F 3	56				

ATEMENT OF DEFIC ID PLAN OF CORRE	IENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED	
		245402	B. WING		12/05/2013		
AME OF PROVIDER GLENWOOD VIL (X4) ID PREFIX TAG REG	LAGE CARE SUMMARY STA	CENTER TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	7'	TREET ADDRESS, CITY, STATE, ZIP CODE 19 SOUTHEAST 2ND STREET SLENWOOD, MN 56334 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETION DATE	
F 356 Contin o The o o The f by the unlicer resider - R - Li vocatio - C o Resider The fa specifi of each o Clea o In a resider The fa make for rev standa The fa staffing require This R by: Based review inform include persor affect and ar	ued From pa current date. total number following cat used nursing nt care per sl egistered nur censed prace onal nurses (ertified nurses dent census. cility must po ed above on n shift. Data r and readate prominent pla tots and visito cility must, u nurse staffing iew at a cost rd. cility must a page at a cost rd. cility must m g data for a r ed by State la EQUIREME I on observa , the facility fa ation was po ed actual hou and. This pr all 58 resider	ge 24 and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). a aides. ost the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to rs. pon oral or written request, g data available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced tion, interview and document ailed to ensure nurse staffing sted in a timely manner, and urs of work for nursing actice had the potential to nts who resided in the facility, mbers or visits who may	F 356	F356: It is the policy of Glenwood Village Care Center to post actual daily staffing hours dail at the beginning of each shift. The following information will be posted facility name, curred date, and total number of actual hours worked by the following categories of licensed and unlicensed staff directly responsible for reside care per shift: registered nurses; licensed practical nurses; certified nurse aides and resident census. The following information will be posted on a daily basis and at the beginning of each shift. T form will continue to be poste in a visible area for residents, staff, visitors, etc to review.	y I nt he		

ATEMENT O	DF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA1	0. 0938-0391 TE SURVEY MPLETED	
		245402	B. WING		12/05/2013		
	(EACH DEFICIENCY	CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	STREET ADDRESS, CITY, STATE, ZIP CC 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE	(X5) COMPLETION DATE	
	posting was observe facility during the init 11/23/13. The form, entitled G Staff Hours and Re- total number of sch- nurse (RN), license nursing assistant (N hours were listed ur and evenings. Eacl for stop and start tir the stop and start tir the stop and start tir on the document wi of staff and total ho On 12/04/13, at 8:3 posting was noted t displayed in the ma within a plastic slee On 12/04/13, at 12: posting from the pri The staffing hours f the 12/03/13 postin protector, and were visitors in the facility When interviewed of director of nursing (scheduler (NS)-N w notices. The DON shifts are not separ	 D p.m. the nursing staffing ed in the front vestibule of the tial tour. It was dated Blenwood Village Care Center sident Census, indicated the eduled hours for registered d practical nurse (LPN) and IA) hours for the day. The nder each shift for nights, days h shift had a general heading mes, however did not include mes for short or partial shifts th the corresponding number urs. 5 a.m., the nursing staffing o be from 12/03/13, and was in vestibule of the facility, ve protector. 48 p.m. the nursing staff or day, 12/03/13 was still up. or 12/4/13 were filed behind g in the plastic sleeve not visible to residents or <i>y</i>. on 12/04/13, at 12:58 p.m. the DON), stated the nursing the stated specific hours of short ately indicated on the staff only the total nursing hours for 	F 3	 Daily nursing staffing post policy was reviewed and remains appropriate. New was created to include sta stop times of each shift Audits will be conducted with x4 to make sure form is fit out correctly. Audits will brought to the quality assurance for compliance review. Licensed staff and nursing scheduler will be educated on the policy by January 7, 2014. Responsible Person: Dire Nursing Completion Date 1/7/2014 	v form art and veekly led be and d		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		E SURVEY PLETED
		245402	B. WING			12/	05/2013
NAME OF F	PROVIDER OR SUPPLIER	J.,			REET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO		CENTER			9 SOUTHEAST 2ND STREET LENWOOD, MN 56334		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 356 F 431 SS=D	NS-N stated she po day the night before charge nurse on the with changes. She not be listed separa total number of nur The copies of the v spreadsheet, dated the facility staffed sep. m. to 9:00 p.m., of shifts of 6:00 a.m. to during this time fra Review of the facilit entitled Posting Da dated 12/10, revea beginning of each so of nursing personn resident care would location, and that to should include the shift for each categ The previous shift's were to be maintain total of 24 hours, the a permanent recore 483.60(b), (d), (e) LABEL/STORE DF	on 12/04/13, at 1:05 p.m. bests the nursing hours for each e The NS-N indicated each e shift is to update the sheet also verified short shifts would ately under the shift times, only sing hours would be adjusted. weekly nursing schedule to 11/28/13 - 12/4/13, revealed short shifts, 400 p.m. or 5:00 on afternoons; as well as short to 11:00 a.m., during the day, me. ty nursing staff posting policy, ily Nursing Staff Schedule, led that within two hours of the shift, the number and category el directly responsible for d be posted in a prominent he nursing staffing information actual time worked during that gory and type of nursing staff. s forms per the facility policy ned with the current shift for a nen filed in the DON's office as d. DRUG RECORDS, RUGS & BIOLOGICALS mploy or obtain the services of		431		· · ·	
	of records of receip controlled drugs in accurate reconcilia records are in orde	cist who establishes a system ot and disposition of all sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3) DATE SURVEY OMPLETED
	•	245402	B, WING	12/03/2013
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 431	reconciled. Drugs and biologica labeled in accordar professional princip appropriate access instructions, and th applicable. In accordance with facility must store a locked compartmen controls, and permi have access to the The facility must pr permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri quantity stored is m be readily detected This REQUIREME by: Based on observa review the facility fa insulin pen was lab 3 or 4 residents (Reinsulin, Findings include:	als used in the facility must be nece with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the ill drugs and biologicals in nts under proper temperature it only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can	F 43	B1F 431:It is the policy of the Glenwood Village Care Center to date insulin pens when the insulin pen is opened.R 5, R 29, R 59 Insulin pens that were not dated was thrown and new pens were initiated and dated when opened.Policy was reviewed and remains appropriate. Will review policy with licensed staff by January 14, 2014.Audits of insulin pens will be conducted weekly x4 to checked for dates on pen when opened.Audits will be brought to the quality assurance for compliance and review.Responsible Person: Director of NursingCompletion Date: 1/7/2014

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE (CONSTRUCTION		E SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	ING		CO	IPLETED		
		· 245402	B. WING		· · · · · · · · · · · · · · · · · · ·	12	12/05/2013		
NAME OF F	PROVIDER OR SUPPLIER	······································			EET ADDRESS, CITY, STATE, ZIP COL SOUTHEAST 2ND STREET	DE .			
GLENWO	DOD VILLAGE CARE	CENTER			ENWOOD, MN 56334				
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 431	Continued From pa	age 28	F	431		•			
	the following was r	ooted:							
	containing Humalo	kPen (dial-a-dose insulin pen) g insulin (used to control high lts with diabetes), 100							
× .	units/milliliters (ml) not labeled with the order, signed 11/15	, dispensed on 8/15/13, was e date that it was opened. R5's 5/13, directed staff to give 4 ml subcutaneously (SQ)			 				
	containing NovoLo a date that it was o the date that it was 11/15/13, directed	exPen (dial-a-dose insulin pen) g insulin, 100 units/ml, without lispensed, was not labeled with s opened. R29's order, signed staff to inject NovaLog FlexPen iding scale, twice daily.							
	During an interview registered nurse (F dated."	v on 12/4/13, at 12:05 p.m. RN)-C stated, "They should be		-					
		tion of the medication cart on /, on 12/4/13, at 12:31 p.m. the d:			•				
	was not labeled wi R59's order, signe	vikPen, dispensed on 8/31/13, th the date that it was opened. d 11/27/13, directed staff to lution SQ, per sliding scale, fou	r .		· . 				
	administration rec	9, and R59's medication ords (MAR) for November and ndicated each had received the rdered.							

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Press REGULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE F 431 Continued From page 29 insulin pens were not currently labeled with a date, but stated she was sure that it had been labeled when opened and that it may have "rubbed off." F 431 During an interview on 12/5/13, at 8:25 a.m. RN-D indicated when insulin pens are opened, "They should be datedWe just talked about that last week." F 431 During an interview on 12/5/13, at 9:10 a.m. RN-C stated, "My expectation would be that the insulin pen be dated when its taken from the refrigerator and used for the resident." F 431 During an interview on 12/5/13, at 9:42 a.m. LPN-B stated she doesn't give RG's evening insulin, but if it wasn't labeled with the date that it was opened, the would, "Go by the date that it was opened, the would oi f she pulled out an insulin pen that was not labeled with the date that it was opened, PN-C stated, "On, yes, that should be thrown." During an interview on 12/5/13, at 10:00 a.m. when asked what she would do if she pulled out an insulin pen that was not labeled with the date it was opened. JPN-C stated, "Nould get rid of it. I wouldn't use it." During an interview on 12/5/13, at 10:00 a.m. where asked what she would do if she pulled out an insulin pen that was not labeled with the date it was opened. According to the Centers for Disease Control and Prevention, Injection Safety, if a multi-dose vial was opened or accessed (e.g., needle-punctured) the vial was to be date date discarded within 28 days, unless the manufacturer specified			AND HUMAN SERVICES			· · · · · · · · · · · · · ·	FORM	: 12/18/2013 APPROVED . 0938-0391
MAKE OF PROVIDER OR SUPPLER STRUET ADDRESS, CITY. STATE ZIP CODE T19 SOUTHEAST 2ND STRUET GLENWOOD VILLAGE CARE CENTER SURVEY AND STRUET (EACH DEFICIENT USET E FRICEDED BY FULL (EACH DEFICIENT VIUST E FRICEDED BY FULL (EACH DEFICIENT) D(MAKE DEFICIENT) F 431 Continued From page 29 (TUDEd Off." F 431 During an interview on 12/5/13, at 8:25 a.m. RN-D indicated when insulin pass ra opend, "They should be datedWe just talked about that last week." F 431 During an interview on 12/5/13, at 9:42 a.m. LPN-B stated shoed when it is taken from the refrigerator and used for the resident." During an interview on 12/5/13, at 9:42 a.m. LPN-B stated shoed when it is taken from the refrigerator and used for the resident." During an interview on 12/5/13, at 10:00 a.m. when asked what she would do if she pulled out an insulin pen that was not labeled with the date that it was opened, LPN-C stated, "Would get rid of it I would't use it." During an interview on 12/5/13, at 10:57 a.m. director of nursing (DON), verified insulin pens should be labeled with the date that they were opened. According to the Centers for Disease Control and Prevention, Injection Safey, if a multi-dos vial was opened or accessed (e				1			(X3) DAT COM	E SURVEY
19 SOUTHEAST 2ND STREET GLENWOOD, NN 56334 CM1 ID FREETX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDENCIES) (EACH DEFICIENCY MUST BE PRECIDENCIES) (EACH CORRECTINA, CATTON SIGULD BE CROSS-REFERENCED TO THE APROCHADTE DEFICIENCY OR LSC IDENTIFYING INFORMATION) Display Operation (EACH CORRECTINA, CATTON SIGULA DE CROSS-REFERENCED TO THE APROCHADTE DEFICIENCY) Operation (EACH CORRECTINA, CATTON SIGULA DE CROSS-REFERENCED TO THE APROCHADTE DUTING an Interview on 12/5/13, at 9:25 a.m. RN-D indicated when its taked about that last week." F 431 During an interview on 12/5/13, at 9:10 a.m. RN-D indicated when it is taken from the refigerator and used for the resident." F During an interview on 12/5/13, at 9:42 a.m. LPN-B stated she doesn't give RS's evening insulin, but if it wasn't labeled with the date that it was opened, She would, "Co by the date that it was opened, LPN-C stated, "Nould get rid of it. I Would't use it." During an interview on 12/5/13, at 10:00 a.m. when asked what she would do to the pulled out an insulin pen that was not labeled with the date it was opened, LPN-C stated, "Nould get rid of it. I Would't use it." During an interview on 12/5/13, at 10:07 a.m. director of nursing (DON). verified insulin pens should be			245402	B. WING	<u>}</u>		. 12	/05/2013
GLENWOOD, MN 56334 (%1) D PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES IN TO A DEFICIENCIES IN RECULATORY OR LSC DENTIFYING INFORMATION) D PROVINCERS PLAN OF CORRECTION OF CORRECTION PRETIX TAG D PROVINCERS PLAN OF CORRECTION (EACH DEFICIENCY) 0000 (EACH DEFICIENCY) F 431 Continued From page 29 Insulin pens were not currently labeled with a date, but stated she was sure that it had been labeled when opende and that it may have "rubbed off." F 431 F 431 During an interview on 12/5/13, at 8:25 a.m. RND-0 indicated when insulin pens are opened, "They should be datedWe just talked about that last week." F 431 Image: Construction of the page 29 Insulin pen be dated when it is taken from the refrigreator and used for the resident." F 431 During an interview on 12/5/13, at 9:10 a.m. RND-0 stated, "We synchration would be that the insulin pen be dated when it is taken from the refrigreator and used for the resident." F During an interview on 12/5/13, at 9:42 a.m. LPN-B stated she doesn't give RS's evening insulin, but if it was mit tabeled with the date that it was opened, LPN-B stated, "On yes, that should be thrown." F During an interview on 12/5/13, at 10:00 a.m. when asked what she would do if she pulled out an insulin pen that was not tabeled with the date it was opened. LPN-C stated, "I would get rid of it. I wouldn't use it." During an interview on 12/5/13, at 10:57 a.m. director of nursing (DON), verified insulin pens should be lated and that the that were opened. According to the Centers for Diseasee Control and Prevention, Injection Safety	NAME OF I	PROVIDER OR SUPPLIER	L				DE	
PREFix TAG CEACH CORRENT A ATTOM & NOTING INFORMATION PREFix TAG CEACH CORRENT A ATTOM & NOTING INFORMATION PREFIX TAG CEACH CORRENT A ATTOM & NOTING INFORMATION PREFIX CEACH CORRENT A ATTOM & NOTING INFORMATION Deficiency is a strengthy and information informati	GLENWO	OOD VILLAGE CARE	CENTER				www.yor	
 insulin pens were not currently labeled with a date, but stated she was sure that it had been labeled when opened and that it may have "rubbed off." During an interview on 12/5/13, at 8:25 a.m. RN-D indicated when insulin pens are opened, "They should be datedWe just talked about that last week." During an interview on 12/5/13, at 9:10 a.m. RN-C stated, "My expectation would be that the insulin pens dated when its taken from the refrigerator and used for the resident." During an interview on 12/5/13, at 9:42 a.m. LPN-B stated she doesn't give R5's evening insulin, but if it wasn't labeled with the date that it was opened, she would, "Go by the date that it was filled." LPN-B stated with the date that it was filled." LPN-B stated, "On, yes, that should be thrown." During an interview on 12/5/13, at 10:00 a.m. when asked what she would do if she pulled out an insulin pen that was not labeled with the date it was opened, LPN-C stated, "I would get rid of it. I wouldn't use it." During an interview on 12/5/13, at 10:57 a.m. director of nursing (DON) verified insulin pens should be labeled with the date that they were opened. According to the Centers for Disease Control and Prevention, Injection Safety, if a multi-dose vial was opened or accessed (e.g., needle-punctured) the vial was to be dated mile scared within 28 days, unless the manufacturer specified 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION
Prevention, Injection Safety, if a multi-dose vial was opened or accessed (e.g., needle-punctured) the vial was to be dated and discarded within 28 days, unless the manufacturer specified	F 431	insulin pens were n date, but stated she labeled when opene "rubbed off." During an interview RN-D indicated whe "They should be da last week." During an interview RN-C stated, "My e insulin pen be dated refrigerator and use During an interview LPN-B stated she o insulin, but if it was was opened, she w was filled." LPN-B filled was 8/15/13. I should be thrown." During an interview when asked what s an insulin pen that was opened, LPN-C wouldn't use it."	ot currently labeled with a e was sure that it had been ed and that it may have on 12/5/13, at 8:25 a.m. en insulin pens are opened, itedWe just talked about that on 12/5/13, at 9:10 a.m. expectation would be that the d when it is taken from the ed for the resident." on 12/5/13, at 9:42 a.m. loesn't give R5's evening n't labeled with the date that it yould, "Go by the date that it verified the date that it was LPN-B stated, "Oh, yes, that on 12/5/13, at 10:00 a.m. the would do if she pulled out was not labeled with the date it C stated, "I would get rid of it. I on 12/5/13, at 10:57 a.m. (DON) verified insulin pens		431			
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UVMU11 Facility ID: 00474 If continuation sheet Page 30 of 3		Prevention, Injectio was opened or acc the vial was to be d days, unless the ma	n Safety, if a multi-dose vial essed (e.g., needle-punctured) lated and discarded within 28 anufacturer specified					

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	12/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		245402	B. WING				12/	05/2013
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, ST			
GLENW	OOD VILLAGE CARE	CENTER			SOUTHEAST 2ND ST ENWOOD, MN 5633			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPP FICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa differently.	ge 30	F4	131				
	for Humalog KwikP information include vials, prefilled pens thrown away after 2 KwikPenmust be	he manufacturer's guidelines en insulin pens, the d, "Once opened, Humalog , and cartridges should be 8 daysIn-use Humalog used within 28 days or be t still contains Humalog."						
	for NovoLog KwikP "Once a NovoLog ł be kept at tempera	the manufacturer's guidelines en, the information included, KwikPen is punctured, it should tures below 86 degrees ays, then discarded."		-				
	dated 7/11, include will be dated when date of "initial entry	led, Medication Containers, d under, "6. All vials, pens, etc. first entered. If there is not a " the dispensing date will be entry" date and the medication coordingly."				÷ .		
					-	•		
					. ·			
	567(02-99) Previous Versions	Obsolete Event ID; UVMU			y ID: 00474			Page 31 of 31

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

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PRINTED: 12/18/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			310000	OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
* 1		245402	B. WING	-		12/	05/2013
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	5	
	OOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET	*	
OLEIT				9	GLENWOOD, MN 56334		
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PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPR		DATE
					DEFICIENCY)		
K 000	INITIAL COMMEN	TS	ĸ	000	1		
	FIRE SAFETY				POCOK FOR K67 WIAW FOR K67		
	THE FACILITY'S P	OC WILL SERVE AS YOUR			for		
-		COMPLIANCE UPON THE		*	IAW	<u> </u>	
\mathbf{X}	/	CCEPTANCE. YOUR			1. 11 . IV		
2		HE BOTTOM OF THE FIRST					÷.
	VERIFICATION OF	S-2567 WILL BE USED AS					
Y	VERIFICATION OF	CONFEIANCE.					
2	UPON RECEIPT C	F AN ACCEPTABLE POC, AN			17.		
~	ONSITE REVISIT	OF YOUR FACILITY MAY BE					
-	CONDUCTED TO				723		
Ì		MPLIANCE WITH THE AS BEEN ATTAINED IN					. · · ·
De.		ITH YOUR VERIFICATION.					
,							
		Survey was conducted by the					
		nent of Public Safety, State					
<i>a</i> .		on. At the time of this survey Care Center was found not in	(a)				
		ince with the requirements for		2			
	participation in Med	licare/Medicaid at 42 CFR,					
\mathfrak{S}		Life Safety from Fire, and the					
K		ional Fire Protection		i i			1
à) Standard 101, Life Safety ter 19 Existing Health Care.			24		
1							()
	PLEASE RETURN				RECEIVED		
j.		R THE FIRE SAFETY			LILOLIVED		
12	DEFICIENCIES (K	IAGO) IU:					
1	HEALTH CARE FIF	RE INSPECTIONS			DEC 3 1 2013		
J.	STATE FIRE MARS	SHAL DIVISION					
	444 CEDAR STRE				MN DEPT OF DUDU O CATTO		
	ST. PAUL, MN 551	01-5145, or			MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISIO		5
	By e-mail to:						
		X 3				*2	2
BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		1 TITLE		(X6) DATE
(γ)	Jose A Krice			_(aministrator		1-13
y deficienc	vistatement ending with	an asterisk (*) denotes a deficiency wh	ich the ins	titut	ion may be excused from correcting provid	ng it is deter	mined that
er safegua	ards provide sufficient pro	etection to the patients. (See instruction or not a plan of correction is provided. F	s.) Exception	ot for	r nursing homes, the findings stated above mes, the above findings and plans of correct	are disclosal	closable 14
s following	g the date these docume	nts are made available to the facility. It	deficienc	ies a	are cited, an approved plan of correction is	requisite to c	continued
gram parti	icipation.						

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

Event ID: UVMU21

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		AND HUMAN SERVICES			š.,	F	ORM A	12/18/2013 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X:	3) DATE COMP	SURVEY LETED
		245402	B. WING	-	*		12/0	5/2013
NAME OF F	PROVIDER OR SUPPLIER	2 31			TREET ADDRESS, CITY, STATE, ZIP CODE	5	,	
GLENWO	OOD VILLAGE CARE	CENTER		l .	19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334			
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K 000	Barbara lundberg@ and Marian Whitney@si THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFC 1. A description of v to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre Glenwood Village C four different times. in the 1962, is 1- st and was determined construction. In 197 the northeast that w (111) construction to the southeast that II (111) construction added to the west ti II(111). The building on the main floor.	Ostate.mn.us Itate.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.		000	DEFICIENCY)			
	throughout the build 13 Standard for the Systems (1999 edit alarm system with a down the corridors smoke detection in the facility has batte	ding in accordance with NFPA Installation of Sprinkler tion). The building has a fire automatic smoke detectors with additional automatic all common use spaces. Also ery powered smoke detection						
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: UVMI	J21	Fac	cility ID: 00474 If co	ontinuatio	on sheel	Page 2 of 4

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

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		AND HUMAN SERVICES				FORM	12/18/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245402	B. WING			12/	05/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENWO	DOD VILLAGE CARE	CENTER			19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(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
K 000 K 067 SS=F	in all resident sleep monitored for autom notification. Becaus 3 additions are of the type allowed for exi- surveyed as one but The facility has a ca- census of 59 at the The requirement at NOT MET as evide NFPA 101 LIFE SA Heating, ventilating, with the provisions of in accordance with specifications. 19	ing rooms. The fire alarm is natic fire department at the original building and the me same type of construction sting buildings, the facility was ilding. apacity of 64 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	÷	000	See Warver Request on attached Sheet	ť,	
	Based on observat could not be verified ventilating and air c installed in accorda 19.5.2.1 and NFPA noncompliant HVAC residents, visitors a Findings include: On facility tour betw on 12/05/13, observ ventilation system in is utilizing the egres	s not met as evidenced by: ions and staff interviews, it d that the facility's general onditioning system (HVAC) is nce with the LSC, Section 90A, Section 2-3.11. A C system could affect all the nd staff of the facility.	4		iity ID: 00474	ation shee	t Page 3 of 4
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: UVMU2	:1	Fac	ility ID: 00474 If continua	ation shee	et Page 3 of 4

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		245402	B. WING			12	/05/2013	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334				
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN CORRECTIVE REFERENCED DEFICIE	ACTION SH	IOULD BE	(X5) COMPLETIO DATE
K 067		ge 3 dent rooms. This finding was intenance Supervisor at the	K 06	7				
-	A waiver was reque year.	sted and approved in previous	5	0	, 192 A		×	
	This deficient pract Maintenance Supe	ice was verified by the visor.	51		3			
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Sheehan, Pat (DPS)

From: Sent:	Sheehan, Pat (DPS) Friday, January 03, 2014 3:21 PM 'rochi_lsc@cms.hhs.gov'
To:	Anderson, James A (DPS); 'ceo@grvillage.org'; Dietrich, Shellae (MDH); 'Fiske-Downing,
Cc:	Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	Glenwood Village Care Center (245402) K67 Annual Waiver Regest - Previous Approved - No changes

This is to inform you that Glenwood Village CC is requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-5-13.

Glenwood Village CC's waiver request includes information that this item will be corrected as part of a 3.6 million dollar addition/renovation to be completed in December, 2014.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor Office: 651-201-7205 Cell: 651-470-4416 Health Care & Corrections Fire Inspections Minnesota State Fire Marshal Division Est. 1905 445 Minnesota St., Suite 145, St Paul, MN 55101-5145 FAX: 651-215-0525 Web: fire.state.mn.us

Request for waiver for K067 - Sprinkled Buildings

A waiver has been previously approved for this building and there have been no physical/structural changes since the approval of the last waiver.

A waiver is requested for K067 for the following reasons.

- A. There will be no adverse effect on the health and safety of the facility's residents and staff because:
 - 1. The building is protected throughout by an automatic sprinkler system installed in accordance with NFPA 13.
 - 2. Facility is within five-minute response time from fire station.
 - 3. The building fire alarm system is monitored to provide automatic fire department notification.
 - 4. Resident sleeping rooms are equipped with battery operated single station smoke detectors that are checked monthly.
 - 5. All air handlers shut down automatically when the fire alarm is activated.
 - 6. All corridors are fully protected by automatic smoke detection.
 - 7. Annual service and maintenance contracts exist to service all the facility's fire protection systems. (e.g. fire alarm, sprinkler system, fire dampers and portable extinguishers.)
 - 8. Fire Drills are conducted quarterly on each shift.
 - 9. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires
 - 10. The facility and campus is smoke free and signs to that effect are prominently posted at all major entrances.

Compliance with K067 WILL BE MET upon completion of the \$3.6 million dollar addition/renovation of the facility that is currently underway. The anticipated completion of this project is slated for December, 2014.

Glenwood Village Care Center 719 Southeast 2nd Street Glenwood MN 56334

Mary D. Kueper administrator