#### CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL ID: UXQR ATE SURVEY AGENCY Facility ID: 00313				
1. MEDICARE/MEDICAID PROVIDER           (L1)         245410           2.STATE VENDOR OR MEDICAID NO           (L2)         585219600		3. NAME AND AD (L3) <b>RICE C</b> A (L4) <b>1801 SO</b> (L5) <b>WILLM</b>	ARE CENTI UTHWEST	ER	IAR AVEN		<ol> <li>TYPE OF ACTION</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OV (L9)	WNERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L 13 PTIP	.7) 22 CLIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After C</li> </ol>	9. Other omplaint	
6. DATE OF SURVEY 05 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/28/2014 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOW         18 SNF       18/19 SNF         78         (L37)       (L38)         16. STATE SURVEY AGENCY REMAIN         See Attached Remarks         17. SURVEYOR SIGNATURE	5 19 SNF (L39)	B. Not in Com Requirement ICF (L42)	nce With equirements Based On: ccceptable POC pliance with Program ents and/or Applied W IID (L43)		And/Or Approved Waivers Of The Following Requirements:        2. Technical Personnel      6. Scope of Services Limit        3. 24 Hour RN      7. Medical Director        4. 7-Day RN (Rural SNF)      8. Patient Room Size        5. Life Safety Code      9. Beds/Room         * Code:       A*         Metical Director      1.12         15. FACILITY MEETS       1861 (e) (1) or 1861 (j) (1):         (L12)       18. STATE SURVEY AGENCY APPROVAL       Date:				
Brenda Fischer, U	*	or be complete	06/02/2014	(L19)			rcement Special	ist 06/04/2014 (L20)	
19. DETERMINATION OF ELIGIBILIT         _X1. Facility is Eligible to P        2. Facility is not Eligible	ГY articipate	20. COM	IPLIANCE WITH C		21. 1.	. Statement of Financia	al Solvency (HCFA-2572) aterest Disclosure Stmt (HCF	'A-1513)	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	DATE E SANCTIONS of Admissions:	24. LTC AGREEME ENDING DATI (L25) (L44) (L45)		VOLUNTARY 01-Merger, Clo 02-Dissatisfact 03-Risk of Invo		<u>INVOLUN</u> 05-Fail to N t 06-Fail to N <u>OTHER</u>	(L30) <u>TARY</u> feet Health/Safety feet Agreement r Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/C 03001		30. REMARKS	s				
	(L28)	05001		(L31)					
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION ( 05/19/2014	OF APPROVAL DAT	ГЕ (L33)	DETERMIN	NATION APPROV	VAL		

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

ID: UXQR

Facility ID: 00313

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

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 05/09/2014, the facility is certified for 78 skilled nursing facility beds.



Medicare Provider # 245410

May 30, 2014

Mr. Tony Ogdahl, Administrator Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, MN 56201

Dear Mr. Ogdahl:

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 May 9, 2014, the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

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

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

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.

ate Compton

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



June 4, 2014

Mr. Tony Ogdahl, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5410023

Dear Mr. Ogdahl:

On April 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 15, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 9, 2014 and therefore remedies outlined in our letter to you dated April 22, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

ate Comston

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



June 4, 2014

Mr. Tony Ogdahl, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, MN 56201

Re: Enclosed Reinspection Results - Project Number S5410023

Dear Mr. Ogdahl:

On May 28, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2014, with orders received by you on April 24, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

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

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 245410	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 5/28/2014
Name	of Facility		Street Address, City, State, Zip Code	
RICE CARE CENTER			1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	NUE

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)	ltem		(Y5)	Date
				Correction					Correction					Correction
	) Profiv	F0156		Completed 04/23/2014		ID Prefix	E0157		Completed 05/08/2014		ID Prefix	E0278		Completed 05/08/2014
			40) 402 40/	-					05/00/2014			483.20(g) - (j)		03/00/2014
	LSC	483.10(b)(5) - (	10), 403.10(1	5)(1)		Keg. # LSC	483.10(b)(11)				LSC	403.20(g) - (l)		
					-									
				Correction					Correction					Correction
II	) Prefix	F0309		Completed 05/08/2014		ID Prefix	F0312		Completed 05/08/2014		ID Prefix	F0314		Completed 05/08/2014
		483.25					483.25(a)(3)					483.25(c)		
	LSC			•							•			
					-									
				Correction					Correction					Correction
11	D Prefix	F0315		Completed 05/08/2014		ID Prefix	F0323		Completed 05/02/2014		ID Prefix			Completed
	Rea. #	483.25(d)		-		Rea.#	483.25(h)		-		Reg. #			
	LSC			•		LSC								
				Correction Completed					Correction Completed					Correction Completed
11	D Prefix					ID Prefix					ID Prefix			
	Reg. #					Reg. #	_				Reg. #			
	LSC					LSC					LSC			
				Correction					Correction					Correction
				Completed					Completed					Completed
11	D Prefix			-		ID Prefix			-		ID Prefix			
	Reg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			
Revi	ewed By		Reviewed I	Зу	Da	te:	Signature o	f Surve	yor:	1			Date:	
State	Agency	/	В	F/KJ	05	5/30/20	14		19	691			5	/28/2014
Revi	ewed By	,	Reviewed I	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
CMS	RO													
Foll	owup to	Survey Comple						-				a Summary of		
		4/3/2	014				Unc	orrecte	a Deficiencies	s (CMS	-2567) Sent	to the Facility?	YES	NO

Form Approved

OMB NO. 0938-0390

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00313	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 5/28/2014
Name	of Facility		Street Address, City, State, Zip Code	
RICE CARE CENTER			1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	NUE

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

(Y4) Item	()	5) Dat	te	(Y4)	Item	(Y5)	Date	(Y	4) Item		(Y5)	Date
		Correc	tion				Correction					Correction
		Compl					Completed					Completed
ID Prefix	20265	05/08/2	2014	'	ID Prefix	20830	05/08/2014		ID Prefix	20855		05/08/2014
0	MN Rule 4658.0085	_			•	MN Rule 4658.0520 Subp.	1		•	MN Rule 4658.0	)520 Subj	5. 2 E.
LSC		_			LSC		_		LSC			
		<b>C</b> a <b>m</b> a a	tion.				Compation					Correction
		Correc Compl					Correction Completed					Correction Completed
ID Prefix	20900	05/08/2		1	ID Prefix	20910	05/08/2014		ID Prefix	21800		04/23/2014
Reg. #	MN Rule 4658.0525 Sub	o. 3			Reg. #	MN Rule 4658.0525 Subp.	5 A.I		Reg. #	MN St. Statute1	144.651 S	ubd. 4
LSC		_							LSC			
		Correc					Correction					Correction
ID Prefix		Compl	eted		ID Prefix		Completed		ID Prefix			Completed
Reg. #		_			Reg. #		_		Reg. #			
•		_			LSC		_		-			
		_					_					
		Correc	tion				Correction					Correction
		Compl	eted				Completed					Completed
ID Prefix					ID Prefix		_		ID Prefix			
Reg. #		_			Reg. #		_		Reg. #			
LSC		_		<u> </u>	LSC		-		LSC			_
		Correc	tion				Correction					Correction
		Compl					Completed					Completed
ID Prefix				1	ID Prefix				ID Prefix			•
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			_
Reviewed By	Reviewe	Ву		Date		Signature of Surv	-				Date:	
State Agency	/	BF/K	J	05	/30/20	14		196	91		0	5/28/2014
Reviewed By	Reviewe	l By		Date	9:	Signature of Surv	eyor:				Date:	
CMS RO												
Followup to	Survey Completed on: 4/3/2014									a Summary of to the Facility?	YES	NO
	4/3/2014 TATE FORM: REVISIT REPORT (5/99)					Page 1 of 1				Event ID:	UXQR12	

#### **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 245410	<b>(Y2) Multiple Constru</b> A. Building B. Wing		N BUILDING 01	(Y3) Date of Revisit 5/15/2014
Name	of Facility			Street Address, City, State, Zip Code	
RICE CARE CENTER				NUE	

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)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			04/07/2014		ID Prefix			04/02/2014		ID Prefix			04/03/2014
0	NFPA 101				-	NFPA 101				-	NFPA 101		
LSC	K0011			<u> </u>	LSC	K0017				LSC	K0029		_
			Comostion					Comodion					Competing
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			04/02/2014		ID Prefix			04/11/2014		ID Prefix			05/09/2014
Rea. #	NFPA 101				Rea. #	NFPA 101					NFPA 101		
-	K0051				-	K0052				-	K0056		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			04/30/2014		ID Prefix					ID Prefix			
Reg. #	NFPA 101				Reg. #					Reg. #			
LSC	K0069				LSC					LSC			
			Correction					Correction					Correction
ID Prefix			Completed		ID Brofiv			Completed		ID Profix			Completed
Reg. # LSC					Reg. #					Reg. #			
				<u> </u>	LSC					130			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #								
LSC					LSC					LSC			
				1									
Reviewed By	/ Rev	viewed B	у	Da	te:	Signature of	fSurve	yor:				Date:	
State Agenc	/	Р	S/KJ	0	06/04/2	014		272	200			05	/15/2014
Reviewed By	/ Rev	viewed B	у	Da	te:	Signature of	fSurve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	on:				Check f	or anv	Uncorrected	Defic	encies. Was	a Summary of		
	4/1/2014	ļ					-				to the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245410	<b>(Y2) Multiple Constr</b> A. Building B. Wing	ADDITION	(Y3) Date of Revisit 5/15/2014
Name	of Facility		Street Address, City, State, Zip Code	
RICE CARE CENTER			1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	NUE

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	(Y!	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(	Y5)	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		04/02/2014	ID Prefix		04/07/2014	ID Prefix			04/11/2014
-	NFPA 101	_	-	NFPA 101		-	NFPA 101		
LSC	K0017	_	LSC	K0027		LSC	K0052		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
					-				
Reg. #		_	Reg. #			Reg. #			_
		_							_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			
Reg. #			Reg. #			Reg. #			
LSC		_	LSC			LSC			_
		Correction			Correction				Correction
ID Prefix		Completed			Completed				Completed
		_			-				
Reg. #		_	Reg. #			Reg. #			
		_							
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix			ID Prefix			
Reg. #			Reg. #			Reg. #			
LSC		_	LSC			LSC			_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
State Agency	/	PS/KJ	06/04/20	14	27	200		05	/15/2014
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Survey Completed on:			Check for any	Uncorrected D	eficiencies. Was	a Summary of		
	4/1/2014			Uncorrecte	d Deficiencies	(CMS-2567) Sent	to the Facility?	YES	NO

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL ID: UXQR TE SURVEY AGENCY Facility ID: 0031					-		
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245410           2.STATE VENDOR OR MEDICAID NO.           (L2)         585219600	).	3. NAME AND ADI (L3) RICE CA (L4) 1801 SOI (L5) WILLM	ARE CENTE	R		ENUP (L6)	E 56201	1. Initia 3. Term 5. Valida	ZPE OF ACTION:     2 (L8)       nitial     2. Recertification       Fermination     4. CHOW       Validation     6. Complaint       Dn-Site Visit     9. Other			
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUF 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA		8. Full Survey After Complaint			
<ul> <li>6. DATE OF SURVEY 04/0</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>	<b>3/2014</b> (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 0 15 ASC 16 HOSP				EAR ENDING E 09/30	DATE: (L3:	5)	
<ol> <li>IILTC PERIOD OF CERTIFICATION         From (a):          To (b):          12. Total Facility Beds         </li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ol>	78 (L18) 78 <sup>(L17)</sup>	B. Not in Com	ce With quirements	/aivers:	2 3 4	. Technic . 24 Hou . 7-Day l . Life Sa	cal Personnel ır RN RN (Rural SNF ıfety Code		uirements: Scope of Service Medical Directo Patient Room Si: Beds/Room	r		
18 SNF 18/19 SNF	19 SNF	ICF	IID				61 (j) (1):		(L15)			
78 (L37) (L38)	(L39)	(L42)	(L43)									
16. STATE SURVEY AGENCY REMARK See Attached Remarks	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):	I								
17. SURVEYOR SIGNATURE		Date :			18. STATE	E SURVE	Y AGENCY A	PPROVAL		Date:		
Karen Aldinger.			05/12/2014	(L19)	Kate JohnsTon, Enforcement Specialist 05/15/2014 (L20)					014 (L20)		
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Part          2. Facility is not Eligible		20. COM	D BY HCFA RE PLIANCE WITH CI ITS ACT:			1. Stat 2. Ow	tement of Finan	cial Solvency (HC	CFA-2572)	1513)		
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMEN ENDING DATE		26. TERN <u>VOLUNTA</u> 01-Merger,	ARY		00	INVOLUNTA	30) <u>RY</u> t Health/Safety		
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L25) (L44)		03-Risk of	Involunta	W/ Reimbursem ry Termination Withdrawal		06-Fail to Mee <u>OTHER</u> 07-Provider S 00-Active	-		
	D. Resente Sus	pension Date.	(L45)									
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMA	RKS						
	(L28)	03001	(L31)									
31. RO RECEIPT OF CMS-1539	32	DETERMINATION O	OF APPROVAL DAT	E	-							
	(L32)			(L33)	DETERM	MINAT	ION APPRO	OVAL				

CENTERS FOR MEDICARE & MEDICAID SERVICES SMITTAL ID: UXQR

Facility ID: 00313

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

STATE AGENCY REMARKS

C&T REMARKS - CMS 1539 FORM

Page 2 Provider Number: 24-5410 Item 16 Continuation for CMS-1539

At the time of the standard survey completed 4/3/2014, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Certified Mail # 7011 2000 0002 5147 5120

April 22, 2014

Mr. Tony Ogdahl, Interim Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5410023

Dear Mr. Ogdahl:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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

Rice Care Center April 22, 2014 Page 2

# <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:

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301

Telephone: (320)223-7338 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 May 13, 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 May 13, 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

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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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

#### 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 July 3, 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 October 3, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

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

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

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

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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.

Tomston

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

DEPARTMENT OF	HEALTH ANI	D HUMAN	SERVICES
CENTERS FOR M	EDICARE & M	/EDICAID	SERVICES

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PRINTED: 04/21/2014 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	MAY 0 1 2014	(X3) DAT	E SURVEY PLETED
		245410	B. WING		MN Dept of Health	04/	/03/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CI 1801 SOUTHWEST V WILLMAR, MN 562	TY, STATE, ZIP CODE VILLMAR AVENUE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORF	R'S PLAN OF CORRECTIC RECTIVE ACTION SHOULI RENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 0	00			
F 156 SS=D	as your allegation of Department's accept bottom of the first probession of the first problem of the substare substar	of correction (POC) will serve of compliance upon the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site y may be conducted to initial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES orm 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 orm each resident who is benefits, in writing, at the time nursing facility or, when the ligible for Medicaid of the that are included in nursing er the State plan and for nay not be charged; those vices that the facility offers sident may be charged, and pes for those services; and	F 1		chment for PoC completion		
LABORATORY	DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		E	(	X6) DATE

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			(X3) DATE COMF	SURVEY
		245410	B. WING			04/	03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
				1801 S	SOUTHWEST WILLMAR AVENUE		
RICE CAR	E CENTER				MAR, MN 56201		
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1							
™::F 156	Continued From page	e 1	F	156			
45	inform each resident	when changes are made to					
	the items and service (i)(A) and (B) of this s	s specified in paragraphs (5) ection.					
•	at the time of admissi the resident's stay, of facility and of charges including any charges under Medicare or by The facility must furni legal rights which incl	s for services not covered the facility's per diem rate. sh a written description of udes:					entre so Provis Buffet V
	A description of the m funds, under paragra	nanner of protecting personal ph (c) of this section;					
	for establishing eligib the right to request an 1924(c) which determ non-exempt resource institutionalization and spouse an equitable cannot be considered toward the cost of the	d attributes to the community share of resources which I available for payment i institutionalized spouse's i her process of spending					
	numbers of all pertine groups such as the S agency, the State lice ombudsman program advocacy network, ar unit; and a statement complaint with the Sta agency concerning re	addresses, and telephone ent State client advocacy tate survey and certification ensure office, the State in the protection and the Medicaid fraud control that the resident may file a fate survey and certification issident abuse, neglect, and esident property in the					

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

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Event ID: UXQR11

Facility ID: 00313

If continuation sheet Page 2 of 49

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PRINTED: 04/21/2014 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB N</u>	<u>NO. 0938-0391</u>
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RICE CAF	RECENTER				SOUTHWEST WILLMAR AVENUE LMAR, MN 56201		n in star Star Star
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F 156	Continued From page	e 2	F	156			· · · · · ·
		pliance with the advance					
· · · · ·	The facility must infor name, specialty, and physician responsible						
	written information, an applicants for admiss information about how Medicare and Medica						642 - M - KOK - O - 25 5 5 5 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2
	by: Based on interview a facility failed to provid noncoverage, or gene discontinuation of Me	is not met as evidenced ind document review, the le the notice of provider eric notice, upon dicare part A services for 1 eviewed for liability notices.					
· · · ·	Findings include:						
1 192	had been admitted to Medicare part A servic Progress and Dischar indicated R23 had me skilled services would There was no indication notice of provider non notify the resident of t	ssion Record indicated he the facility on 1/13/14, on ces. The Physical Therapist ge Summary dated 2/27/14, at the therapy goals and be ending on 2/27/14. on R23 had received a coverage (CMS 10123) to he right to an expedited Improvement Organization.					

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Event ID: UXQR11

Facility ID: 00313

If continuation sheet Page 3 of 49.

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# F 156 Notice of Rights, Rules, Services, Charges

### **Corrective Action:**

R 23 discharged from facility

### **Corrective Action – identify other residents**

Effective 4/7/2014 all patients being discharged from facility will be given a 48 hour notice of denial.

### **Corrective action to Prevent Reoccurrence:**

Medicare Denial Completion has been added to the check list to alert Nursing or Social Services to complete Medicare Denial 48 hours before discharge.

Business office personal has developed an internal check list for completion for discharged patients

### **Monitoring for Compliance**

Random Audits will be completed weekly by the DON or Designee to assure Medicare denials were given. This audit will continue for 90 days and the results brought to the QA committee for recommendations on the need for further audits.

## **Date of Completion**

April 23, 2014

PRINTED: 04/21/2014 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY OMPLETED
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		245410	B. WING			04/03/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
RICE CAE	RECENTER			1801 SOUTHWEST WILLMAR AVENUE		
				WILLMAR, MN 56201		
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F 156	Continued From pa	ge 3	F 15	6		
	business office mar discharged to home Medicare part A day	on 4/2/14, at 12:00 p.m. nager stated R23 was a on 2/28/14, utilizing only 43 ys, and should have been Provider Noncoverage, but				
19 1. h		sted, but not provided by the				
F 157	facility. 483.10(b)(11) NOTI		F 15	7		
SS=D	(INJURY/DECLINE	(ROOM, ETC)		Refer to attachment fo	or PoC	
es Vest	consult with the rest	ediately inform the resident; ident's physician; and if sident's legal representative		and date of completion	ı	
	or an interested fam accident involving th	nily member when there is an ne resident which results in otential for requiring physician				
	intervention; a signi physical, mental, or	ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial				
	status in either life the clinical complication	hreatening conditions or s); a need to alter treatment need to discontinue an				
	existing form of trea consequences, or to	tment due to adverse o commence a new form of ision to transfer or discharge				
		e facility as specified in				
·	and, if known, the re	o promptly notify the resident sident's legal representative				
	change in room or ro	member when there is a commate assignment as 5(e)(2); or a change in				

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PRINTED: 04/21/2014. FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO	OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	- (X3) DATE COM	SURVEY PLETED
		245410	B. WING		04,	/03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
RICE CAR	E CENTER			1801 SOUTHWEST WILL WILLMAR, MN 56201	WAR AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From pag	e 4	F	157		
· · · · · ·	resident rights under	Federal or State law or ied in paragraph (b)(1) of				4 (y
	the address and pho	ord and periodically update ne number of the resident's or interested family member.				
		Γ is not met as evidenced				· · ·
		and document review, the			v	. : .
		the physician/practitioner s (R36) developed pressure				
	Findings include:				-	
		imum Data Set (MDS) dated was cognitively intact, was				
•		cers, but did not have any				
	registered nurse (RN noted on R36's right i	n 4/1/14, at 2:15 p.m. with )-G. A pressure ulcer was inner buttocks, that was a edness surrounding the				-
	area. R36 stated, "I l a while." RN-G was	have had that sore for quite unsure if the physician or d been notified of R36's				· · ·
	2/19/14, "Patient note shearing to middle of	gress notes identified on ed to have small area of left buttocks measuring 2 y] 0.5 cm. Appears to be				· ·· ·

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

Event ID: UXQR11

Facility ID: 00313

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PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	VIEDICAID SERVICES					J. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI				E SURVEY PLETED
		245410	B. WING			04	/03/2014
NAME OF P	ROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTHWEST WILLMAR AVENUE		
	E CENTER				VILLMAR, MN 56201		
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F 157	calmo [protective barr continue to monitor." Sheet dated 2/19/14, thickness loss of derm open ulcer with a red slough) pressure ulce scant amount of drain pink, and wound edge listed as being from, " indicated the practitio notified of the develop Review of the nurse 2/21/14, did not indicate informed of the press developed on 2/19/14	ing transfers. Will apply ier cream] to area and R36's Wound Progress included a stage 2 (partial his presenting as a shallow pink wound bed, without r, with a pink wound bed, age, surrounding tissue as normal. The wound was Shearing." The form her and family had not been oment of the pressure ulcer. bractitioner (NP) note dated ate the NP had been ure ulcer which had	F	157			- 143-14 Net 144 Net 144 O Net 144 O
	skin assessment for h with the following resu number "1) Banmchal .75 cm." Review of the physicia not indicate the physic	3/11/14, indicated, "Weekly igh risk patient completed ults." Under "skin issues," ole [sic] right buttock 1 cm x an note dated 3/19/14, did cian had been informed of					
•	2/19/14. R36's Progress Notes "Observed wound to o evening. 1.75 inches surrounding multiples skin shearing." When interviewed on	en though it developed on dated 4/1/14, indicated, coccyx/buttock crease this a 3 inches, reddened areas small areas of stage 2 or 4/1/14, at 2:43 p.m. RN-C e NP had been notified of t was not sure.					

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Facility ID: 00313

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# F 157 Notification of Physician

### **Corrective Action:**

Res 36 physician notified of pressure ulcer on April 9, 2014

### Corrective Action - Identify other residents:

All residents/patients that have pressure areas have been reviewed to ensure physician notification per policy

### **Corrective action to Prevent Reoccurrence:**

Education will be completed on May 8, 2014 regarding the current policy of Notification of changes in resident conditions.

### **Monitoring for Compliance:**

Audits will be completed by RN Care Manager &/or DON weekly at wound meeting to assure the physician has been notified for all pressure ulcers or changes of ulcer.

Results will be brought to QA committee for recommendation on the need to further audit

### Date of completion

May 8, 2014

PRINTED: 04/21/2014 FORM APPROVED

STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245410	B. WING		04/03/2014
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COI 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLET E APPROPRIATE DATE
F 157	2/19/14, which contin physician or NP were to determine if a char needed to heal the pr	bed a pressure ulcer on ued to become larger, the never notified of the ulcer, nge to the plan of care was	F 15	7	
<i>:</i>	included, "RCC [Rice immediately inform th resident's physician	Care Center] will e resident; consult with the Any significant change such e ulcer from stage 1 to	F 27	8	
SS=D	ACCURACY/COORE	t accurately reflect the		Refer to attachment f and date of completic	
	A registered nurse me each assessment with participation of health				
	A registered nurse me assessment is complete	ust sign and certify that the eted.			
		completes a portion of the n and certify the accuracy of sessment.			
	willfully and knowingly false statement in a r subject to a civil mone \$1,000 for each asse willfully and knowingly	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual			
		nd false statement in a is subject to a civil money nan \$5,000 for each			

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

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Facility ID: 00313

If continuation sheet Page 7 of 49

PRINTED: 04/21/2014 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVEL OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		245410	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER	······································	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
RICE CAR	RECENTER			SOUTHWEST WILLMAR AVENUE LMAR, MN 56201	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 278	Continued From page assessment.	97	F 278		
	Clinical disagreemen material and false sta	t does not constitute a tement.			
	by: Based on interview, a facility failed to ensur				
1	coding instructions fo included, "Review th evidence of a trial of a resident-centered toile trial should include ob of toileting patterns w	ent Assessment Instrument) r a toileting program, e medical record for			
	diary." "Review recor as frequency, volume daytime, quality of stru- those who are experie "Simply tracking conti- bladder record or voic considered a trial of a resident-centered toile current toileting progra criteria must be met, " individualized, resider that was based on an	ds of voiding patterns (such , duration, nighttime or eam) over several days for encing incontinence." nence status using a ling diary should not be n individualized, eting program." For a am or trial the following implementation of an nt-specific toileting program			

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

Event ID: UXQR11

Facility ID: 00313

If continuation sheet Page 8 of 49

TATEMENT	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245410	B. WING		0.	4/03/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	E CENTER			801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
 • F 278	Continued From page	e 8	F 278			
	the individualized pro	gram was communicated to verbally and through a care				
		nd written report; notations				•
• .	program and subseq needed."					
	2/14/14, included she frequently incontinent toileting program had					
	program. The MDS a	as on a current toileting also included a diagnosis of sived a diuretic (water pill)				
	R36's Bladder Asses	ement datad 2/12/14				
	included risk factors f including impaired me	for urinary incontinence, bility with dependent ge on way to bathroom,				· · · · · · · · ·
	urgency-unable to su failure, and use of a c also did not include a	ppress, congestive heart Jiuretic. The assessment ny voiding patterns as				
	directed by the RAI M	lanuel.				
-		ated 2/19/14, included risk				
		required to toilet, urinary e associated skin damage,				
	of a diuretic. The typ	ty, urinary urgency, and use e of urinary incontinence				- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	time due to physical of	onal (can't get to the toilet in disability, external obstacles, or communicating." An				

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

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Event ID: UXQR11

Facility ID: 00313

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# F278 Assessment Accuracy/Coordination/Certified

### **Corrective Action:**

Res 36 Bowel & Bladder assessment was reassessed on 4/14/04 - 4/16/2014. Assessment accurately reflected the residents care plan that staff are providing

### Corrective Actions - identify other residents:

- The RAI process was reviewed and is current
- All residents with urinary incontinence assessments and care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

### **Corrective Action to Prevent Reoccurrence:**

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of MDS matches the care plan. Nursing staff are to alert Clinical Coordinator if changes, significant change will be evaluated at that time.

### **Monitoring for Compliance:**

DON or Designee will audit bladder assessment to ensure resident assessment accurately reflects the care plan. Audits will be done weekly for 4 weeks then 2 times a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.

#### **Completion Date:**

May 8, 2014

	MENT OF HEALTH AN				FORM	D: 04/21/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		245410	B. WING		04/	03/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAF	RECENTER			801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 278	Continued From page	<b>A A</b>	F 278			1999 - 1999 - 1999 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 -
		; compounded by loss of	1 270			
	mobility. She is on di	uretics. Incontinence is				
	chronic, per AL [assis indicated care plannir	ted living]." The form ig would occur, "Proceed to				
	care plan to assist wit	h toileting and attempt to				
		e as able." There was no nent has been completed				
	that included a three	-				
		a voiding pattern or not as				1 - s
	directed by the CMS I	KAI Manuel.				
ar Antonio	-	2/20/14, included, a recent				
	decline in activities of	daily living, staff were with toileting, monitor for				
	increased incontinenc	e and/or constipation and				· • • • • •
		are physician] if indicated." address risk factors of				
		e, or to direct staff on any				
	program to maintain c incontinence.	r improve urinary				
	incontinence.					
		4/1/14, at 2:43 p.m. RN-C to the toilet when they get				ur un das Bræite
	her up for meals or the	erapy. There is no				
		roiding patterns had never pattern, frequency, volume,				
		stream. RN-C had not				
		ssessment, as the assisted rom stated R36 had been				
	-	of urine. An actual toileting				
		en trialed and she was not program, as indicated by				
	the 2/14/14, MDS.	program, as mulcated by				
F 309	483.25 PROVIDE CAI		F 309	Refer to attachment for PoC		, ,
SS=D	HIGHEST WELL BEIN	lG		and date of completion		

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Event ID: UXQR11

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#### PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245410	B. WING			04/	03/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	E CENTER				01 SOUTHWEST WILLMAR AVENUE ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
: 4				200			
F 309	provide the necessar or maintain the highe mental, and psychoso accordance with the o	eceive and the facility must y care and services to attain st practicable physical,	F	309	, ,		
	and plan of care.		-				
•	by: Based on observatio review, the facility fail	<ul> <li>is not met as evidenced</li> <li>n, interview, and document</li> <li>led to coordinate care with</li> <li>nit to include fluid intake</li> </ul>					2006 ROVIT E.(295
2 a. 2. . 8 °.		ialysis access site, and es for 1 of 1 resident (R152) r dialysis care.					· <u>;</u>
	Findings include:						· · · · · · · · · · · · · · · · · · ·
2000 1 , - 1	dated 1/27/14, includ intact, had diagnoses disease (ESRD), and received a therapeuti tracking MDS's indica hospitalized 2/8/14 to	c diet. Entry and discharge ated R152 had been 9 2/14/14, 2/27/14 to 3/11/14,					
	and 3/18/14 to 3/21/1						
	problem statement of to] ESRD; hepatic en dysfunction caused b remove toxic substan Dialyzing [sic] 3 days	y the liver being unable to ices from the blood],					

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Event ID: UXQR11

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#### PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			SURVEY
		245410	B. WING			04/	03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE		· ·
RICE CAR	E CENTER			1801 SOUTHWEST WIL WILLMAR, MN 5620			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From page	a 11	F	309			• •
1 000		in Litchfield." R152's goal					÷ .
4.5		alysis runs while here AEB					
. At		lity to complete 3.5 hour run,			· .		
4		and maintain VS [vital					
		ons included, "Follow uding diet restrictions and 1.5					
	L [liters] fluid restriction						
		ord with to all runs. Weigh					
		e nutrition care plan dated					• • •
-		"Provide 2 Gram Sodium,					5 1. 13 11 1
		[potassium], 1,500 cc [cubic 1.5 liters] restriction per					1 M.1
		nitor weight and meal intake."					
		-					
2	included, "Diet order: sodium 1000 ml [milli				÷		
	amounts of potassiun	on used to remove large n from the body, typically					
	used if dialysis runs a						
		evels] 15 gm [grams]/60 ml: NLY IN EMERGENCY. PRIOR TO TAKING "					x
		ns] every 8 hours as needed					
	for nausea with vomit						
	•	nunication Record dated					
	1000 cc/day." The ca updated to reflect this						
	When interviewed on	4/1/14, at 1:00 p.m. R152					
	stated she was on 10	00 cc per day fluid					
		large water mug at her pproximately 240 cc of water					
	7(02-99) Previous Versions Obs		l	Facility ID: 00313	If conti		<u> </u>

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

. . . ( Facility ID: 00313

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		MEDICAID SERVICES				NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245410		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING			04/03/2014	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COD	-	
RICE CAR	E CENTER			801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pag	e 12	F 309			
1 303			1 000			
		e gets the mug filled a , but she knows she has to				
		e, which is hard for her due to				
		stated she only gets 1000				
		o drinks less than that. R152				
		lications of her liver and				
	kidney disease inclue	ding: pain, skin being itchy,				
		and vomiting. R152's				
	dialysis access site v	vas on her left arm, as an AV				
	fistula [where an arte	ery and vein are surgically				10 July 10
2		ccess site for the needle for				
501- -		d when she is done with				:
GC	each dialysis run, the	e dialysis unit will place a tight ess site.  When she is getting				
		equests the bandage be				
		is uncomfortably tight, and				
		pped. R152 stated some				
		he dressing for her, others				
	will not, it depends o					
	addition, R152 stated	d she use to go to dialysis				
	three days a week, b	out this has been increased to				. *
		she has too much fluid. The				
		ect staff on care of the				
		nausea, vomiting, itching, or				
	the 1000 cc fluid rest					
	When interviewed or					
		I)-G stated R152 is on a				
		on and monitors her own				
		provides her with a mug of				
		day, 120 cc of a nutritional day with her medications, and				
	bowever much water	it takes to swallow her				1.1.1.2.1
		e times each day. RN-G did				
		fluid dietary gives R152 with				
ulu J	meals, as this is not	coordinated with nursing.				
17 6010	The facility does not	track fluid intake for R152.				
						1

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Facility ID: 00313

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### PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

#### DEPARTMENT, OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245410	B. WING		04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		REET ADDRESS, CITY, STATE, ZIP CODE	
	E CENTER			301 SOUTHWEST WILLMAR AVENUE /ILLMAR, MN 56201	· · · .
				PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 309	Continued From page	ə 13	F 309		
		ss site, this is left up to the			
	dialysis unit. R152 ha	ad been having sea and vomiting, she had			
	given her a medicatio	on for nausea earlier, and			
		nortly afterwards. RN-G ks, she checks the access			
		sure patency, this is not			· · · · · ·
	documented any whe				
	R152 was observed	on 4/2/14, at 8:00 a.m.			1 문 문 .
	consuming breakfast	, R152 had 90 cc of milk, coffee, and 120 cc lemon			
	lime soda. When R1	52 was finished with			
	breakfast, she had co	onsumed 360 cc total of the eakfast. On R152's bedside			
1.	table was 240 cc of v				
. 2.					· · · .
an a	When interviewed on	a 4/2/14, at 8:15 a.m. dietary			
	aide (DA)-A stated R	152 was on a 1500 cc per			
	day fluid restriction, a	and provided a card utilized indicated R152 should be			* * * *
ľ	provided with 120 cc	of each milk, juice and decaf			
	coffee at breakfast, 1	20 cc of each juice and			
	water at lunch and su 840 cc provided by d	upper. This was a total of lietary each day. DA-A	'		
	stated, "There are so	many people in and out of			
	the dining room, we d	don't have control if other s too," noting soda had been			
	provided by a visitor.				
	R152 was observed	at the noon meal on 4/2/14,			
	at 12:15 p.m. she ha	d been provided with 180 cc			
- 1 - 1		juice, and 90 cc of brown 12:30 p.m. a visitor had			11 11 11 11 11 11 11 11 11 11 11 11 11
2010 N 121	provided R152 with a	a can of Shasta cola. When			
	finished R152 had dr	ank at total of 390 cc. of the			
FORM CMS-25	37(02-99) Previous Versions Ob	solete Event ID: UX	QR11 Fac	cility ID: 00313 If contir	uation sheet Page .14 of 49

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PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·				0. 0300-0031
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245410	B. WING			04	/03/2014
	ROVIDER OR SUPPLIER	I		180	REET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTHWEST WILLMAR AVENUE LLMAR, MN 56201		· .
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page 570 cc offered at the approximately 100 cc from the mug at her b	meal. In addition, c of water was now missing	F	309			
	12:30 p.m. the dialys Memorial Hospital, st decrease her fluids to RN-I stated the facilit R152's dialysis acces dialysis to ensure are should check the site of infection at least di a book at the nursing the dialysis patient.	a telephone, on 4/2/14, at is manager, RN-I, for Rice ated R152 had orders to o 1000 cc a day, on 2/14/14. y nurses should be checking as site upon return from a is not bleeding, and for a pulse (bruit) and signs aily. The facility should have home about how to care for Only one book is kept in the provided for each resident. hould be followed.	· .				
	12:45 p.m. the dietici well as consulting die communication shee dialysis to the facility changed from 1500 c change occurred due doctor] order on 3/12 R152 could not keep herself, as she had ir confusion related to and extreme thirst. T had trouble managin drink soda pop. The tracking R152's fluids restriction for her. Go on a fluid restriction c	elevated ammonia levels, The dietician stated R152 Ing her thirst, and liked to facility should have been as and managing the fluid enerally when a resident is dietary would divide fluids to include meals, med pass,					

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

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Event ID: UXQR11

Facility ID: 00313

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245410	B. WING			. 04	4/03/2014	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RICE CARE CENTER				1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201			· · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
E 200	Continued From por	no 15	F	309				
F 309	Continued From page			309				
1		ld normally be care planned The dietary card and care						
<i></i>		een updated when R152's fluid						
	restriction changed,	as well as a determination						
		2 could have with med						
	passes. This had b	een missed. Dialysis goal is						
4	to remove less than	3 kg [kilograms] of fluid with had been often requiring well						
	over that amount. th	nerefore she was increased					5.7469	
		to 4 times a week on					<ul> <li>5.1.223</li> </ul>	
		also been hospitalized for						
	fluid over load and r						• ,	
		oval of fluid in the abdominal a care planning conference						
	with the dialysis inte	erdisciplinary team on 3/22/14.						
	R152's care plan sh	ould have been updated at						
	that time.							
÷ .								
	Mar interviewed o	-1/2/14 at 1:00 p m the						
	director of nursing (	n 4/2/14, at 1:00 p.m. the DON) was unable to find any					ie ie s N	
	book or instructions	from the dialysis unit on						
	caring for the dialys	is patient. The DON stated						
		access site should have been						
		added to R152's treatment						
• · · •	sheets for monitorin	g by the nurses. Emergency 52 was unable to make it to						
	dialvsis, had bleedir	ng from the dialysis site, or						
	critical lab values sh	hould have been care planned						
	also.							
	Mhon interviewed a	n 1/2/14 at 1.45 n m the						
		n 4/2/14, at 1:45 p.m. the )-E stated she had noted					a second	
	today that R152's fl	uid restriction had decreased		ŀ			·	
• .	from 1500 cc to 100	0 cc on 3/12/14. This was					al stere	
	missed. The facility	's routine would be to set up						
		uld be provided at each meal,						
	how much fluids cou						_	

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Facility ID: 00313

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		245410	B. WING			04/03/2014
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE,		
RICE CAR	RECENTER		,	1801 SOUTHWEST WILLMAR AV WILLMAR, MN 56201	/ENUE	
			I		N OF CORRECTION	(X5)
(X4) ID PREFIX TAG	. (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETIC
F 309	Continued From pag	e 16	F 3	99		
1 000	would be in the care	plan. It had been missed for				
	R152.					· · · ·
	R152 was discharge	d from the facility on 4/2/14,				100 g a 10 g
	at 2:00 p.m. having o	consumed 850 cc of the 1200				
		the facility, prior to the ement, refill of the water mug				
1)¥	in her room, or fluids	with medications remaining				
	for the day.					
	When interviewed or	n 4/2/14, at 2:00 p.m. the				
	DON had found the I	book on caring for the book had been located in				
a an	the nursing home po	rtion of the building, not in				1948 - 1 1929 - 2 1929 - 2 1920 - 2 192
en e		vhere R152 had resided. The included Guidelines for				
	Dialysis Nursing Hor	ne Patients, and instructions				
	blood from the acces	blood pressures or draw ss arm. Need to check the				
		a pulse, if no pulse to call the ve dressing in 2 hours after				
	dialysis, if the site wa	as bleeding to apply pressure				-
	for 15-30 minutes. I form each day with p	o send a communication pertinent information.				
	Information was also	n included on potential In such as excess fluid gains,				
	itching, and elevated	potassium levels. The DON				
	stated care of the ac restrictions should ha	cess site and fluid ave care planned, monitored				
	and documented by	the facility, but had not.				
		Is an ital Diabusia Desta and				••
. 8 	Agreement dated Ja	lospital Dialysis Protocol nuary 2007, included, "A				
		plan will be developed by the ns from both RMH and				
ORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: UX	 QR11	Facility ID: 00313	If continuation sh	eet Page 17 of
 3 <sup>+</sup>						

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## F 309 Provide Care/Services For Highest Well Being

## **Corrective Action:**

Res 152 was discharged from the facility

## Corrective Action - identify other residents:

All residents receiving dialysis services have been identified. Dialysis Educational manual is in each neighborhood for reference of emergency procedures for staff to refer to.

New Dietary form will be used for documentation of fluids after each meal. Information will be given to med nurse at the end of the shift for fluid intake totals. Dietary will have, on patient dietary card, fluid amounts for each meal

E-mar dialysis section has been added to include orders for dialysis patients to individualize care. This will include: care of access site, emergency procedures

## **Corrective action to Prevent Reoccurrence:**

Education will be completed on May 8, 2014 regarding residents receiving dialysis fluid restriction documentation, dialysis educational manual location, & adding nursing orders in the Treatment section of E-mar.

## Monitoring for Compliance:

Audits will be completed by DON &/or Designee weekly for one month then twice a month for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits.

## Date of Completion:

May 8, 2014

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245410	B. WING		04/03/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 309	Continued From page	9 17	F 30	9	
	a change in fluid rest facility failed to comm to staff. In addition, t care planning in place			· · ·	:
	intake. The facility di planning in place on l complications of dialy dialysis access site. on caring for the dialy not available on the u	ed, and did not track fluid d not have any care now to manage potential rsis or how to manage the The facility did have a book rsis unit, however, this was nit where R152 resided and vledgeable on how to find			in Ha Solar Solar Solar Solar
F 312	483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives th		F 31	Refer to attachment for PoC and date of completion	
	by: Based on observatio review the facility faile	is not met as evidenced n, interview and document ed to ensure oral hygiene 1 of 3 residents (R 29) who ce with oral care.			
	8-14-13 identified R29	(Minimum data set) dated ) was cognitively intact, had and needed extensive			

# PRINTED: 04/21/2014

STATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
AND PLAN OF	CORRECTION			NG			
		245410	B. WING	0.77		04	03/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		· ···
RICE CAR	E CENTER		1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201				
	· · · · · · · · · · · · · · · · · · ·				PROVIDER'S PLAN OF CORRECTIO		(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 312	Continued From page		F	312	~		
	2/19/14 activities of c assessment identified	d R29 needed extensive ming and personal hygiene					
	The care plan dated with activities of daily and impaired mobility care plan directed sta	2/21/14 indicated a problem living related to weakness y due to Parkinsons. The aff to provide extensive r dressing and grooming due			•		- 1712- 4 - 1925 - 3 - 2 (252) - 2 (252) - 3
	stated, "They never to to brush my teeth my the last time her teet she was staying on t she has her own tee dentures due to the r only eat chopped foo	on 4/1/14 at 1:20 p.m. R29 brush my teeth, I would like vself but I can't." She stated h were brushed was when he therapy unit R29 stated th, and is unable to wear roof of her mouth. She can be because she only has a er mouth, and wants staff to				÷,	
	An interview on 4/1/ <sup>2</sup> assistant (NA)-K said to get dressed and if brushed she will ask	d R29 sits on side of the bed she (R39) wants her teeth					· .
	NA-I stated R29 sits partially washes here with the rest. NA-I s	on 4/1/14 on 1:48 p.m. with s on the side of the bed and self a little but we help her tated R29 can only get into er wheelchair and staff					
	a.m. to 9:00 a.m. R2	bservation on 4/2/14 6:50 9 was not assisted by staff 6:50 a.m. R29 was in her			litv ID: 00313 If con		

# F 312 Oral Hygiene

## **Corrective Action:**

Res 29 oral hygiene is offered to resident every AM/PM . Staff is allowing R29 to continue to be independent with brushing of teeth; electric toothbrush has been provided to help with oral hygiene. Staff will assist if resident is unable.

### Corrective Action – Identify other residents

Oral Hygiene Policy has been reviewed & updated. Refusal of oral care planned and risk/benefit explained to resident regarding lack of oral hygiene. Oral exam is completed by license staff at least quarterly and PRN.

All residents have been identified if they have dentures, partials or own teeth and pink care card updated with this information for staff.

### **Corrective action to Prevent Reoccurrence:**

Education with all nursing staff will be completed May 8, 2014 reviewing the updated policy of oral hygiene. Pink Care cards reviewed with staff and providing oral hygiene every AM & PM with cares. Staff is to assist with oral hygiene if assistance is necessary. If resident refuses oral care, this will be care planned and risk/benefit explained to resident regarding lack of oral hygiene.

### **Monitoring for Compliance**

Random Audits will be completed by DON or RN/LPN 2 times a week for one month then 1 time a week for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits

### **Date of Completion**

May 8, 2014

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT O	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE S COMPLE	ETED .
		245410	B. WING _			04/0	3/2014
				1801	EET ADDRESS, CITY, STATE, ZIP CODE SOUTHWEST WILLMAR AVENUE LMAR, MN 56201		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 312 F 314 SS=G	recliner and stated s with brushing her tee brush in R29's bathr tooth brush remaine 9:00 a.m. she still ha her teeth. During an interview and NA-J both state brush her teeth this she needed assistan knew if R29 had der they have never ass During interview on nurse (RN-A) state not been getting her complains." 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil	he did not get assistance ath this morning. The tooth bom drawer was dry. The d dry, and R29 confirmed at ad not been assisted to brush on 4/2/14 at 9:00 a.m. NA-I d they did not assist R29 to morning, they were not aware nce. Neither NA-I or NA-J ntures or natural teeth, since sisted her with oral hygiene. 4/2/14 at 9:10 a.m. registered d she was not aware R29 has r teeth brushed, "She never ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the		312	Refer to attachment for Po and date of completion	C	
	individual's clinical they were unavoida	condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and					
	by: Based on observa review, the facility (R79_R36 and R1	NT is not met as evidenced tion, interview, and document failed to ensure 3 of 4 residents 50) with pressure ulcers, were ed and/or provided care to					· ·

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		TE SURVEY
		245410	B. WING				04/03/2014
				1801	EET ADDRESS, CITY, STATE, ZIP COD SOUTHWEST WILLMAR AVENUE LMAR, MN 56201	E	
NOL OAN					PROVIDER'S PLAN OF CO	PRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN(	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	
F 314	Continued From pag	e 20	F	314			
	ensure current press to prevent the develo	sure ulcers were healing and opment of new pressure date actual harm for R79.					
	Findings include:						
	indicated R79 was c extensive assistance repositioning in bed ulcer (PU) developm	a Set (MDS) dated 2/19/14 ognitively intact, but required with transferring and and was at risk for pressure nent. The MDS also identified of peripheral vascular y and hypertension.					- 1:20 - 2:00 - 2:00 - 2:00 - 2:00 - 2:00 - 2:00 - 2:00 -
	The 2/19/14 Pressu Assessment (CAA)	re Ulcer Care Area identified R79 was at risk for					
	unstageable PU due slough/eschar. The	e for bed mobility, and had an e to coverage of wound by CAA also identified risk					••• ••• •••
• -	factors of immobility and recent decline i (ADL).	, incontinence, poor nutrition, n activities of daily living					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	scale dated 3/21/14 meaning he was at PU. He currently ha new sores." The as had slight limited m problems of friction probably slide to so chair Maintains re or bed most of time The interventions in	ssment (with Braden Scale) identified R79 scored an 18, risk for the development of ad PU "bilateral to feet, with no ssessment also indicated he obility, with potential and shearing due to "skin me extent against sheets, elatively good position in chair but occasionally slides down." included pressure relieving the care, application of					
	dressing/ointments	and other preventative or	(0.0.11	Facil	ity ID: 00313	If continuation	sheet Page 21 c

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245410	B. WING		0	4/03/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
	RECENTER			1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	ENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
···						
F 314	was no indication a tu scheduled was imple	nd "prevalon boots." There urning and repositioning mented even though R79	F 3	14		
•	was at risk for PU, ha at risk for having frict	ad limited mobility, and was ion and shearing of his skin.				
	wounds to lower extr The care plan directe to open areas as per practitioner]" The p decline in mobility an interventions of "Nurs with ADL's and mobil Physical therapy (PT (OT) five times a wee endurance and stren of a turning and repo though R79 needed was at risk for pressu	kin, recurrent skin ry disease and chronic emities and skin tears easily. d staff to "Dressing changes CNP [certified nurse olan also identified he had a d weakness, with the sing will provide assistance ity per therapy directives." ) and occupational therapy ek for improved mobility, gth. There was no mention sitioning scheduled even staff assistance with mobility, ure ulcer development and assure ulcers which were not				1946 1946 1946 1946 1947 1946
•	nursing assistant (NA bath this morning and spot on the bottom se	on 4/1/14 at 2:10 p.m. A)-L stated she gave R79 a d noticed R79, "Had an open o we put Calizone lotion it is rea was smaller than an				
	registered nurse (RN stated R79 has some	on 4/1/14 at 2:25 p.m. with )-C unit clinical coordinator open areas on his legs, due RN-C did not mention R79 ters on his buttocks.				۰. 
	R79 was observation	44444				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI				E SURVEY IPLETED
		245410	B. WING			04	4/03/2014
NAME OF PF	OVIDER OR SUPPLIER	······		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	ECENTER		1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
							5 - KK P
F 314	Continued From page		F	314			
	regular high back cha his feet firmly on the	2:58 p.m. R79 was sitting in a air with a cushion asleep with floor. R79 continued to sleep					
- -	unknown NA entered feet onto a chair. Th repositioned R79, an	until 2:04 p.m. when an the room and placed his e unknown NA did not d only placed his feet onto a					
	3:58 p.m. when an us staff came into the ro	t in the same positioned until hknown physical therapy hom and did exercises with ned in the same chair during					a tradita Program
- たい 11:00 19時	this time and when the the unknown therapy	he exercises were completed staff, replaced R79's feet on fore. The unknown therapy					
	staff did not offer to a different position. At sit in the same chair	ssist R79 off the chair into a 4:41 p.m. R79 continued to for 3 hours and 43 minutes					
	without being reposit	ioned during this time.					
	An interview on 4/1/1 had not moved from	4 at 4:50 p.m. R79 said he the chair since lunch.  R79's					
	family member (F)-A	who was present during the					
	interview stated R79	has a new open area and a					1 1 1 1 1 1
		buttock. During an interview n. with licensed practical					1
	nurse (LPN)-A said F	R79's feet were sore so he					
	doesn't move much a	any more but just sits there.					
	On 4/1/14 at 4:52 p.r	n. NA-DD stated she was					
	UNSURE WHEN R/9 Wa	as last repositioned and sisted R79 to a standing					
	position. Near R79	scrotal area there was an					
	open area approxima	ately 0.3 cm X 0.3 cm. There					
	was a scabbed area	approximately 0.8 cm x 0.3					: .*
	cm on R79's right tu	perosity and an open area					
	0.8 cm x 0.3 cm on h	is left tuberosity. NA-DD and open areas. NA-DD and					
alla Mad	NA-S confirmed the NA-S verified R79 di	d not have a specific turning					
	or repositioning sche		1				1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245410	B. WING		04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTHWEST WILLMAR AVENUE	Ξ
RICE CAR	E CENTER			/ILLMAR, MN 56201	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 314	Continued From page	e 23	F 314		• • •
		s in the same location.			
	a.m. R79 was in his r a regular chair with h	oservation on 4/2/14 at 7:50 room again sitting in room on his feet up on a folding chair.			
	when F-A came to vis	positioned until 9:55 a.m. sit. He continued to remain in			
	this chair until 11:00 by NA-Y to ambulate	a.m. when he was assisted to the dining room for the 3 hours and 10 minutes			(m ) 2027 - 1.3550
	measured the pressu There was an open a on the right ischeal t cm on the left. The s	on 4/2/14 at 1:45 p.m. RN-E ure ulcers on R79 buttocks. area that measured 0.9 x 0.5 tuberosity and 0.7 cm x 0.4 scrotal area measured 0.6			÷
	on the scrotum from other open areas on skin was poor and ag considered pressure clinical manager dec	stated R79 had an open area "shearing" as well as two his ischeal tuberosity. R79 greed the shearing were ulcers. She stated the RN cides if a resident needs to be and repositioning schedule, ave in place.		· · ·	
	Progress Sheets from identify any pressure and bilateral ischeal the 3/27/14 progress area on scrotum with drainage. Possibly fir mention of the bilate ischeal tuberosity, ev tuberosity was obser 4/2/14. These press reassessed or monit	Progress Notes and Wound m 2/20 through 4/1/14 did not e ulcers for R79's scrotum tuberosity until 3/27/14, when a note indicated, "Small open n a small amount of bloody rom shearing." There was no eral pressure ulcers on the ven though the right ischeal rved to be scabbed over on sure ulcers had not been tored and measured on a ermine location, staging, size,			

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د . مربع Facility ID: 00313

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		ATE SURVEY OMPLETED
		245410	B. WIŅG		· · · · · · · · · · · · · · · · · · ·		04/03/2014
				1801	ET ADDRESS, CITY, STATE, ZIP COL SOUTHWEST WILLMAR AVENUE		·
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	MAR, MN 56201 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	surrounding wound e a stage 2 pressure ul	l bed and description of dges even though they were cer (Partial thickness loss of a shallow open ulcer with a	F	314			
	development and dev 2 pressure ulcers, on and one on each isch date of development, reassessed these pre what interventions sh decrease the risk of I pressure ulcers. Also pressure ulcers were provided intervention	risk for pressure ulcers veloped three separate stage e on his scrotum on 3/27/14, heal tuberosity, unknown The facility did not essure ulcer, to determine hould be implemented to help R79 from developing further there was no indication the consistently monitored and s to promote the healing of s which caused actual harm					
	2/14/14, included, sh required extensive to mobility, transfers an frequently incontinen diagnoses of heart fa for pressure ulcers, a skin damage but did ulcer.	imum Data Set (MDS) dated e was cognitively intact, total assistance with bed d toileting and was t of bladder. R36 had allure and arthritis, was at risk and had moisture associated not have current pressure					
	(CAA) dated 2/14/14 for development of p requiring extensive a	r Care Area Assessment , listed R36 had risk factors ressure ulcers including, issistance with bed mobility, bowel incontinence, poor					

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1			COM	PLETED
		245410	B. WING _			04	/03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	E CENTER				SOUTHWEST WILLMAR AVENUE LMAR, MN 56201		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
							1.1.¥.1.
F 314	Continued From page	25	F	314			
		in bed, requires regular					
	schedule of turning r	elated to pressure, and					
	moisture associated s	skin damage. The analysis					
	of findings included, "	[R36] needs extensive help					
	to make position char	nges and do any offloading ng lift at present.  Has a					·
	brace to her R [right]	leg r/t [related to] knee fx					
	[fracture]." The care	planning decision was					
	marked as yes, and "	Proceed to care plan to					10 A.
. '		and repositioning, provide					2
<u>Se</u> 1	thorough cleansing."						
tur ta Nasa	P36 was observed in	bed, on her back with the					
	head of bed up appro	primately 45 degrees, on					
	4/1/14, from 1:00 p.m	. until 2:15 p.m. At 2:15					
	p.m. R36's pressure i	ulcer with registered nurse					
	(RN)-G was observe	d, on R36's buttock which					
	was a shallow crater	with redness surrounding "I have had that sore for					
	the area. R36 stated, quite a while " and co	mmented that she always					
	sleeps on her back d						
	breathing and this po	sition was the most					
		RN-G stated the nurse aides					
		when ever they get her up					
	repositioning schedul	out R36 was not on a timed					
		om shearing from the use of					
	the ceiling lift sling, w	hich she was no longer					
		does slides down in bed,					
	placing her at risk for	further shearing, RN-G					
	confirmed they had n	ot implemented any ent the potential shearing of					
	R36, from sliding dow						
							1.1
. 1		bed, on her back with the					
		approximately 45 degrees,					:
1. d	on 4/2/14, from 6:45 4/3/14, from 8:00 a.m	a.m. until 7:53 a.m. and on					1 .

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES & MEDICAID SERVICES

		MEDICAID SERVICES	(X2) MULT	IPLE CON	ISTRUCTION	(X3) DATE COMP	SURVEY LETED
ATEMENT O	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					· · · ·
		245410	B. WING_			04/	03/2014
	OVIDER OR SUPPLIER	210110			ET ADDRESS, CITY, STATE, ZIP CODE		
					SOUTHWEST WILLMAR AVENUE	NUE	
RICE CAR	E CENTER			WILL	MAR, MN 56201 PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE	COMPLETION
		26	F	314			
F 314		on 4/1/14, at 2:15 p.m. nursing					
•	assistant (NA)-AA	stated R36 was not on any					
	ropositioning schee	dule, she lays on her back					
	when in bed, she w	vill change positions when ever rapy or meals. NA-AA stated					
	R36 had been ill re	ecently, and didn't always get					
	up.						
	During interview 0	n 4/2/14, at 7:53 a.m. NA-A					
	etated R36 was no	ot on a repositioning schedule,					12
<u>_</u> ].	she will mostly lay	on her back in bed, with head little. However, sometimes R36					
1797 171	will get up into her	wheel chair.					
	"Crack in COCCVX &	ote dated 2/12/14, included, area, no drainage noted.					
	Calazime applied.	" This area was not identified					
et 1	as to if it was a pr	essure ulcer, or any further ing size, wound bed, drainage,					· · · · ·
÷	description includ	sue surrounding wound, or if any					1 1 1
	pain was associat	ted with it.					
	The progress not	e on 2/19/14, indicated "Patient					
	noted to have sm	all area of shearing to middle of					
	left buttocks mea	suring 2 cm [centimeters] x [by]					
	0.5 cm." R36's W	ound Progress Sheet dated a stage 2 (partial thickness loss					
	of dermis present	ting as a shallow open ulcer with					
	a red nink wound	bed, without slough) pressure					
	ulcer, with a pink	wound bed, scant amount of nding tissue pink, and wound					
	edges normal.						
		te on 3/11/14, indicated, "Weekly					
	kin assessment	for high risk patient completed					
	with the following	results." Under "skin issues,"					
s e	number "1) Banr	nchable [sic] right buttock 1 cm x was no way to determine if the					
alter a s	./5 cm." I nere	e ulcer on the left buttocks had				continuation s	

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM OMB NC	0: 04/21/2014 APPROVED 0: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		(X3) DATE COMF	SURVEY
		245410	B. WING _				04/	03/2014
NAME OF PF	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			EET ADDRESS, CITY, ST			
RICE CAR	E CENTER				LMAR, MN 56201			·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECT CTIVE ACTION SHOL NCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 314	Continued From page	e 27	F 3	314				
New Come		s was the same area as						
	she had been hospita on 3/24/14 had return hospital return Skin F 3/24/14, indicated sh	a dated 3/20/14, indicated alized with pneumonia, and ned to the facility. R36's Risk Assessment dated e did not have any pressure asues on her buttocks or						
汉王 	assessment (a scale ulcer risk) was comp included risk factors ulcers that included: chronic incontinence cast/brace/splint, ste skin, bedfast, very lir control body position	roid use, occasional moist nited ability to change and , as well as a problem with he form indicated a plan of ed to prevent the				·		
	The 4/1/14 progress wound to coccyx/but 1.75 inches x 3 inche surrounding multiple skin shearing." The pain, wound bed, de wound edges or if th	note, indicated, "Observed tock crease this evening.						· · · · · · · · · · · · · · · · · · ·
	included nursing wo ADL's [activities of d therapy directives."	e plan updated 2/20/14, uld provide assistance with aily living] and mobility per The care plan did not cors listed on the CAA and	KQR11	Faci	lity ID: 00313	if o	continuation she	et Page 28 of 49

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04/03/2014

(X3) DATE SURVEY COMPLETED

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING \_\_\_\_ . B. WING \_ 245410

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE	
RICE CAR	RECENTER		ILLMAR, MN 56201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		F 314		
F 314	Continued From page 28			
	Skin Risk Assessment to determine appropriate interventions to help prevent the development of			
	pressure ulcers even though R36 was at risk for			
· ·	the development of PU and currently had a stage			· · ·
	two pressure ulcer.			
				• • •
	When interviewed on 4/1/14, at 1:55 p.m. the			
	house supervisor, registered nurse (RN)-E,			
	stated she was not aware R36 had any pressure			
5. P	ulcer at any time. RN-E was unsure if the			14.5
	2/12/14, 2/19/14, and 3/11/14, pressure ulcers			
; ·	had healed during the hospital stay, or before R36's hospital stay or if they did not heal at all.			
	R36's nospital stay of it they did not near at all.			
	•			· .
	When interviewed on 4/1/14, at 2:43 p.m. the			
	clinical coordinator, RN-C verified there was no			
	timed repositioning plan for R 36, staff would			
	reposition her when ever she got up for therapy or			
	meals even though R36 spent most of the time in			
	bed on her back due to breathing difficulty. There			
	was no toileting plan, even though R36's pressure			
	ulcer CAA of 2/14/14, indicated urinary incontinence placed R36 at risk for development			
	of pressure ulcers. RN-C stated she had no way			
	to determine when the, "Crack in coccyx area,"			
	identified on 2/12/14, had healed, or when or if,			
	the stage 2 pressure ulcer identified on 2/19/14,			
	had healed, or if the area identified on 4/1/14,			
	was the same area as had been identified on			
	2/12/14, 2/19/14, or 3/11/14. RN-C stated R36			
	should have been reassessed after R36 had			· · · ·
	returned from the hospital weaker, and was			
	spending more time in bed.			
	Although R36 was at risk for pressure ulcers and			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	had developed a pressure ulcer on 2/19/14 to			1.1
	present, these ulcers had not been consistently			
	monitored on a weekly basis to determine			

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	04/21/2014 APPROVED 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	INSTRUCTION	(X3) DATE S COMPL	
STATEMENT C AND PLAN OF	OF DEFICIENCIES	IDENTIFICATION NUMBER:				COMPL	
		245410	B. WING			04/0	03/2014
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
			<b>5</b> .		I SOUTHWEST WILLMAR AVENUE		
	E CENTER		ID		PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	Should be Ppropriate	DATE
F 314	location, staging, siz and description of su Also, a comprehensi	e, exudate, pain, wound bed irrounding wound edges. ve assessment had not been ine what interventions should ielp decrease the risk of R36	F	314			
	indicated R150's ad indicated R150 had and was at risk for c ulcers. The MDS als required limit ability assistance for trans	rd review for pressure ulcers, mission MDS, dated 1/23/14, no unhealed pressure ulcers development of pressure so indicated the resident for bed mobility and extensive fers. In addition, the MDS multiple diagnoses including sion, arthritis, and			·		
	indicated the reside of pressure ulcer ris identifying R150 wa development. The Area Assessment (	ment, completed on 1/18/14, ent had a Braden Scale [scale sk factors] score of 16, as at risk for pressure ulcer resident's pressure ulcer Care CAA), dated 1/27/14, identified by to improve ability to offload					
1. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	"Skin: has rough, to admit. Needs help i.e. recliner." The assist with offloadi offending [sic] area calazime PRN [as						
	A review of R150's dated 1/25/14, ide	s, Resident Progress Notes, ntified the resident continued to					eet Page 30 of 49
		Event ID: U	IXQR11	Fa	cility ID: 00313	If continuation sh	eet Page 30 of 49

Event ID: UXQR11

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO.	04/21/2014 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ISTRUCTION	(X3) DATE S COMPL	
		245410	B. WING			04/0	3/2014
NAME OF PF	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
<b>RICE CAR</b>	E CENTER				MAR, MN 56201		
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F 314	have complaints of te coccyx and area to le measured 4 cm [cent note indicated the an covered with Mepilex notes, dated 1/26/14 continued to complai area with "Calmo app throughout shift. Cali discomfort." Again, d identified R150 had a on (L) [left] buttock n a.m. Area cleansed, covered with a Mepil notes, dated 1/29/14 Practitioner (NP), ob buttocks, noted this sliding forward on se ordered "Calizime to times a day]; do not software cushion in Although the facility R150 was at risk for and identified R150 the left buttock, afte was not updated to as prescribed by the promote healing an additional pressure did not identify what implemented to pre- pressure ulcers.	enderness and discomfort to off inner buttocks which imeters] by 1.5 cm. The ea had "Calmo applied and " The resident's progress , identified that R150 n of discomfort to coccyx oblied various times	F3	114			
	the care plan was n	ot updated to reflect the ment ordered 1/29/14 by the					et Page 31 of 49

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Event ID: UXQR11

Facility ID: 00313

If continuation sheet Page 31 of 49

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# F 314 Treatment/SVCS to Prevent/Heal Pressure Sores

### **Corrective Action:**

Res 36 Revised comprehensive pressure ulcer risk assessment completed on April 14, 2014. Appropriate interventions to prevent further development of additional pressure ulcers have been added to care plan. Wound progress sheet reviewed and updated. R36 discharged from facility on April 23, 2014 with no open areas.

Res 79 expired at hospital

Res 150 closed record review/discharged

Skin Care Policy reviewed and updated

## Corrective Action-identify other residents:

All Residents with pressure ulcers have been reviewed for appropriate assessment. Wound monitoring progress sheet reviewed to ensure current pressure ulcers are healing and to prevent the development of new pressure ulcers.

Care plan interventions reviewed for appropriate interventions to prevent the development of new pressure ulcers.

LTC Pink care cards updated with repositioning guidelines, Therapy Suites patient roster updated with heart shape if patient needs assistance with repositioning.

## Corrective action to prevent reoccurrence:

Education will be completed on May 8, 2014 regarding the Skin Care Policy to all nursing staff. Review of LTC Pink care cards with repositioning guidelines, Therapy Suites patient roster reviewed with heart shape if patient needs assistance with repositioning.

## Monitoring for Compliance:

Audits will be completed by RN Clinical Coordinator &/or DON weekly at Wound meetings in each neighborhood to assure wound monitoring sheets are completed and pressure ulcer is healing and measures in place to prevent the development of new pressure ulcers.

Care plans will be reviewed weekly at wound meeting for appropriate interventions.

High risk residents/patients pink care cards or patient roster will be reviewed for accuracy.

Results will be brought to QA committee for recommendation on the need to further audit.

## **Completion Date:**

May 8, 2014

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OVIDER OR SUPPLIER	243410		1801	ET ADDRESS, CITY, STATE, ZIP CODE SOUTHWEST WILLMAR AVENUE		
RICE CAR	ECENTER			WIL	LMAR, MN 56201		AVE)
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· · F 314	Continued From pag	e 31	F	314			
•	nurse practitioner.						
	A policy entitled Skin	Care, Rice Care Center,					
	dated 3/10, included	, a purpose of, "To maintain					
	skin integrity, preven promote healing of n	t skin breakdown, and to					
ק ה ע נו	procedure identified	upon admission or hospital					
	return, a skin assess	ment would be completed					
	within 24 hours; a co assessment with Bra	omprehensive risk oden scale would e					
	completed along wit	h a tissue tolerance test (a					
	test to see how long	skin can withstand pressure)					
	would be completed	. If a resident was found to eakdown, skin would be					
	be at risk for skin bre	nd documented in the					:
	progress notes. Res	sidents with reddened, open					
	areas, or ulcers wou	Id be entered on the					
:	treatment sheet, and	d documented on weekly to given, interventions to					
	prevent further brea	kdown, size, depth, odor, and					
	drainage," The polic	cy further indicated the					
	physician would be	consulted with if there was ge in the ulcer. The policy					
	any significant chain	on of an "Avoidable Pressure					
	Ulcer," which include	led, "an ulcer that has					
	developed because	one or more of the following					
	were not done: a re	esidents clinical condition was actors were not identified,					
	interventions were r	not implemented, or					
	effectiveness of interrevised.	erventions not monitored or					
F 315	483.25(d) NO CATH	HETER, PREVENT UTI,	F	315	Refer to attachment for P	oC	
SS=D	DECTORE DI ADDI				and date of completion		
	Based on the reside	ent's comprehensive			and date of completion		•
	assessment, the fac	cility must ensure that a					
	resident who enters	the facility without an					
	inducilling catheter	is not catheterized unless the					1

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	· · · · · · · · · · · · · · · · · · ·	COMILETED
		245410	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
RICE CAR	RECENTER			LLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 315	Continued From pag	e 32	F 315		
1 010		ndition demonstrates that			
	who is incontinent of	necessary; and a resident bladder receives appropriate es to prevent urinary tract			
		ore as much normal bladder			
H +		T is not met as evidenced			
	review, the facility fai assess, and place in	on, interview, and document iled to comprehensively terventions to improve or intinence for 1 of 2 residents			
	(R36) reviewed for u				
•	Findings include:				
	D261a admission Min	imum Data Set (MDS) dated			
	2/14/14, included she required extensive as	e was cognitively intact, ssistance with mobility,			
	incontinent of bowel	. R36 was frequently and bladder, had a trial			
	on a current toileting	n no improvement, and was program. The MDS also of heart failure and arthritis, tic (water pill) daily.			
		sment dated 2/13/14,			
	including impaired m	for urinary incontinence, obility with dependent age on way to bathroom,			
		ppress, congestive heart			

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PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 04/03/2014 B. WING 245410 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201 RICE CARE CENTER (X5) PROVIDER'S PLAN OF CORRECTION COMPLETION DATE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 3323 F 315 Continued From page 33 F 315 R36's Urinary Incontinence Care Area Assessment (CAA) dated 2/19/14, included risk factors for urinary incontinence including, extensive assistance required to toilet, urinary incontinence, moisture associated skin damage, pain, restricted mobility, urinary urgency, and use of a diuretic. The type of urinary incontinence was listed as, "Functional (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating." An analysis of findings included, "[R36] is frequently incontinent of bladder, compounded by loss of mobility. She is on diuretics. Incontinence is chronic, per AL [assisted living]." The form indicated care planning would occur, "Proceed to care plan to assist with toileting and attempt to decrease incontinence as able." R36's care plan dated 2/20/14, included, "Recent decline in ADL's r/t [related to] CHF [congestive heart failure], RA [rheumatoid arthritis], weakness, COPD [coronary obstructive pulmonary disease] R [right] patellar [knee] fx [fracture]; Here for short term stay with desire to return to community." The goal for R36 was, "Will regain independence in ADL's [activities of daily living] to allow safe return to community." Staff were instructed to, "Assist with toileting, monitor for increased incontinence and/or constipation and notify PCP [primary care physician] if indicated." The care plan did not address the risk factors of immobility, diuretic use, or to direct staff on any program to maintain or improve urinary incontinence even though the assessment identified these areas of risk for R36. R36 was observed on 4/1/14, at 2:15 p.m. she

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STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		245410	B. WING _		•	04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
	E CENTER				SOUTHWEST WILLMAR AVENUE LMAR, MN 56201	
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F 315	Continued From page	e 34	F3	315		
1 010	had been assisted to					
	assistant (NA)-L and	NA-AA. R36's incontinent				
		she voided in the toilet.				:
	NA-AA stated R36 w	as not on any routine st when they get her up, or				
tist Tur	R36 calls to get her i	ncontinent product changed.				
	R36 had been ill rece	ently and did not always get				
	up.					
	•					
	had been assisted fro NA-L and NA-A. R36 toilet at this time, and	n 4/2/14, at 7:53 a.m. she om bed to her wheel chair by 5 was not assisted to the d her incontinent product was			·	
		NA-A stated R36 does not				. ] 1.1
	whenever she gets u	st gets her pad changed p into the wheel chair.				
						·
	When interviewed or	n 4/1/14, at 2:43 p.m. RN-C ent had not been developed				
	for R36 regarding to	leting needs for staff, the use				
	of a diuretic with the	possible need to toileting			ж	· ···
	shortly after taking th	ne diuretic. The assessment 6 had urgency, nor were there				
		er environment was modified				
	to aid with functional	incontinence. RN-C had not				
	assessed or evaluate	ed any voiding patterns to				
	determine an approp	oriate toileting plan. RN-C en ill frequently and often did				
	not get up out of bed	<ol> <li>There was no plan to</li> </ol>				
	assist R36 with toilet	ing needs at these times, or				
	to maintain or improv	ve her urinary incontinence.				
	director of nursing (E with interventions sh	n 4/3/14, at 2:00 p.m. the DON) stated an assessment ould have been developed ntaining or improving urinary				

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# F 315 No Catheter, Prevent UTI, Restore Bladder

### **Corrective Action:**

Resident 36 Comprehensive Assessment with analysis and interventions put in place to improve or maintain urinary incontinence completed on April 16, 2014

## **Corrective Actions-identify other residents:**

All residents with urinary incontinence assessments & care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

## Corrective Action to Prevent reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of the MDS matching the care plan. Nursing staff are to alert the Clinical Coordinator if there changes, significant change will be evaluated at that time.

### **Monitor for Compliance:**

DON or Designee will audit bladder assessment to ensure completion and interventions are indentified on Care Plan to improve or maintain urinary incontinence. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audits.

### Date of Completion:

May 8, 2014

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
		MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE SURVEY
STATEMENT C AND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
		245410	B. WING		04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE	
RICE CAR	E CENTER		1	WILLMAR, MN 56201	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 315	continence.		F 31	5	
F 323 SS=E	facility. 483.25(h) FREE OF HAZARDS/SUPERV The facility must ens environment remains as is possible; and e	ISION/DEVICES	F 32	<sup>3</sup> Refer to attachment fo and date of completion	
	by: Based on observatii review the facility fai assessed for safe tra LIKO brand mechan brand lift harness with had not recommenc brand lifts. This affer R70, R40, R51, and brand mechanical lift Findings include: R36's admission Mit 2/14/14, included sh diagnoses of heart f	T is not met as evidenced on, interview, and document led to ensure resident were ansfers with the use of the ical standing lift with an EZ nich the LIKO manufacture ed to be used for the LIKO cted 5 of 5 residents (R36, R11) who used the LIKO t.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/03/2014 B. WING 245410 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1801 SOUTHWEST WILLMAR AVENUE RICE CARE CENTER WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) ID SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 323 Continued From page 36 F 323 R36's ADL (activities of daily living) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) included, R36 had a fracture knee cap, and was totally dependent upon staff for transfers with a ceiling lift (a full body lift). The form indicated care planning would occur to address this. R36's care plan dated 2/20/14, included, "Nursing will provide assistance with ADL's and mobility  $\leq i$ per therapy directions." The care plan did not t en direct staff on which type of mechanical lift, harness/vest, or leg strap should be used. R36's physical therapy and occupational therapy notes were reviewed from 2/7/14 through 3/31/14, and failed to direct nursing staff on any transfer techniques. The notes did indicate R36 varied from total staff assist to two person assist for transfers. R36 was observed on 4/1/14, at 2:15 p.m. being assisted from her bed to her wheel chair by nursing assistant (NA)-L and NA-AA. A transfer belt was placed up under R36's axilla (arm pits). NA-L and NA-AA attempted to lift R36 into a standing position, R36 was unable to bear any weight. Registered nurse, (RN)-C who was the clinical coordinator came into room, and witnessed R36 not bearing any weight. RN-C instructed NA-L and NA-AA to use the mechanical standing lift which was a LIKO brand instead. The LIKO mechanical standing lift was brought into the room, R36's feet were placed on the foot platform, an EZ-way brand lift harness was placed under R36's arms, pulled in front of

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Event ID: UXQR11

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		245410	B. WING			04/03/2014
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
RICE CAR	E CENTER				)1 SOUTHWEST WILLMAR AVENUE LLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page	e 37	F	323		
·	her body, and fastene belt on the LIKO lift to	ed with a belt. There was no o secure R36's legs. The				
	R36 off the bed with i down, and R36 was i knees were bent, and	on and NA-AA started to lift t. R36's buttocks hung n a sitting position, with her d was unable to bear any rere being pulled up by the				:
	lift and she kept sayir being lifted. R36 wa the bathroom, and re	ng, "Owe, owe, owe," while s transported by the lift into mained in a sitting position and her arms were pulled				
	up by the harness lift placed on the toilet. bathroom and witnes	under her axilla. R36 was RN-C came into the sed R36 in the LIKO				
	transferred off the toil attempted to provide	e EZ Way harness being let. While NA-AA and NA-L pericare with the lift in the 6's buttocks continued to				
1	hang down in a sitting bear any weight and to get placed back or	g position, she was unable to was yelling during this time to the toilet twice, which 36 stated she wasn't really in				
•	pain, but was more, "	Stiff," because her legs he was unable to stand.				an ann an Ann Ann
	stated R36 could son assist, but has been returned from the ho	4/1/14, at 2:35 p.m. NA-L netimes transfer with two weaker since she had spital with pneumonia. NA-L		ı		
	LIKO lift to secure the was missing, and wa been missing. NA-L s	es used the leg strap on the e resident's legs, but this one s unsure how long it had stated the EZ-Way harness				
		<o because="" mechanical="" the<br="">omfortable for residents, than</o>				

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PRINTED: 04/21/2014 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 04/03/2014 B. WING 245410 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1801 SOUTHWEST WILLMAR AVENUE RICE CARE CENTER WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 38 When interviewed on 4/1/14, at 2:40 p.m. RN-C stated R36 use to be a full mechanical lift with a ceiling lift, had been improving and staff were able to transfer her with two assist and a transfer belt, but R36 had recently been hospitalized with pneumonia and had returned to the facility on 3/24/14, much weaker. R36 had not been re-evaluated for transfers, but was working with therapy on getting stronger. If R36 would be unable to stand, she would expect staff to get the standing lift. She did not expect them to use the Ċ; ceiling lift, even if R36 could not stand up, as the ceiling lift sling had caused skin shearing to R36's buttocks. When interviewed on 4/1/14, at 4:00 p.m. NA-E stated she had worked in the facility for over five years, she remembered being trained many years ago by the director of nursing (DON) on how to use the lifts. When ever a new nursing assistant starts, other nursing assistants train them on how to use the lifts. NA-E verified they were allowed to use the EZ Way harness's with the LIKO lifts. The residents like them better, they are not as stiff as the LIKO harness's and they do not use the leg strap on residents. The LIKO harness's (vests) wrap around the torso and are not as comfortable as the EZ Way harness's which do not wrap around the body. When interviewed on 4/1/14, at 4:05 p.m. NA-DD stated most residents like the EZ Way harness instead of the LIKO harness's, and they are allowed to interchange the harness and mechanical lift. She started working at the facility a year ago and another nursing assistant showed her how to use the standing LIKO lift.

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		D HUMAN SERVICES				FORM	): 04/21/2014 1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245410	B. WING			04/	03/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	ECENTER		·		01 SOUTHWEST WILLMAR AVENUE ILLMAR, MN 56201		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	39	F	323		•	
	DON stated staff do u the LIKO standing lifts When nursing assista assistant will show the leg strap would be us it, this should be care if R36 could not stand	4/1/14, at 4:10 p.m. the use the EZ Way harness for s, they are interchangeable. Ints are hired, another em how to use the lifts. The ed only if the resident needs planned. The DON stated d up in the LIKO standing lift, consulted with therapy nsfers.					
- 	assisted from bed to NA-A. R36 was very edge of bed, NA-L an R36 stated she was of appointment yesterda weak. A transfer belt arms and she was ins bed with her hands.	h 4/2/14, at 7:53 a.m. being the wheel chair by NA-L and shaky while trying to sit on hd NA-A had to hold her up. but for hours at doctors ay, and was feeling very was placed under R36's structed to push off of the R36 was pulled upwards by bivoted into her wheel chair, bare much weight.					
	stated R36's transfers so much edema in he the transfer belt unde her arms and should stand at all, they use but R36 "Does not do shoulders have arthri	4/2/14, at 8:00 a.m. NA-A s usually go poorly, she has er abdomen, they need to put er her arm pits, this pulls on lers. When R36 can not the LIKO standing lift on her, o well, she hangs, and her tis." The full lift, the ceiling se the sling had caused a "					

· (47)

Facility ID: 00313

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STATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			E SURVEY PLETED		
		245410	B. WING		04	/03/2014		
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP (				
RICE CAR	E CENTER			1 SOUTHWEST WILLMAR AVEN LLMAR, MN 56201	JE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 323	Continued From page	e 40	F 323					
1								
• •	When interviewed on							
		PTA)-H stated she had been e had not been asked, nor						
		commendations to nursing						
	on how to transfer R3							
		4/2/14 at 8:05 a m DN C						
. *	stated she was not av	4/3/14, at 8:05 a.m. RN-C						
		urning from the hospital. No				100 100		
	-	blems to her. She was not						
	aware R36 could not	stand in the lift and her						
	•	as she hung from her axilla						
		to be reassessed for her						
		would remain safe during						
1	transfers.							
,	R70's diagnoses from	the Minimum Data Set						
		uded left- sided hemiplegia,						
		roses. The MDS also						
		nitively intact, and required with the physical support of						
		The Care Area Assessment						
.:		9/27/2013, indicated R70						
	was unstable, and on	ly able to balance if assisted						
		required assistance for all						
	-	are plan, updated 3/18/2014,				1.0		
		IKO [brand name] stand (a sist lift), for transfers, to be						
		t) side neglect for safety,						
		ul of [R70's] position of left						
	ankle/foot so it [sic] do							
		g when in the stand. The						
		oom, undated, directed staff one assist" and use "EZ						
	to transfer R/U with "C					1		

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

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Event ID: UXQR11

Facility ID: 00313

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		D HUMAN SERVICES				FORM	: 04/21/2014 APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE S COMPL	
-		245410	B. WING			04/0	3/2014
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	E CENTER				LMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE-PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 323			F	323			
- 36 gr - 2	nursing assistant (NA	n 4/2/2014 at 9:24 a.m., .)-A assisted R70 to transfer					
	stand-assist lift in fro R70's bed, NA-A retr	onto the tollet in the A positioned a LIKO brand nt R70's wheel chair. From eved a large maroon and ss, with an "EZ" insignia on					
	the label. NA-A plac back and underneath then attached the en handlebar of the lift.	ed the harness behind R70's of each of R70's arms, and ds of the harness to the NA-A also fastened the seat					
	torso in place. NA-A lift platform, and info starting. As the hand	e harness around R70's positioned R70's feet on the med R70 the lift was llebars raised, R70 grasped					
	the handlebar with o hand was near her s clutching a book. Du	nly her right hand. R70's left houlder, positioned as if ıring the lift, R70's lower right umped up to the padded leg					
	guide. Neither R70's touched the lift leg p would go behind R70	s left lower leg, nor left knee ad.  The leg strap, which )'s legs, was not attached,			· · ·		
	During the lift and tra completely upright, b	out rather hanging in the lift,					
• •	moved the lift into th onto the toilet. NA-A then transferred R70	ported R70's weight. NA-A e bathroom and lowered R70 assisted R70 with toileting, I from the toilet into the					
	verified R70's legs w	2/2014 at 9:29 a.m., NA-A rere not strapped on the lift					
	during the transfer. it [the leg strap] on, verified the lift stand	NA-A said "I don't always put guess I should." NA-A also used for R70's transfer was					
	was an "extra large"	also verified the sling used maroon and green "EZ" \-S said "That's what fits					

Facility ID: 00313

If continuation sheet Page 42 of 49

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		E SURVEY PLETED
		245410	B. WING		04	/03/2014
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	ZIP CODE	
RICE CAR	E CENTER			1801 SOUTHWEST WILLMAR A WILLMAR, MN 56201	VENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 323	Continued From page [R70] best."	9 42	F	323		
	NA-Q stated R70 only on the lift during trans fully grab with her left to make sure R70's fe so they doesn't twist person." NA-Q said t	n 4/2/2014 at 12:34 p.m., y uses her right hand to hold sfers, because [R70] "can't t side." NA-Q said you had eet were flat on the platform, off, as [R70] is "a large the foot straps on the stand used "for [R70]and any				
	Set, dated 9/24/2013 chronic pain, and and identified R40 as mild that R40 required exit transferring, with the person. The Care Ar	n the annual Minimum Data , included osteoarthroses, emia. The MDS also dly, cognitively impaired, and ensive assistance for physical assistance of one ea Assessment (CAA) for 3, identified R40 required				-
	assistance from staff all transitions, and th her knees. A Rice C Restraints/Adaptive I indicated R40 occasi [brand name] stand ( device) for transfers.	to maintain balance during nat R40 struggles with pain in are Center Assessment for Equipment, dated 3/1/2014, onally required use of an EZ a mechanical stand-assist The care sheet in R40's ted staff to transfer R40 with				
	nursing assistants (N transfer R40 from the wheel chair. A LIKO mechanical stand-as in front of R40, who h maroon-colored harm	n 4/2/2014 at 11:34 a.m., IA)-S and NA-Q prepared to a toilet in her room into the [brand name] stand (a sist device) was positioned had a green and less under her arms, and er torso, in a U-shaped				

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

Event ID: UXQR11

Facility ID: 00313

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		ID HUMAN SERVICES					FORM APPROV	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					MB NO. 0938-03	391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI			(>	(3) DATE SURVEY COMPLETED	
		245410	B. WING				04/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			TREET ADDRESS, CITY, STATE, ZIP CODE			
RICE CAR	E CENTER				801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		JLD BE	(X5) COMPLETIO DATE	ON
F 323	seatbelt buckle, which ran parallel to and un each of the ends wer- hooks on the lift's har lift, and told R40 to "h moved upward, R40 When R40 was uprig adjusted R40's clothin out of the bathroom, chair. R40 was obse had a firm grip on the wearing shoes, and b platform, and her legg guides of the lift. The behind R40's right an but was dangling at ti R40 was lowered into unbuckled the safety harness from around wheel chair and push Then, NA-S exited th and placed it atop a p room. An insignia "E and maroon-colored during the transfer fo During an interview of NA-S said R40 occass [brand name] stand" device) for transferring lift. NA-S said that st "Likko" lift as the "EZ EZ-Stand are two bra	a was secured to R40 with a h was in place. The harness derneath R40's arms, and e fastened to corresponding halebar. NA-S started the hold on." As the handlebars said "it hurts, hurry up." ht in the stand, NA-Q ng, and NA-S moved the lift and in front of R40's wheel rved standing upright, and e handle bars. R40 was both feet were flat on the lift s were against the leg leg strap, which would go d left legs, was not secured, he side of R40's leg. After the wheel chair, NA-S belt and removed the R40. NA-Q adjusted the hed R40 out of the room. e room carrying the harness bortable piano near R40's Z" was visible on the green harness that was used r R40. Alter the stand-assist ng. NA-S verified that the lift R40 was the "LIKO" brand taff routinely referred to the stand" lift. [Likko and	F	323				
	maroon-colored harn was the one used for	ess with the 'EZ' insignia R40's transfers. NA-S R40's lift and transfer from						

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Facility ID: 00313

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PRINTED: 04/21/2014

	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         245410		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED 04/03/2014	
		B. WING			
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			1801	I SOUTHWEST WILLMAR AVENUE	
RICE CAP	RECENTER		WIL	LMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
. F 323	Continued From page	. 44	F 323		
1 020			F 323		
		chair, the leg strap on the NA-S said the leg strap			
		ed" while transferring R40,			
		when using the "EZ Stand."			
		ose of the strap was to keep			
		moving or slipping out of			
•		ransferred. NA-S said that if			
		n to "kick back", move or curl nsfer, then "we would put the			
	strap on."	ister, then we would put the			
	licensed practical nur of leg straps when tra "EZ Stand" was "a ma stated she has "heard straps were not alway LPN-C said it was "go and nurses to put the	n 4/2/2014 at 12:02 p.m., se (LPN)-C stated that use insferring a resident on an atter of safety." LPN-C d and seen" that the safety vs used on the "EZ" stands." bod practice" for the aides legs straps "every time" the t transfers. LPN-C was			
		and" brand harnesses were			
	used with the "Likko"	brand lifts. "We always			
		s], LPN-C stated, "I thought			
• *	they were interchange	eable."			
	registered nurse (RN) and R70 utilized stand	n 4/3/2014 at 10:41 a.m., -B verified that both R40 d lifts for transfers. RN-B ons for residents was care			
	planned, and "would e	expect" nursing assistants to transfers and apply "safety			
		aps" during transfers. RN-B			
		part of "an employee's			
		RN-B acknowledged the			
	facility utilized LIKO b	rand stand lifts, and also			
		"EZ Stand", a different			
	brand. RN-B was una	aware of any difference			

Event ID: UXQR11 Facility ID: 00313

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245410		(X2) MULTIPLE A. BUILDING _		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		B. WING		04/03/2014		
NAME OF PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	ECENTER			801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 45 and "LIKO" brand lifts, and	F 323			
	the slings or harness					
	J					
	(MDS) dated 2/5/14 i and was cognitively dated, 2/13/14 indica	nge minimum data set ndicated R51 had dementia impaired. R51's care plan ted R51 was an extensive n an EZ stand to transfer to				
	the LIKO mechanical	n 4/2/14, at 8:00 a.m. .)-L was assisting R51 with standing lift. NA-L used an				
	EZ Way harness beh abdominal strap, and					
-	to raise R51 up out of with the LIKO lift to R	f bed and transferred him 51's wheelchair. R51 into elchair and NA-L removed				
	R11's quarterly minim	num data set (MDS) dated 11's had severe cognitive				
	assistance for transfe EZ stand (mechanica	R11 was an extensive to total rs with 1 or 2 staff and the I standing lift). A Balance				• • • •
	Assessment dated 3/ EZ stand for transfers	29/14 indicated R11 used an s.				
	NA-L assisted R11 wi	n 4/2/14, at 9:11 a.m. of th the LIKO mechanical ced a maroon color sling,				

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Facility ID: 00313

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(Y2) MUT	IPLE CONSTRUCTION		OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         245410       245410		A. BUILDIN			(X3) DATE SURVEY COMPLETED		
		B. WING			04/03/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE		
RICE CAR	ECENTER			1801 SOUTHWEST WILLMAR A WILLMAR, MN 56201	AVENUE .	: .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page	46	<b>F</b> 2	22			
1 525	Continued From page		F 3	23			
	to raise R11 out of the him into the bathroom using the bathroom, F	ed into the wheelchair. The					
	verified she uses the residents with the LIK stated the mechanical facility were LIKO lifts used were EZ Way ha harnesses. NA-L stat	m. an interview with NA-R EZ Way harnesses on O lift. At 12:28 p.m. NA-L standing lifts used in the and verified the harnesses irness and not the LIKO ed that new harnesses KO lifts but they did not				- 12/16/9 - 12/17/- - 22/12/16/9 - 22/12/16/	
		rap on them that buckled					
	the physical therapist use a mechanical star	n 4/2/2014 at 12:37 p.m., (PT)-A stated in order to nd lift, a resident would ability to bear weight," have				, <b></b>	
	sufficient range of mot shoulder strength, and PT said a resident sho "sitting in a wheel chai PT said the sling or ha bearing the weight of a stated safety precautio when a resident is trar	ion, have arm and I do so "without pain." The puld not look like they're r" while using the lift. The					
	provided staff training	(OT)-A stated that she on proper use of the er, the OT stated, that she ays" lock the seat belt					

Facility ID: 00313

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:		IG		PLETED	
		245410	B. WING		04	/03/2014	
NAME OF PI	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP (		· . ·	
RICE CAR	E CENTER			1801 SOUTHWEST WILLMAR AVEN WILLMAR, MN 56201	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
engla i ji Mana							
F 323	Continued From page straps" before transfe stand-assist lifts.	• 47 rring a resident using the	F 3	23			
Det	by the facility, that incoverselves that a standing lift. In harness's from other of form a sitting position if the resident couldn' a sling that fits under full support. This court	Service Summary provided sluded three different type could be used with the LIKO None of these included companies. A passive lifting with Sabina form indicated t stand or cooperate to use the residents buttocks for Id be used infrequently, if ole to bear weight, staff were I body lift with a sling.				. <u>11</u>	
	a.m. the LIKO Barrier health care ergonomi been at the facility a f staff on the use of the Sabina), the resident have muscle tone and DHCE stated the leg remind the resident m DHCE stated the only used on the LIKO lifts are vests that wrap ar other harness's are no	telephone April 2, at 9:30 Free Access, director of cs (DHCE), stated he had ew years ago and trained I LIKO standing lift (named must be able to bear weight, d ability to follow commands. strap is an option to use to ot to step off the platform. harness's that should be , is the LIKO brand, these ound the residents torso, ot made the same way and particular machine, and is					
	dated 1/25/2010 with signed in, and provide Training Outcomes Cl						

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

Event ID: UXQR11

Facility ID: 00313

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/21/201 FORM APPROVEI IB NO: 0938-039
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION			B) DATE SURVEY COMPLETED
		245410	B. WING				04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	<b>1</b>		STREET ADDRESS,	CITY, STATE, ZIP CODE	I	04/03/2014
RICE CAR	ECENTER						
()(())				WILLMAR, MN 5			·····
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID. PREFIX TAG	(EACH	DVIDER'S PLAN OF CORF I CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	- 19			·		
1 020	including the ability o 20% of his weight at upper body control ar	f the patient to bear about least on one leg, have some nd have the ability to follow	F 32	23			
ین م <sup>یر</sup> ین ۲	unpredictable the Sat Under, "Vest applicat of Sabina Vests must	f patients weak, confused or fetyVest should be used." ion and connection, all types be applied with the patient The vest application is at					
	the patient's low back umbilicus. Connect the connection appropriate connection style different	and/or just below the he vest using the style of te for that vest. The vest rs with the SupportVest					10 - 13 38 4 1 - 49 - 1 2 - 19 - 1 2 - 19 - 19
AP.	using a belt clip desig using a criss-cross "D	n and the SafetyVest styles " ring connection."					·
	•						
							4 - 4 3 - 54
ORM CMS-2567(	(02-99) Previous Versions Obso	lete Event ID: UXQR	 11	acility ID: 00313	If	continuation	sheet Page 49 of 49

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## F323 Free of Accident Hazards/Supervision/Devise

### **Corrective Action:**

Resident # 36, 11, 51, 40 & 70 have all been assessed by RN Clinical Coordinator & Barrier Free Access for safe transfers when using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

### Corrective Action – Identify other residents:

RN Clinical Coordinator in each neighborhood & Barrier Free Access has assessed other residents/patients using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

RN Clinical coordinator will monitor significant changes in resident/patient for the use of Liko Standing Mechanical lift or Hoyer lift. OT/PT Screening will be obtained if RN deemed appropriate.

### **Corrective Action to Prevent Reoccurrence:**

Education was completed on April 25, 2014 to all nursing staff for the appropriate harness size & style for each resident/patient. Pink card in Long Term Care has been reviewed for accuracy of how resident transfers. Therapy Suites roster identifies how patient is to transfer

### **Monitoring for Compliance:**

Random audits will be completed by DON or RN Clinical Coordinator for the proper use of Liko Sabina Standing mechanical lift. This audit will continue for 90 days and the results brought to the QA committee for recommendation on the need for further audits.

### Date of Completion:

May 2, 2014

		ID HUMAN SERVICES	FSY	10023	FOR	D: 04/21/2014 M APPROVED
		MEDICAID SERVICES			1	D. 0938-0391
		IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING 01	- MAIN BUILDING 01	1° (	E SURVEY PLETED
		245410	B, WING		04	/01/2014
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CAR	ECENTER			LLMAR, MN 56201		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
CENTERS FOR MED STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION NAME OF PROVIDER OR SU RICE CARE CENTER (X4) ID PREFIX TAG (EAC FIRE SAF THE FACIL ALLEGATI DEPARTM SIGNATUF PAGE OF USED AS N UPON REC ONSITE R CONDUCT SUBSTAN REGULATI ACCORDA A LIFE SAF Minnesota Fire Marsha Rice Care (D be in subst requirement Medicare/M 483.70(a), edition of N (NFPA) Sta CORRECT DEFICIENCE HEALTH CA	INITIAL COMMENTS		K 000			
	FIRE SAFETY					
	ALLEGATION OF CO DEPARTMENTS ACC SIGNATURE AT THE PAGE OF THE CMS- USED AS VERIFICAT UPON RECEIPT OF A ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COMP REGULATIONS HAS	BOTTOM OF THE FIRST 2567 FORM WILL BE TON OF COMPLIANCE. AN ACCEPTABLE POC, AN YOUR FACILITY MAY BE LIDATE THAT PLIANCE WITH THE		POC 04 78 5-5-14		
	Minnesota Departmer Fire Marshal Division. Rice Care Center - Bu be in substantial comp requirements for partic Medicare/Medicaid at 483.70(a), Life Safety edition of National Fire	cipation in 42 CFR, Subpart from Fire, and the 2000 e Protection Association , Life Safety Code (LSC), ealth Care. HE PLAN OF THE FIRE SAFETY IGS) TO: INSPECTIONS AL DIVISION		RECEIVE MAY - 1 2014 MN DEPT. OF PUBLIC SAF STATE FIRE MARSHAL DIV	Ĩ	
ABORATORY	RECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE
anth	my Joza	ahl actin	a admin	istrator les	sril 28	1,2014

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that april 28 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/21/2014

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 04/21/2014 FORM APPROVED

OFILIER	to i on medionite a	MEDICAID OLIVIOLO			ONB	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION - MAIN BUILDING 01		DATE SURVEY OMPLETED
		245410	B. WING			04/01/2014
	PROVIDER OR SUPPLIER		18	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHWEST WILLMAR AVENUE ILLMAR, MN 56201	J	04/01/2014
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	ST. PAUL, MN 55101 By e-mail to: Marian.Whitney@stat THE PLAN OF CORR DEFICIENCY MUST I FOLLOWING INFORM 1. A description of what to correct the deficient	-5145, or e.mn.us RECTION FOR EACH INCLUDE ALL OF THE MATION: at has been, or will be, done cy. bsed, completion date. de of the person tion and monitoring to	K 000			
	at 6 different times. The constructed in 1965 and Type II(111) construction was constructed on the building and was deter construction. Since the 1995 addition are both they were both inspect Existing Healthcare read The facility is equipped that has smoke detection	ilding 01, is a 1-story nent that was constructed ne original building was nd was determined to be of on. In 1995, an addition e south side of the original rmined to be of Type II (111) e original building and the o Type II (111) construction ted as Building 01 under quirements. d with a fire alarm system ion in the corridors and in o the corridors, and that is				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	F CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		
		245410	B. WING		0.	4/01/2014
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		10112014
RICE CAF	RECENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 000	automatic fire sprinkl inspection the facility and had a census of The requirement at 4	lity is fully protected by an ler system. At the time of the r has a capacity of 78 beds 74. 22 CFR, Subpart 483.70(a) is	K 00	0		
K 011 SS=E	If the building has a one nonconforming build barrier having at lease rating constructed of addition. Communic corridors and are pro-	ETY CODE STANDARD common wall with a ing, the common wall is a fire st a two-hour fire resistance materials as required for the ating openings occur only in	K 01	1		
	Based on observation revealed that 1 of 1 ff facility did not meet to two hour fire separation accordance with NFF Code" 2000 edition (In These deficient cond products of combustion building to another, we					
	04/01/2014, observat hour fire separation v	en 11:00 AM to 3:00 PM on ions revealed, that the 2 vall that is separating the and the 1995, 2011, and				

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

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
			JUI - MAIN BUILDING UT			
	245410	B. WING		04/(	01/2014	
ROVIDER OR SUPPLIER						
RECENTER			WILLMAR, MN 56201			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIC DATE	
<ul> <li>the 2014 additions conditions:</li> <li>1. A penetration at that is going throug Storage room and the other side of the and</li> <li>2. In the 90 minute located outside of the storage outside outside of the storage outside outsi</li></ul>	has the following deficient round the fire sprinkler piping gh that wall of the Kitchen Dry a personnel office located on e 2 hour fire separation wall, e fire rated double doors the Kitchen Dry Storage room	K 0	<sup>11</sup> Mechanical contractor wa and fire caulked around n Rick Wandersee, Mainten be responsible to monitor and fill wall penetrations Smoke barrier brushes ha installed on the noted do	oted pipe. ance, will ring for as needed. ve been or. Rick	4-7-14	
inch gap between the This deficient cond Interim Administrat NFPA 101 LIFE SA Corridors are sepa constructed with at rating. In sprinklen required to resist the non-sprinklered bu above the ceiling. at the underside of permitted by Code, waiting areas, dinir may be open to the conditions specified be separated from walls if the gift shop	the two doors. ition was confirmed by the or (TO). FETY CODE STANDARD rated from use areas by walls least ½ hour fire resistance ed buildings, partitions are only ne passage of smoke. In ildings, walls properly extend (Corridor walls may terminate ceilings where specifically Charting and clerical stations, ng rooms, and activity spaces a corridor under certain d in the Code. Gift shops may corridors by non-fire rated o is fully sprinklered.)	K 01	responsible for monitorin smoke barrier issues on d for installing brushes whe	g future oors and		
	ROVIDER OR SUPPLIER RECENTER SUMMARY (EACH DEFICIE REGULATORY ( Continued From pa the 2014 additions conditions: 1. A penetration an that is going throug Storage room and the other side of th and 2. In the 90 minute located outside of th and 2. In the 90 minute located outside of th in the 2 hour fire se inch gap between th This deficient cond Interim Administrat NFPA 101 LIFE SA Corridors are sepa constructed with at rating. In sprinkler required to resist th non-sprinklered bu above the ceiling. at the underside of permitted by Code. waiting areas, dinir may be open to the conditions specified be separated from walls if the gift shop	F CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         245410         RECENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3 the 2014 additions has the following deficient conditions:         1. A penetration around the fire sprinkler piping that is going through that wall of the Kitchen Dry Storage room and a personnel office located on the other side of the 2 hour fire separation wall, and         2. In the 90 minute fire rated double doors located outside of the Kitchen Dry Storage room in the 2 hour fire separation wall there is a 1/4 inch gap between the two doors.         This deficient condition was confirmed by the Interim Administrator (TO).	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245410         ROVIDER OR SUPPLIER         RE CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         Continued From page 3         the 2014 additions has the following deficient conditions:         1. A penetration around the fire sprinkler piping that is going through that wall of the Kitchen Dry Storage room and a personnel office located on the other side of the 2 hour fire separation wall, and         2. In the 90 minute fire rated double doors located outside of the Kitchen Dry Storage room in the 2 hour fire separation wall there is a 1/4 inch gap between the two doors.         This deficient condition was confirmed by the Interim Administrator (TO).         NFPA 101 LIFE SAFETY CODE STANDARD         K 01         Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gif shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)	F CORRECTION       IDENTIFICATION NUMBER:       A, BUILDING 01 - MAIN BUILDING 01         245410       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         RE CENTER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       DEFICIENCY PRECENTER         Continued From page 3 the 2014 additions has the following deficient conditions:       DEFICIENCY 1. A penetration around the fire sprinkler piping that is going through that wall of the Kitchen Dry Storage room and a personnel office located on the other side of the 2 hour fire separation wall, and       K 011         2. In the 90 minute fire rated double doors located outside of the Kitchen Dry Storage room and a personnel office located on the other side of the Xitchen Dry Storage room in the 2 hour fire separation wall, and       Smoke barrier brushes ha installed on the noted door Wandersee, Maintenance responsible for monitorin smoke barrier brushes ha installed on the noted door Wandersee, Maintenance responsible for monitorin smoke barrier issues on d for installing brushes whe Interim Administrator (TO).         NFPA 101 LIFE SAFETY CODE STANDARD       K 017         Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dning rooms, and activity spaces may be open to the corridor sby non-fire rated walls if the gift shop is fully sprinklered.)	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - MAIN BUILDING 01       COMPLET         REVENUER       B. WING       04//         REVENUER       STREET ADDRESS, CITY, STATE, 2P CODE       100 SOUTHWEST WILLMAR AVENUE         RECENTER       D. PROVIDERS PLAN OF CORRECTION SOUTHWEST WILLMAR, NM SEGOI       PROVIDERS PLAN OF CORRECTION SOUTHWEST WILLMAR, NM SEGOI         Continued From page 3       D. PREVENT OF DEFICIENCES       D. PREVENT PLAN OF CORRECTION SOUTHWEST WILLMAR, NM SEGOI         Continued From page 3       K 011       Mechanical contractor was recalled and fire caulked around noted pipe         1. A penetration around the fire sprinkler piping that is going through that wall of the Kitchen Dry Storage room and a personnel office located on the other side of the 2 hour fire separation wall, and       K 011         2. In the 90 minute fire rated double doors located outside of the Kitchen Dry Storage room in the 2 hour fire separation wall, and       Smoke barrier brushes have been installed on the noted door. Rick Wandersee, Maintenance, will be responsible to monitoring future smoke barrier issues on doors and for installing brushes where needed.         This deficient condition was confirmed by the Interim Administrator (TO).       K 017         Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In spinklered buildings, partitions are only required buildings, walls properly extend above the ceiling. (Corridor walls may teminate at the underside of ceilings where specificality permitted by Code. Charting and derical stations, wa	

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

AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A BULTONG of ANNI BULDING of AUXIEST       COMPLETED         AND OF CORRECTION       A BULTONG of A SUPPLEX       STREET ADDRESS, GITY, STATE, 2P COOC         MALE OF PROVIDER OF SUPPLEX       STREET ADDRESS, GITY, STATE, 2P COOC       OWNOW		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, SIATE, 2P CODE 1991 SOUTIVIEST WILLMAR AVENUE WILLMAR, MR SE201       PREET ADDRESS, CITY, SIATE, 2P CODE 1991 SOUTIVIEST WILLMAR AVENUE WILLMAR, MR SE201     CONSTRUCTION (CONSTRUCTION)       PREOUZINEY SOLT BEREFICED BY FULL CAN DEPENDENT WILL BEREFICED BY FULL TWILL MAR, MR SE201     PROVIDER OF MOULD GE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       K 017     Continued From page 4     K 017       K 017     Continued From page 4     K 017       This STANDARD is not met as evidenced by: Based on observations and staff inter/www, It was revealed that the facility that are not in compliance with NFPA LIG Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 the exiting capabilities for 51 of 74 residents, staff and visitors.     Fire caulk was used to fill noted holes.       Findings include:     4.       On facility four between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility had numerous penetrations include:     4.       On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility had numerous penetrations include:     4.       1. A 1 inch diameter hole located in the calling tile by the med room storage by the receptionist desk, 2. A 2 inch by 34 inch hole in the calling tile by the med room storage by the receptionist desk, and 3. A 14 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk, and 3. Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will							
NAME OF ROMORE OR SUPPLIER         STREET ADDRESS, CITY, STREE, 28 CORE           RCE CARE CENTER         Ist SOUTWEST WILLMAR AVENUE           CAND CLARE CENTER         International State (State (Sta			245410	B, WING	and the second	04/	01/2014
INCE CARE CENTER       WILLMAR, MN 56201         (P41) PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (CARCH DEFICIENCY MOST DE PECEDED BY TULL RECOULTORY OR USC IDENTIFYING INFORMATION)       PD PREFIX TAG       PROVIDENTIFYING INFORMATION       PROVIDENTIFYING	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	
PAND PREFIX TAG         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICITION MORE EPRECEDED OF FULL RECOLLINGY OF DEEDENTIFYING INFORMATION)         PROVIDER'S PLANOF CONNECTION (EACH DEPICITION STADUE) E CROSS-REFERENCE TO UN SHOULD BE DEPICIENCY)           K 017         Continued From page 4         K 017           This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility several penetrations located throughout the facility several penetrations located throughout the facility several penetrations could in the event of a fire, allow smoke and fames to spread throughout the facility. Sators.         K 017           Findings include:         f.           On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations in celling tile by the med room storage by the receptionist desk, 2. A 2 inch by 3/4 inch hole in the celling tile by the med room storage by the receptionist desk, and 3. A 11/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.         J.           3.         Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed.         4-2-1	RICE CAR	ECENTER					
Presext No.         Exclusion percence of the percence per visual economic constructions and staff interview, it was revealed that the facility several penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 10.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and fiames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 51 of 74 residents, staff and visitors.         Fire caulk was used to fill noted holes. Fire caulk was used to fill noted holes. A 2 inch by 3/4 inch hole in the ceiling tile bocated in the day room next to the receptionist desk, and 3. A 1/4 inch gap around the multiple sprinkler heads located in the day room by the receptionist desk.         Fire caulk was used to fill noted holes. A 2. A 2. Fire caulk was used to fill noted holes. A 2. Fire caulk was used to fill noted holes. A 2. A 2 inch by 3/4 inch hole in the ceiling tile located in the day room perton by the receptionist desk.         Fire caulk was used to fill noted holes. A 2. A 2. A 2. A 2. A 2. A 2. A 2. A 2					and the second se	SCOTION	
This STANDARD is not met as evidenced by:         Based on observations and staff interview, it was revealed that the facility several penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and filames to spread throughout the facility is smoke and filames to spread throughout the facility and unerase making them untenable, which could negatively affect the exiting capabilities for 51 of 74 residents, staff and visitors.       fire caulk was used to fill noted holes.       4-2.1         No facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility. Such locations include:       fire caulk was used to fill noted holes.       4-2.1         No facility had numerous penetrations in ceiling tile by the med room storage by the receptionist desk, and       fire caulk was used to fill noted holes.       4-2.1         No A 1 inch diameter hole located in the ceiling tile located in the day room next to the receptionist desk, and       A. 14 inch diameter hole located in the ceiling tile located in the day room by the receptionist desk, and       fire caulk was used to fill noted holes.       4-2-1         Staff interview.       3.       Fire caulk was used to fill noted holes.       4-2-1	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
Based on observations and staff interview, it was revealed that the facility several penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 51 of 74 residents, staff and visitors.       Fire caulk was used to fill noted holes.       4-2-1         Findings include:       1.       Fire caulk was used to fill noted holes.       4-2-1         No facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility had numerous penetrations in colling tiles that are located throughout the facility. Such locations include:       1.       A 1 inch diameter hole located in the ceiling tile located in the day room next to the receptionist desk.       2.       Fire caulk was used to fill noted holes.       4-2-1         8.       4.14 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.       3.       Fire caulk was used to fill noted holes.       4-2-1         9.       Fire caulk was used to fill noted holes.       4-2-1       4-2-1	K 017	Continued From page	e 4	ĸ	017		
Findings include:LOn facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility had numerous penetrations in ceiling tiles that are located throughout the facility. Such locations include:Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed.1. A 1 inch diameter hole located in the ceiling tile by the med room storage by the receptionist desk, 2. A 2 inch by 3/4 inch hole in the ceiling tile located in the day room next to the receptionist desk, and 3. A 1/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.A.Fire caulk was used to fill noted holes. Fire caulk was used to fill noted holes. Fire caulk was used to fill noted holes.4-2-1 Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed.3. A 1/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.3.Fire caulk was used to fill noted holes. Fire caulk was used to fill noted holes.4-2-1 Rick Wandersee, Maintenance, will		Based on observation revealed that the faci- located throughout the compliance with NFP Sections 19.3.6.2 and passage of smoke. The could in the event of flames to spread thro- corridors and areas in which could negative capabilities for 51 of	ns and staff interview, it was lity several penetrations e facility that are not in A Life Safety Code 101 (00) d 8.2.4.4.1 in resisting the This deficient conditions a fire, allow smoke and hughout the effected naking them untenable, ly affect the exiting				
1. A 1 inch diameter hole located in the ceiling tile by the med room storage by the receptionist desk, 2. A 2 inch by 3/4 inch hole in the ceiling tile located in the day room next to the receptionist desk, and 3. A 1/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.J.Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed.4-2-13. A 1/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk.J.Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will4-2-1		On facility tour betwe 04/01/2014, observa facility had numerous that are located throu	tions revealed, that the penetrations in ceiling tiles	Å.	Rick Wandersee, Mainte be responsible to monito fill holes or replace ceilir	nance, will (	4-2-14
desk. جي جي جي جي جي جي جي جي جي ڪري جي جي ڪري ڪري ڪري ڪري ڪري ڪري ڪري ڪري ڪري ڪر		<ol> <li>A 1 inch diameter tile by the med room desk,</li> <li>A 2 inch by 3/4 inc located in the day roo desk, and</li> <li>A 1/4 inch gap aro</li> </ol>	storage by the receptionist th hole in the ceiling tile om next to the receptionist und the multiple sprinkler	2.	Rick Wandersee, Mainter be responsible to monito fill holes or replace ceilin	nance, will or for and	4-2-14
This deficient condition was confirmed by the Interim Administrator (TO).		desk. This deficient conditio	on was confirmed by the	3.	Rick Wandersee, Mainter be responsible to monito fill holes or replace ceilin	nance, will or for and	4-2-14

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILD 245410 B, WING NAME OF PROVIDER OR SUPPLIER RICE CARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 029 Continued From page 5 K	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM	0
NAME OF PROVIDER OR SUPPLIER         RICE CARE CENTER         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)         K 029       Continued From page 5       K         K 029       NFPA 101 LIFE SAFETY CODE STANDARD       K         SS=D       One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire       ID	STREET ADDRESS, CITY, STATE, ZIP CODE       1801 SOUTHWEST WILLMAR AVENUE       WILLMAR, MN 56201       ID     PROVIDER'S PLAN OF CORRECTION       IEFIX     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COM	(X5) IPLETION
NAME OF PROVIDER OR SUPPLIER         RICE CARE CENTER         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)         K 029       Continued From page 5       K         K 029       NFPA 101 LIFE SAFETY CODE STANDARD       K         SS=D       One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire       ID	STREET ADDRESS, CITY, STATE, ZIP CODE       1801 SOUTHWEST WILLMAR AVENUE       WILLMAR, MN 56201       ID     PROVIDER'S PLAN OF CORRECTION       IEFIX     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COM	(X5) IPLETION
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG         K 029       Continued From page 5       K         K 029       NFPA 101 LIFE SAFETY CODE STANDARD       K         SS=D       One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire       ID	WILLMAR, MN 56201         ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         K 029	IPLETION
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG         K 029       Continued From page 5       K         K 029       NFPA 101 LIFE SAFETY CODE STANDARD       K         SS=D       One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire       ID	K 029	IPLETION
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         K 029       Continued From page 5       K         K 029       NFPA 101 LIFE SAFETY CODE STANDARD       K         SS=D       One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire       Note that the second se	K 029	IPLETION
K 029 NFPA 101 LIFE SAFETY CODE STANDARD K SS=D One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire		
<ul> <li>and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</li> <li>This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 18 of 74 residents, staff and visitors.</li> <li>Findings include:</li> <li>On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed, that the</li> </ul>		
following deficient conditions were identified:		

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

Facility ID: 00313

If continuation sheet Page 6 of 12

PRINTED: 04/21/2014 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING 01	ONSTRUCTION MAIN BUILDING 01	(X3) DATE COMP	SURVEY
		245410	B. WING		04/	01/2014
	ROVIDER OR SUPPLIER	L	180	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHWEST WILLMAR AVENUE LLMAR, MN 56201	1	0112014
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 029	<ul> <li>sprinkler piping abov room in the wall that i from the corridor.</li> <li>2. There are penetrative the fire sprinkler pipin wall and into three root where the piping pass corner of the wall that from the laundry room and through the north</li> </ul>	e 6 tration found around the e the entry door to the boiler s separating the boiler room tions that were found around g that passes through two oms. The penetrations start ses through that northwest is separates the boiler room n, across the laundry room west corner of the opposite the laundry room from a	K 029	Holes were filled with fire sealed with fire caulk. Rick Wandersee, Maintenance, responsible to monitor for holes as needed. Penetrations were covered sheetrock and sealed with caulk. Rick Wandersee, Maintenance, will be responded	« will be and fill with fire posible	4-2-14
K 051 SS=D	Interim Administrator NFPA 101 LIFE SAFE A fire alarm system w devices or equipment NFPA 72, National Fir effective warning of fir Activation of the comp manual fire alarm initi extinguishing system patient sleeping areas that manual pull station nurse's stations. Pull path of egress. Electrit tests are available. A power is provided. Fir maintained in accordar records of maintenany There is remote annu	TY CODE STANDARD ith approved components, is installed according to re Alarm Code, to provide re in any part of the building. olete fire alarm system is by ation, automatic detection or operation. Pull stations in s may be omitted provided ons are within 200 feet of stations are located in the ronic or written records of a reliable second source of	K 051	penetrations as needed.		

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245410			ONSTRUCTION (X: MAIN BUILDING 01	3) DATE SURVEY COMPLETED	
		245410	U. WING	OT D		04/01/2014	
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHWEST WILLMAR AVENUE		
RICE CAF	RECENTER			WIL	LMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 051	Continued From pag	e 7	K	051			
	Based on observation revealed that the fact unobstructed access actuated alarm-initiat throughout the facility 101 Life Safety Code 9,6.2.6 as well as NF Code (99), Sections condition could adve initiate the fire alarm emergency actions, a notification in the even negatively affecting 5 visitors of the facility. Findings include: On facility tour betwee 04/01/2014, observat manual fire alarm put original 1965 building	y in accordance with NFPA e (00), Sections 19.3.4.2 and PA 72 National Fire Alarm 2-8.2.1. This deficient rsely affect the ability to system and delay and emergency forces ent of an emergency, thus 51 of 74 residents, staff, and			This room was temporarily being used for storage. It is now cleane out and the noted fire pull station is clear of obstructions.		
	pull station in the eve requirements of both NFPA 72 (99) require	ess to that manual fire alarm ent of an emergency. The the NFPA 101 (00) and the e that manual fire alarm structed and accessible at all			Rick Wandersee, Maintenance, will be responsible to monitor for and remedy pull station obstructions.		

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Facility ID: 00313

If continuation sheet Page 8 of 12

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

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTH	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMPLETED
		245410	B. WING		04/01/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RICE CAR	ECENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
K 051	Continued From pag	e 8	K 0!	51	
K 052 SS=F	Interim Administrator NFPA 101 LIFE SAF	ETY CODE STANDARD	K 0!	52	
	installed, tested, and with NFPA 70 Nation 72. The system has and testing program	equired for life safety is maintained in accordance al Electrical Code and NFPA an approved maintenance complying with applicable A 70 and 72. 9.6.1.4			
	Based on observation revealed that the fact maintain the fire alar	not met as evidenced by: on and staff interview, it was ility had failed to install and m system in accordance with 2000 NFPA 101, Sections		Original inspection date w rescheduled and conducte April 11, 2014 by Simplex. inspection report is locate	ed on The
	19.3.4.1 and 9.6, as Sections 7.1. This de adversely affect the f system, and could de and emergency action	well as 1999 NFPA 72, eficient condition could functioning of the fire alarm elay the timely notification ons for the facility thus 74 of 74 residents, staff, and		Fire Safety Documentation Future inspections, 12 mo from the most recent insp will be scheduled in advar Rick Wandersee, Mainten and noted on the Mainter	n Book. Inths Dection, Ince by ance,
	Findings include:			schedule/calendar.	
	On facility tour betwe	en 11:00 AM to 3:00 PM on			

		MEDICAID SERVICES				OMB NO	D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION Main Building 01		E SURVEY PLETED
		245410	B. WING			04	/01/2014
	ROVIDER OR SUPPLIER	1			ET ADDRESS, CITY, STATE, ZIP CODE SOUTHWEST WILLMAR AVENUE	1 04	0 1 2014
RICE CAP	CENTER .			WILL	MAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
K 052	of all available fire all last 12 months, and I Administrator (TO), t inspection the facility	tion revealed from a review arm documentation for the by a interview with the	КC	052			
K 056 SS=C	Interim Administrator NFPA 101 LIFE SAF If there is an automatinstalled in accordant for the Installation of provide complete con- building. The system accordance with NFF Inspection, Testing, a Water-Based Fire Pro- supervised. There is supply for the system systems are equippe	ETY CODE STANDARD tic sprinkler system, it is ce with NFPA 13, Standard Sprinkler Systems, to verage for all portions of the n is properly maintained in PA 25, Standard for the and Maintenance of otection Systems. It is fully a reliable, adequate water n. Required sprinkler d with water flow and tamper electrically connected to the	ĸ	956			
	Based on observation revealed that the facing system was not instand accordance with NFF Installation of Sprinkle to maintain the sprinkle	not met as evidenced by: ons and staff interview, it was lity's automatic fire sprinkler lled and maintained in PA 13 the Standard for the er Systems (99). The failure der system in compliance ould allow system being place					

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

Facility ID: 00313

If continuation sheet Page 10 of 12

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		and the second se	011101110	0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		245410	B. WING		04/	01/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
RICE CAR	ECENTER			1801 SOUTHWEST WILLMAR A WILLMAR, MN 56201	VENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
K 056	protection system ca emergency that could visitors and staff of th Findings include: On facility tour betwee 04/01/2014, observa sprinkler heads locat area were heavily co colored scale like ma possible sealing the plug assemble in pla	g a decrease in the fire pability in the event of an d affect 18 of 74 residents, ne facility. een 11:00 AM to 3:00 PM on	K	256 The noted sprink scheduled for rep Wandersee, Mair responsible to mo remedy sprinkler and functionality	placement. Rick ntenance, will be onitor for and head cleanliness	41 Admin 9-14 6-11
K 069 SS=C	Interim Administrator NFPA 101 LIFE SAF Cooking facilities are with 9.2.3. 19.3.2.0 This STANDARD is Based on observatio determined that the fi the accessibility to the station for the hood s compliance with the Fire Extinguishing sy This deficient condition of the kitchen's hood event of a fire above	ETY CODE STANDARD protected in accordance 5, NFPA 96 not met as evidenced by: ons and staff interview, it was acility has failed to ensure e manual activation pull suppression system is in requirements of NFPA 96 stems (98) section 7-5.1. on would delay the activation suppression system in the the cooking area of the egatively affecting 18 of 74	K	069		

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

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMPI	
		245410	B. WING			04/0	01/2014
	ROVIDER OR SUPPLIER	L:		1801 \$	ET ADDRESS, CITY, STATE, ZIP CODE SOUTHWEST WILLMAR AVENUE MAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 069	Continued From page	ə 11	ĸ	069			
	04/01/2014, observat manual pull station for suppression system v stand mixer, shelving these obstructions pr manual pull station in emergency in the fac	or the kitchen's hood fire was blocked by a large floor and a storage counter. event the accessibility to the the event of a fire ility's kitchen.			The mixer noted in this deficient has been relocated. The shelf in this deficiency will be cut do a size that will allow for visibilit accessibility of the fire pull stat Rick Wandersee, Maintenance be responsible to monitor for a remedy pull station obstruction	noted wn to ty and tion. , will and	4-30-14
FORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: UX	QR21	Facility	ID: 00313 If contin	uation shee	Let Page 12 of 12

Facility ID: 00313

#### PRINTED: 04/21/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 02 - 2011 ADDITION 245410 B. WING 04/01/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE RICE CARE CENTER WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 100 M 18 5-5-14 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE, YOUR 0.5-13-SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE **REGULATIONS HAS BEEN ATTAINED IN** ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey. the Rice Care Center - Building 03, additions were found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY MAY - 1 2014 DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS N DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 28 ctena 2014 ane

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - 2011 ADDITION	(X3) D.	ATE SURVEY DMPLETED
		245410	B, WING			04/01/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	By e-mail to: Marian.Whitney@stat THE PLAN OF CORF DEFICIENCY MUST FOLLOWING INFORI 1. A description of whito correct the deficien	e.mn.us RECTION FOR EACH NCLUDE ALL OF THE MATION: at has been, or will be, done cy. osed, completion date. tile of the person tion and monitoring to	К 00	00		
	five separate additions four different times. The first addition was 1-story addition without located on the south se determined to be of Ty The second addition without located on the south se Building - 01 and was V(111) construction. in 2013, and is a 1-store basement that is located northwest wing of Build determined to be of Ty	- Building 03 consists of s that were constructed at built in 2011, and is a ut a basement that is ide of Building - 01 and was ype V(111) construction. vas built in 2012, and is a ut a basement that is ide of the northeast wing of determined to be of Type The third addition was built my addition without a ed on the south side of the				

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Facility ID: 00313

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2014 FORM APPROVED OMB NO 0938-0391

CENTER	SFUR MEDICARE &	MEDICAID SERVICES				ONB NC	0.0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 12 - 2011 ADDITION	(X3) DATE COMF	SURVEY
		245410	B. WING			04/	01/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	801 SOUTHWEST WILLMAR AVENUE		
RICE CAR	RECENTER			v	VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
K 000 K 017 SS=C	building that were bot additions are 1-story a that are located on the and on the west side determined that both V(111) construction. Since the five addition Type V(111) construct one building labeled a Health Care facility st The facility is equippe that has smoke detec spaces that are open facility's fire a; arm sys automatic fire departm is fully protected by an system. At the time of has a capacity of 78 b The requirement at 42 MET. NFPA 101 LIFE SAFE Corridor walls form a smoke. Such walls are the ceiling where the	h built in 2014, both additions without basements e west side of Building - 01 of the 2011 addition. It was 2014 additions are of Type hs are all constructed of tion, they were inspected as as Building - 03 and to New andards. d with a fire alarm system tion in the corridors and in to the corridors. The stem is also monitored for nent notification. The facility h automatic fire sprinkler of the inspection the facility beds and had a census of 74 2 CFR, Subpart 483.70(a) is ETY CODE STANDARD barrier to limit the transfer of re permitted to terminate at ceiling is constructed to limit . No fire resistance rating is		000			
	This STANDARD is n	ot met as evidenced by:					

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Facility ID: 00313

If continuation sheet Page 3 of 7

CENTERS FOR MEDICARE & MEDICAID SERVICES

ULNILIN	SFOR MEDICARE &	WEDIGAID SERVICES				OND NC	0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 2 - 2011 ADDITION	(X3) DATE COMP	SURVEY PLETED
		245410	B. WING	-		04/	01/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				18	301 SOUTHWEST WILLMAR AVENUE		
RICE CAP				N	ALLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	revealed that the facili corridor that was not it Life Safety Code 101 8.2.4.4.1 in resisting to deficient conditions or allow smoke and flam effected corridors and untenable, which cou- exiting capabilities for visitors. Findings include: On facility tour betwee 04/01/2014, observative was a ceiling tile hang located directly across entrance in the corridor vertical penetration the 6 inches by 24 inches This deficient condition Interim Administrator NFPA 101 LIFE SAFE Door openings in smo 20-minute fire protect 1¾-inch thick solid bo protective plates that from the bottom of the Horizontal sliding doo Swinging doors are an swings in an opposite self-closing and rabbe	ns and staff interview, it was ity had a penetration in the n compliance with NFPA (00) Sections 19.3.6.2 and he passage of smoke. This build in the event of a fire, les to spread throughout the l areas making them ld negatively affect the 6 of 74 residents, staff and en 11:00 AM to 3:00 PM on tions revealed, that there ging from the grid system s from the Physical Therapy or ceiling that is creating a at measured approximately		017	The ceiling tile noted in this deficiency was damaged. Rick Wandersee, Maintenance, be responsible for the replacem of the damaged tile and in monitoring for future damaged tile replacement.	nent	4-2-14

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Facility ID: 00313

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

CENTER	S FOR MEDICARE &	WEDIGAD OLIVIOLO	OMB NO. 093				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG 02 - 2011 ADDITION	(X3) DATE COMP		
		245410	B. WING		04/0	01/2014	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				1801 SOUTHWEST WILLMAR AVENUE	Ξ		
NICE CAP				WILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
K 027	Continued From pag	e 4	ĸ	027			
	Based on observation revealed that the fact proper protection for doors located throug accordance with NFF (2000 edition) section Fire Doors and Fire M condition could negative residents, staff, and products of combust	PA Life Safety Code 101 n 19.3.6.3.1., and NFPA 80 Windows (99). This deficient tively affect 23 of 74 visitors, by allowing the ion to migrate between s making the corridor					
	On facility tour betwee 04/01/2014, observed corridor smoke barrin addition next to reside between the smoke of an inch in width, w	een 11:00 AM to 3:00 PM on ations revealed, that the er doors located in the 2011 dent room 201 had a gap barrier doors measuring 1/4 which is greater than the gap of 1/8 of an inch.		Smoke barrier brushes installed on the noted Wandersee, Maintena responsible for monito smoke barrier issues o for installing brushes	door. Rick Ince, will be oring future on doors and	4-7-14	

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - 2011 ADDITION	1 Y Y	TE SURVEY
		245410	B. WING		04/04/2014	
	ROVIDER OR SUPPLIER	240410		STREET ADDRESS, CITY, STATE, ZIP CODE	1 (	4/01/2014
	NONDER ON GOI'LER			1801 SOUTHWEST WILLMAR AVENUE		
RICE CAR	RECENTER			WILLMAR, MN 56201		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 027	Continued From page	e 5	K 0:	27		
	This deficient condition Interim Administrator	on was confirmed by the				
K 052	052 NFPA 101 LIFE SAFETY CODE STANDARD K SS=F		K 0	52		
00-г	installed, tested, and	equired for life safety is maintained in accordance				
		al Electrical Code and NFPA an approved maintenance				
	and testing program of	complying with applicable A 70 and 72. 9.6.1.4				
	Based on observatio revealed that the faci maintain the fire alarr the requirements of 2 19.3.4.1 and 9.6, as w Sections 7.1. This de adversely affect the fir system operability an notification and emer- thus negatively affect and visitors of the fact	not met as evidenced by: in and staff interview, it was lity had failed to install and in system in accordance with 2000 NFPA 101, Sections well as 1999 NFPA 72, eficient condition could unctioning of the fire alarm id could delay the timely gency actions for the facility ing 74 of 74 residents, staff, cility.		Original inspection date v rescheduled and conduct April 11, 2014 by Simplex inspection report is locate Fire Safety Documentatio	ed on . The ed in the	4-11-1
	Findings include:	en 11:00 AM to 3:00 PM on		Future inspections, 12 mc from the most recent insp		
	04/01/2014, observat of all available fire ala	ion revealed during a review arm documentation for the		will be scheduled in advar	nce by	
	last 12 months, and a Administrator (TO), th	nat at the time of the		Rick Wandersee, Mainten and noted on the Mainte		
		had failed to conduct the and inspection of the facility's		schedule/calendar.		

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 02 - 2011 ADDITION         245410       B. WING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY         RICE CARE CENTER       1801 SOUTHWEST WIL         WILLMAR, MN 5620	, STATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF	R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE COMPLETIO RENCED TO THE APPROPRIATE DATE DEFICIENCY)
K 052       Continued From page 6       K 052         fire alarm system.       This deficient condition was confirmed by the       Interim Administrator (TO).	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5120

April 21, 2014

Mr. Tony Ogdahl, Interim Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5410023

Dear Mr. Ogdahl:

The above facility was surveyed on March 31, 2014 through April 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Rice Care Center April 21, 2014 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to Brenda Fischer at Minnesota Department of Health, 3333 W Division, #212 St Cloud Mn 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

ate Compton

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

RECEIVED

PRINTED: 04/21/2014 FORM APPROVED

Minneso	ta Department of Healt	h					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION		(X3) DATE S COMPL	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			UOIMI L	
		00313	B. WING			04/0	3/2014
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,		MN Dept of Health St.Cloud		
NAME OF P	ROVIDER OR SUPPLIER				01.01000		the the training of
RICE CAF	RE CENTER		UTHWEST WILLMA	RAVENUE			
	· · · · · · · · · · · · · · · · · · ·		R, MN 56201		· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments		2 000				
	*****ATTEN	ITION*****					
	NH LICENSING C	ORRECTION ORDER					
		linnesota Statute, section ion order has been issued					
		If, upon reinspection, it is					
		ncy or deficiencies cited					
		ted, a fine for each violation					
		e assessed in accordance					
		es promulgated by rule of					
i s	the Minnesota Depar	tment of Health.					
	Determination of whe	ther a violation has been					
	corrected requires co						
		ule provided at the tag					
		e number indicated below.					la de la contra
		several items, failure to					
case to c		e items will be considered					
		∟ack of compliance upon y item of multi-part rule will					
		ent of a fine even if the item					
		ing the initial inspection was					
	corrected.	-					
		earing on any assessments					
	•	non-compliance with these a written request is made to					
	•	n 15 days of receipt of a					
	notice of assessment						
	INITIAL COMMENTS						
	On March 31, 2014 t						4 . L.Y.
		eartment's staff, visited the he following correction					
	orders are issued.						
		gn and date, make a copy of					
	these orders and retu						
-		nt of Health, Division of					
Minnesota Do	partment of Health					<u></u>	
		SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	тіт	LE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Acting administrator UXQR11 . Og

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STATE FORM

<u>nil 30, 2014</u> If continuation sheet 1 of 46

Minneso	ta Department of Healt	h		-	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00313	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		1801 SC	UTHWEST WILL	MAR AVENUE	
		WILLMA	R, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 000	Continued From page	e 1	2 000		
· •	Compliance Monitorir Certification Program Suite 212, St Cloud, I	, 3333 West Division St,			
2 265	MN Rule 4658.0085 I Resident Health Stati	•	2 265	Refer to attachment for Po and date of completion	c .
	policies to guide staff physicians, physician practitioners, and if kr legal representative of member of a resident accident, or death. A nursing services, and attending physician m development of these have criteria which ac appropriate notification A. an accident inv results in injury and h	assistants, and nurse nown, notify the resident's or an interested family 's acute illness, serious t a minimum, the director of the medical director or an oust be involved in the policies. The policies must diress at least the in times for: volving the resident which as the potential for requiring			
	physical, mental, or p example, a deterioration	nange in the resident's osychosocial status, for ion in health, mental, or n either life-threatening			· · · · · ·
	example, a need to di of treatment due to ac begin a new form of tr				
	resident from the nurs	ransfer or discharge the sing home; or unexpected resident deaths.			
Ainnesota Der	partment of Health				

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If continuation sheet 2 of 46

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	a.	00313	B. WING		04	/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP ÇODE		
	ECENTER	1801 SO	UTHWEST WILLMA	AR AVENUE		
RICE CAR	ECENTER	WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From page	e 2	2 265			
	by:	nt is not met as evidenced n, interview and document				
	review, the facility fai	led to notify the r when 1 of 3 residents (R36)				
ivat Marita	Findings include:					· · · · · · · · · · · · · · · · · · ·
	2/14/14, included she	imum Data Set (MDS) dated e was cognitively intact, was lcers, but did not have any ers.				
	registered nurse (RN noted on R36's right shallow crater, with r area. R36 stated, "I a while." RN-G was	n 4/1/14, at 2:15 p.m. with I)-G. A pressure ulcer was inner buttocks, that was a edness surrounding the have had that sore for quite unsure if the physician or d been notified of R36's				2000 2010 2010 2010 2010 2010 2010 2010
	2/19/14, "Patient not shearing to middle of cm [centimeters] x [b wear lift sheet sits du calmo [protective ban continue to monitor." Sheet dated 2/19/14	gress notes identified on ed to have small area of f left buttocks measuring 2 by] 0.5 cm. Appears to be uring transfers. Will apply rrier cream] to area and R36's Wound Progress , included a stage 2 (partial mis presenting as a shallow				
	open ulcer with a rec slough) pressure ulc	l pink wound bed, without er, with a pink wound bed, nage, surrounding tissue				

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	OF DEFICIENCIES F CORRECTION	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00313	B. WING	· · · · · · · · · · · · · · · · · · ·	04/03/2014
	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
•		1801 SO	UTHWEST WILLMA	AR AVENUE	
RICE CAR	E CENTER	WILLMA	R, MN 56201		•••
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLET
2 265	Continued From pag	e 3	2 265		
	listed as being from, indicated the practition	les normal. The wound was "Shearing." The form oner and family had not been opment of the pressure ulcer.			
	Review of the nurse 2/21/14, did not indic informed of the press developed on 2/19/1				
	skin assessment for with the following res	n 3/11/14, indicated, "Weekly high risk patient completed sults." Under "skin issues," able [sic] right buttock 1 cm x			
ini Maria Maria	not indicate the phys	cian note dated 3/19/14, did sician had been informed of ven though it developed on			•
	"Observed wound to evening. 1.75 inches	es dated 4/1/14, indicated, o coccyx/buttock crease this s x 3 inches, reddened areas small areas of stage 2 or			
	When interviewed o stated she thought t the pressure ulcer, b	n 4/1/14, at 2:43 p.m. RN-C he NP had been notified of but was not sure.			
	2/19/14, which conti physician or NP wer	oped a pressure ulcer on nued to become larger, the re never notified of the ulcer, ange to the plan of care was pressure ulcer.			
	A facility policy entit included, "RCC [Ric	led Skin Care, dated 3/2010,			

STATE FORM

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## 2265 Notification of Physician

#### **Corrective Action:**

Res 36 physician notified of pressure ulcer on April 9, 2014

### Corrective Action - Identify other residents:

All residents/patients that have pressure areas have been reviewed to ensure physician notification per policy

#### Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding the current policy of Notification of changes in resident conditions.

### **Monitoring for Compliance:**

Audits will be completed by RN Care Manager &/or DON weekly at wound meeting to assure the physician has been notified for all pressure ulcers or changes of ulcer.

Results will be brought to QA committee for recommendation on the need to further audit

#### Date of completion

May 8, 2014

	a Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/03/2014	
		00313	B. WING			
	ROVIDER OR SUPPLIER	1801 SO	DDRESS, CITY, ST			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	R, MN 56201 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLE	
2 265	as change of Pressustage 2" Suggested Method of nursing (DON) or de medical director to u procedures for wher changes in the resid staff. The DON or d audits of resident re- physician had been	Any significant change such ire ulcer from stage 1 to of Correction: The director of isigee could work with the	2 265			
2 830	Proper Nursing Care Subpart 1. Care in g receive nursing care custodial care, and s individual needs and the comprehensive r plan of care as deso 4658.0405. A nursir of bed as much as p written order from th resident must remain prefers to remain in	general. A resident must and treatment, personal and supervision based on I preferences as identified in resident assessment and cribed in parts 4658.0400 and ng home resident must be out ossible unless there is a e attending physician that the n in bed or the resident	2 830	Refer to attachment for P and date of completion	oC	
	by: Based on observatio	n interview and document				

ATEMENT	Department of Heal OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SI COMPLE	
	00111201101		B, WING		04/0	3/2014
		00313				
AME OF PR	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
	E CENTER			AR AVENUE		
			AR, MN 56201	PROVIDER'S PLAN O	FCORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
2 830	Continued From page	ge 5	2 830			
	review the facility fa	ailed to coordinate care with				
	an outside dialysis ι	unit to include fluid intake				
	restrictions, care of	dialysis access site, and				
	emergency procedu	ires for 1 of 1 resident (R152)				
	who was reviewed f	for dialysis care.				
	Findings include:					Sec. 1
	-					1. 1. 1. 1.
		Ainimum Data Sat (MDS)				
	R152's admission Minimum Data Set (MDS) dated 1/27/14, included she was cognitively intact, had diagnoses of cirrhosis, end stage renal					
	disease (ESRD), ar	nd a hip fracture. R152				
	received a therapeutic diet. Entry and discharge					· · · ·
	tracking MDS's indi	tracking MDS's indicated R152 had been				
	hospitalized 2/8/14 and 3/18/14 to 3/21	to 2/14/14, 2/27/14 to 3/11/14,				
	and 3/18/14 to 3/21	1/14.				
	R152's care plan d	ated 1/29/14, included a				
	problem statement	of, "Hemodialysis r/t [related				
	to] ESRD; hepatic	encephalopathy [brain d by the liver being unable to				
	dysfunction caused	ances from the blood],				
	Dialyzing [sic] 3 da	ys/week at RMH [Rice				
	Memorial Hospital]	while at Therapy Suites;				
	usually dialyzes [si	ic] in Litchfield." R152's goal				
	was, "Will tolerate	dialysis runs while here AEB				
	[as evidenced by]	ability to complete 3.5 hour run, iid and maintain VS [vital				
	signs1 Staff instru	ictions included, "Follow				
	physician orders in	ncluding diet restrictions and 1.5				
	L [liters] fluid restri	ction. Send Dialysis				
	Communication Re	ecord with to all runs. Weigh				
	daily and record."	The nutrition care plan dated to "Provide 2 Gram Sodium,				
	High Protein Low	K+ [potassium], 1,500 cc [cubic				
	centimeters, equa	I to 1.5 liters] restriction per				
	physician order A	Ionitor weight and meal intake."				

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STATEMENT	a Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED
AND PLAN O	FUUKKEUTIUN		A. BUILDING:		
		00313	B. WING		04/03/2014
NAME OF PE	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
			UTHWEST WILLM	AR AVENUE	
RICE CAR	ECENTER	WILLMA	R, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETE
2 830	Continued From pag	e 6	2 830		nger van t
	R152's Physician Or	der Report dated 3/12/14,			
	included, "Diet order	: diabetic/dialysis diet, low			
	sodium 1000 mi (mii centimeters) fluid rei	liliters, equal to cubic striction."  "Kayexalate			
	suspension [medica	tion used to remove large			
	amounts of potassiu	m from the body, typically are missed or critically			
	elevated potassium	levels] 15 gm [grams]/60 ml:			
÷.	120 ml oral. TAKE	ONLY IN EMERGENCY.			1967 - 19
	CONTACT DIALYS	S PRIOR TO TAKING." ams] every 8 hours as needed			
	for nausea with vom	niting.			
	R152's Dislysis Cor	nmunication Record dated			
	3/11/14, included, "I	Fluid restriction is less than			
	1000 cc/day." The	care plan had not been			
	updated to reflect th	his change.			
	When interviewed c	on 4/1/14, at 1:00 p.m. R152			
	stated she was on	1000 cc per day fluid a large water mug at her			
	bedside containing	approximately 240 cc of water			
	in it. R152 stated s	he gets the mug filled a			,
	watch her fluid intal	y, but she knows she has to ke, which is hard for her due to			
	extreme thirst. R15	52 stated she only gets 1000			
	cc from the facility,	so drinks less than that. R152			
	stated she has com	nplications of her liver and uding: pain, skin being itchy,			
	and extreme nause	a and vomiting. R152's			
	dialysis access site	was on her left arm, as an AV			
	tistula [where an ar	tery and vein are surgically access site for the needle for			
т. 1	dialvsis] R152 sta	ted when she is done with			
	each dialvsis run, t	he dialysis unit will place a tight			
	bandage on this ac	cess site. When she is getting			

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STATEMENT	Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
ND PLAN O	F CORRECTION	IDENTIFICATION NOMEEN.			04	/03/2014
-		00313	B. WING			
NAME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE			
			UTHWEST WILLM	AR AVENUE		
RICE CAR	E CENTER	WILLMA	R, MN 56201	PROVIDER'S PLAN OF COF	RECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	COMPLETE DATE
2 830	Continued From pag	je 7	2 830			
		equests the bandage be				
	removed because it	t is uncomfortably tight, and				
	the bleeding has sto	pped. R152 stated some				
	nurses will remove t	he dressing for her, others				
	will not, it depends of	on who is working. In ad she use to go to dialysis				
	addition, R152 state	but this has been increased to				
	four days a week as	s she has too much fluid. The				142011
	care plan did not dir	ect staff on care of the				8.73M 3
	dialysis access site	, nausea, vomiting, itching, or				1 . cr. ma
	the 1000 cc fluid res	STICTION.				
	When interviewed o	on 4/1/14, at 1:30 p.m.				
	registered nurse (R	N)-G stated R152 is on a				
	1500 cc fluid restric	tion and monitors her own				
17 J. (	fluid intake, nursing	provides her with a mug of day, 120 cc of a nutritional				
3	supplement twice a	a day with her medications, and				
	however much wat	er it takes to swallow her				
	medications two m	ore times each day. RN-G did				
	not know how muc	h fluid dietary gives R152 with ot coordinated with nursing.				1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -
	The facility does no	ot track fluid intake for R152.				
far	RN-G stated staff of	to not remove the dressing on				
	R152's dialysis aco	cess site, this is left up to the				
	dialysis unit. R152	had been having ausea and vomiting, she had				
	complications of ha	ation for nausea earlier, and				
	R152 had vomited	shortly afterwards. RN-G				
	stated when she w	orks, she checks the access				
	site for a pulse to	ensure patency, this is not				
	documented any v					1 - 2 - 2 - 2 - 2
	R152 was observe	ed on 4/2/14, at 8:00 a.m.				
	consuming breakf	ast, R152 had 90 cc of milk,				
	120 cc water, 120	cc coffee, and 120 cc lemon R152 was finished with				
	lime soda. vvnen	d consumed 360 cc total of the				
	Department of Health					ontinuation sheet

TATEMENT	a Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
ND PLAN O	FOUNEDHON	00313	B. WING		04	/03/2014
			DDRESS, CITY, STATE,	ZIP CODE		
IAME OF PF	OVIDER OR SUPPLIER		JTHWEST WILLMA			·
RICE CAR	E CENTER		R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIEN(	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pag	le 8	2 830			
2 030						
	450 cc's offered at b table was 240 cc of v	reakfast. On R152's bedside water.				
	aide (DA)-A stated F day fluid restriction, by dietary. The carc provided with 120 cd	n 4/2/14, at 8:15 a.m. dietary 3152 was on a 1500 cc per and provided a card utilized d indicated R152 should be c of each milk, juice and decaf				
	water at lunch and s 840 cc provided by stated, "There are s the dining room, we	120 cc of each juice and supper. This was a total of dietary each day. DA-A o many people in and out of don't have control if other Is too," noting soda had been r.				
	at 12:15 p.m. she h water, 120 cc of rec juice. In addition, a provided R152 with finished R152 had o 570 cc offered at th	at the noon meal on 4/2/14, ad been provided with 180 cc l juice, and 90 cc of brown t 12:30 p.m. a visitor had a can of Shasta cola. When drank at total of 390 cc. of the e meal. In addition, cc of water was now missing r bedside.				
	12:30 p.m. the dialy Memorial Hospital, decrease her fluids RN-I stated the fac R152's dialysis acc dialysis to ensure a should check the si of infection at least a book at the nursi	via telephone, on 4/2/14, at visis manager, RN-I, for Rice stated R152 had orders to to 1000 cc a day, on 2/14/14. ility nurses should be checking viess site upon return from area is not bleeding, and ite for a pulse (bruit) and signs daily. The facility should have ing home about how to care for . Only one book is kept in the				

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		00313	B. WING		04	/03/2014
		STREET A	DDRESS, CITY, STATE	, ZIP CODE		
NAME OF PF	ROVIDER OR SUPPLIER		UTHWEST WILLM			
RICE CAR	E CENTER		R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIEN)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
		- 0	2 830			
2 830			,			a de la composición d
	facility, they are not	provided for each resident.				-
	These instructions s	nould be followed.				
	When interviewed, v	ia telephone, on 4/2/14, at				
	12:45 p.m. the dietic	ian for the dialysis unit, as				
	well as consulting di	etician for the facility, stated a				
	communication shee	et should have gone from				
	dialysis to the facility	when R152's fluid restriction			•	5 - S
	changed from 1500	cc to 1000 cc per day. This e to a nephrologist [kidney				
	change occurred du	2/14. The dietician stated				
	D152 could not keep	b track of fluid restrictions				
	herself, as she had	intermittent extreme				
	confusion related to	elevated ammonia levels,				1. A.
	and extreme thirst	The dietician stated R152		·		
	had trouble manage	ng her thirst, and liked to				
	drink soda pop. The	e facility should have been				
	tracking R152's fluid	ls and managing the fluid				
	restriction for her. C	Generally when a resident is				
	on a fluid restriction	dietary would divide fluids				
	throughout the day	to include meals, med pass,				
	and any fluids the re	esident could have in				
	between. This wou	d normally be care planned				e e e e e e e e e e e e e e e e e e e
	and documented.	The dietary card and care				4 <sup>1</sup>
	plan should have be	een updated when R152's fluid				
	restriction changed	as well as a determination				
	now much fluid R15	2 could have with med een missed.  Dialysis goal is				
	passes. This had b	3 kg [kilograms] of fluid with				
	to remove less that	had been often requiring well				
	each run, but K152	nerefore she was increased				
	from 3 times a wee	k to 4 times a week on		· ·		
	3/27/14 R152 had	also been hospitalized for				
	fluid over load and	required abdominal				
	parathenteses (rem	ioval of fluid in the abdominal		,		
	cavity), R152 had	a care planning conference				
	with the dialysis int	erdisciplinary team on 3/22/14.				
	R152's care plan sl	nould have been updated at				
	that time.					
	epartment of Health					

TATEMENT (	Department of Health	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	LETED
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00313	B. WING		04	/03/2014
		STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
IAME OF PR	OVIDER OR SUPPLIER		OUTHWEST WILLM	AR AVENUE		
RICE CARI	ECENTER	WILLM	AR, MN 56201	PROVIDER'S PLAN OF COR	PECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
2 830	Continued From pag	je 10	2 830			
	When interviewed 0	n 4/2/14, at 1:00 p.m. the				
	director of nursing (	DON) was unable to find any				
	book or instructions	from the dialysis unit on				· · · ·
	caring for the dialys	is patient. The DON stated access site should have been				
	care planned and a	idded to R152's treatment				111
	sheets for monitorin	g by the nurses. Emergency 52 was unable to make it to				1997 - 19
	dialysis had bleedil	ng from the dialysis site, or				
	critical lab values sl	hould have been care planned				
· •	also.					
	When interviewed of	on 4/2/14, at 1:45 p.m. the				
	dietary mentor (DM	I)-E stated she had noted luid restriction had decreased				
	from 1500 cc to 10	00 cc on 3/12/14. This was				
17 1	missed. The facilit	y's routine would be to set up buld be provided at each meal,				
	mod pass and at (	other times. This information				
	would be in the car	re plan. It had been missed for				
	R152.					
	-					
	R152 was dischare	ged from the facility on 4/2/14,			,	
	as being provided	g consumed 850 cc of the 1200 by the facility, prior to the				
	ovening meal SUD	plement, refill of the water mug				
	in her room, or flui	ids with medications remaining				
	for the day.					
		4/2/14 at 2:00 nm the				· · · · ·
	DON had found th	l on 4/2/14, at 2:00 p.m. the ne book on caring for the				
	dialysis natient T	The book had been located in				-
•	the nursing home	portion of the building, not in	ie			
	the Therapy Suite	es where R152 had resided. Th 12, included Guidelines for	-			

Minnesota Department of Health STATE FORM

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Minnesota	Department of Health	1	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
AND PLAN OF	CORRECTION	DENTIFICATION NOMBER	A. BUILDING.			
			B. WING		04	/03/2014
		00313				
		STREET AD	DRESS, CITY, STATE	, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER	1801 SOU	THWEST WILLM	AR AVENUE		
RICE CAR	E CENTER		r, MN 56201			
1402			ID	PROVIDER'S PLAN C (EACH CORRECTIVE A	OF CORRECTION	(X5) COMPLETE
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
			2 830			
2 830	Continued From pag	e 11	2 000			1
		me Patients, and instructions				
	Dialysis Nursing hor	blood pressures or draw				
	blood from the acce	ss arm. Need to check the				
	eccose site daily for	a pulse, if no pulse to call the				
	the lucie unit to remo	we dressing in 2 hours and				
	dialysis if the site w	as bleeding to apply plessure		*		
	for 15-30 minutes.	To send a communication				
	form each day with	pertinent information.				· · ·
	Information was als	o included on potential				
	medical complication	in such as excess fluid gains,				
	itching and elevate	d potassium levels. The DON				
	atotod care of the a	ccess site and fluid				
	restrictions should	have care planned, monitored				
	and documented by	y the facility, but had not.				
		Lucyital Dichusis Protocol				
	The Rice Memorial	Hospital Dialysis Protocol anuary 2007, included, "A				
	Agreement dated	re plan will be developed by the				
	comprenensive ca	ams from both RMH and				
	facility."					
1						
a a se	Even though the d	ialysis unit had communicated				
* *	a change in fluid r	estrictions on 3/11/14, the				
	f - allity failed to col	mmunicate the new restriction				
	to staff In additio	n, the facility did not have any				
	are planning in p	lace to ensure the liulu				
	restriction was foll	owed, and did not track fluid				
	intake The facilit	v did not have any care			÷	
	planning in place	on how to manage potential				
		lialysis or how to manage the				
	diolygis access si	te. The facility did have a book				
	an earing for the (	tialysis unit. nowever, uns was				
	not available on t	he unit where R152 resided and				
	nurses were not	knowledgeable on how to find				
	this information.					
		tion interview and document				
	Based on observ	ation, interview, and document				
		failed to ensure resident were				entinuation choot 15
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Minnesota	Department of Healt	h (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CTATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SOPPEIEROE/	A. BUILDING:			
AND PLAN OF			- WINC		04	/03/2014
		00313	B. WING			
		STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER	1801 SOL	JTHWEST WILLM	AR AVENUE		
RICE CARE	ECENTER	WILLMAR	R, MN 56201	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
-			2 830			
2 830	Continued From page	ge 12	2000			
1 - 1 1 - 10 1	LIKO brand mechan brand lift harness w had not recommend	ansfers with the use of the nical standing lift with an EZ which the LIKO manufacture ced to be used for the LIKO ected 5 of 5 residents (R36, d R11) who used the LIKO lift.				an an An Anna Anna Anna Anna Anna Anna A
	Findings include:					
in an Deal Deal	2/14/14, included	Iinimum Data Set (MDS) dated she was cognitively intact, had t failure and arthritis, and assistance for transfers.				
	Status/Rehabilitat Assessment (CA) knee cap, and wa	ies of daily living) Functional tion Potential Care Area A) included, R36 had a fracture as totally dependent upon staff a ceiling lift (a full body lift). The re planning would occur to				
	will provide assis per therapy direct	dated 2/20/14, included, "Nursing stance with ADL's and mobility ctions." The care plan did not nich type of mechanical lift, leg strap should be used.			,	
18 19 19 19 19	notes were revie and failed to dir	herapy and occupational therapy ewed from 2/7/14 through 3/31/14, ect nursing staff on any transfer e notes did indicate R36 varied assist to two person assist for	,		× .	
Minnesot	a Department of Health		6899	UXQR11	lf	continuation sheet

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TATEMENT	Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
ND PLAN O	FCORRECTION		A. BOILDING			
		00313	B. WING		04/03/2014	
	OVIDER OR SUPPLIER		DDRESS, CITY, STAT			
		1801 SO	UTHWEST WILLN	IAR AVENUE		
RICE CAR	E CENTER	WILLMA	R, MN 56201		(X5)	
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE	
2 830	Continued From pag	je 13	2 830			
		www.u.u.o.df.n.m.boing				
	R36 was observed of	on 4/1/14, at 2:15 p.m. being				
	assisted from her be	ed to her wheel chair by A)-L and NA-AA. A transfer				
	nursing assistant (N	under R36's axilla (arm pits).				
	Delt was placed up t	tempted to lift R36 into a				
	standing position. R	36 was unable to bear any				
	weight Registered	nurse, (RN)-C who was the				
	clinical coordinator	came into room, and				
	witnessed R36 not	bearing any weight. RN-C				
	instructed NA-L and	NA-AA to use the				
	mechanical standin	g lift which was a LIKO brand				
	instead. The LIKO r	mechanical standing lift was				
	brought into the roc	m, R36's feet were placed on			1.5	
	the foot platform, and	n EZ-way brand lift harness R36's arms, pulled in front of				
	was placed under i	ened with a belt. There was no				
	helt on the LIKO lift	to secure R36's legs. The				
é.N	I IKO lift was turned	d on and NA-AA started to lift			A 144 1	
2	R36 off the bed wit	h it. R36's buttocks hung				
×	down and R36 was	s in a sitting position, with her			a d	
	knees were bent. a	ind was unable to bear any				
	weight R36's arms	were being pulled up by the				
	lift and she kept sa	ying, "Owe, owe, owe," while				
	being lifted. R36	was transported by the lift into				
	the bathroom, and	remained in a sitting position ad, and her arms were pulled				
	with her knees ber	lift under her axilla. R36 was				
	up by the namess	t. RN-C came into the				
	bathroom and with	essed R36 in the LIKO				
	mechanical lift with	n the EZ Way harness being				
	transferred off the	toilet. While NA-AA and NA-L				
	attempted to provi	de pericare with the lift in the				
	stand up position.	R36's buttocks continued to				
	hang down in a sit	ting position, she was unable to				
	bear any weight a	nd was yelling during this time				
Sec. 1	to get placed back	conto the toilet twice, which				
1. 1. e.	NA-AA completed	. R36 stated she wasn't really in				
	pain, but was mor	e, "Stiff," because her legs d she was unable to stand.				
	were too weak an Department of Health	u she was unable to stand.				

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STATEMENT	Department of Healt DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00313 B. WING			04/03/2014	04/03/2014	
		STREET A	DDRESS, CITY, STATI	E, ZIP CODE			
NAME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLM				
RICE CAR	E CENTER		R, MN 56201				
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY 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 COMPT	LETE	
			2 830				
2 830	Continued From page	je 14	2000				
		· · · ·					
				•			
	When interviewed o	n 4/1/14, at 2:35 p.m. NA-L					
	stated R36 could so	metimes transfer with two weaker since she had					
	assist, but has been	ospital with pneumonia. NA-L					
	stated they sometim	nes used the leg strap on the					
	LIKO lift to secure t	he resident's legs, but this one					
	was missing and w	as unsure how long it had		X			
	boon missing NA-	stated the EZ-way namess					
	was used with the L	IKO mechanical because the					
	harness was more	comfortable for residents, than					
	the LIKO harness v	vas.					
	When interviewed	on 4/1/14, at 2:40 p.m. RN-C					
	stated R36 use to t	be a full mechanical lift with a					
	equiling lift had bee	n improving and staff were					
1	able to transfer her	with two assist and a transfer ecently been hospitalized with					
a anta T	belt, but R36 had r	d returned to the facility on					
- 1	2/24/14 much wea	aker. R36 had not been					
	ro-evaluated for tra	ansfers, but was working with					
	thorapy on detting	stronger. It R36 would be					
	unable to stand s	he would expect start to get the					
	standing lift. She	did not expect them to use the					
2.5	ceiling lift, even if	R36 could not stand up, as the d caused skin shearing to R36's					
1. A.	buttocks.						
	DULLOUNS.						
	When interviewed	l on 4/1/14, at 4:00 p.m. NA-E					
	stated she had wo	orked in the facility for over five					
	years, she remen	bered being trained many years or of nursing (DON) on how to					
	use the lifts Whe	n ever a new nursing assistant					
	starts other nursi	ing assistants train them on now					
	to use the lifts N	A-E verified they were allowed					
	to use the F7 Wa	v harness's with the LIKO Ints.					
	The residents like	e them better, they are not as					

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TATEMENT (	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	LETED
AND PLAN OF	CORRECTION		B. WING		04	/03/2014
		00313	DRESS, CITY, STATE,	ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER	1801 SOL	JTHWEST WILLMA	R AVENUE		-
	ECENTER		R, MN 56201			(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
		19.15	2 830			
2 830	stiff as the LIKO har the leg strap on resi	ness's and they do not use dents. The LIKO harness's the torso and are not as EZ Way harness's which do				
5.	stated most resider instead of the LIKO allowed to intercha	on 4/1/14, at 4:05 p.m. NA-DD hts like the EZ Way harness harness's, and they are nge the harness and e started working at the facility other nursing assistant showed standing LIKO lift.				2003 2004 2004 2004
	DON stated staff d the LIKO standing When nursing ass assistant will show leg strap would be it, this should be c	on 4/1/14, at 4:10 p.m. the o use the EZ Way harness for lifts, they are interchangeable. istants are hired, another them how to use the lifts. The used only if the resident needs are planned. The DON stated tand up in the LIKO standing lift, ave consulted with therapy transfers.				
	assisted from bec NA-A. R36 was edge of bed, NA- R36 stated she w appointment yest weak. A transfer arms and she wa bed with her han	d on 4/2/14, at 7:53 a.m. being to the wheel chair by NA-L and very shaky while trying to sit on L and NA-A had to hold her up. vas out for hours at doctors terday, and was feeling very belt was placed under R36's as instructed to push off of the ds. R36 was pulled upwards by and pivoted into her wheel chair, e to bare much weight.				

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	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	LETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		04/	04/03/2014	
		00313				1.18	
	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
				ARAVENUE			
ICE CAR	E CENTER		AR, MN 56201	PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETE	
(X4) ID PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	DATE	
2 830	Continued From pag	je 16	2 830				
	stated R36's transfe so much edema in h the transfer belt und her arms and shoul stand at all, they us but R36 "Does not o choulders have ath	n 4/2/14, at 8:00 a.m. NA-A rs usually go poorly, she has her abdomen, they need to put ler her arm pits, this pulls on lders. When R36 can not e the LIKO standing lift on her, do well, she hangs, and her iritis." The full lift, the ceiling use the sling had caused a n."					
1999 Ng 199 	physical therapy ai	on 4/2/14, at 9:50 a.m. d (PTA)-H stated she had been she had not been asked, nor recommendations to nursing R36.					
	stated she was no transferring since one had reported aware R36 could n buttocks hung dow and that R36 need transfer ability so transfers.	on 4/3/14, at 8:05 a.m. RN-C t aware how R36 was returning from the hospital. No problems to her. She was not not stand in the lift and her vn as she hung from her axilla ded to be reassessed for her she would remain safe during					
	dated 9/24/2013, obesity and ostec identified R70 as extensive assista one, for transferri (CAA) for falls da	from the Minimum Data Set included left- sided hemiplegia, oarthroses. The MDS also cognitively intact, and required nce, with the physical support of ing. The Care Area Assessment ated 9/27/2013, indicated R70 d only able to balance if assister R70 required assistance for all	f t				

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STATEMENT (	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	LETED
AND PLAN OF	CORRECTION	IDENTIFICATION NONIBER.	A, BUILDING.			
		00313	B. WING	·	04	/03/2014
			DDRESS, CITY, STATE	E, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER	1801 SO	UTHWEST WILLM	AR AVENUE		
RICE CAR	E CENTER		R, MN 56201			(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE
		47	2 830			
2 830	Continued From page	je 17				
f.e		care plan, updated 3/18/2014,				
	I' shad at off to USA					
	- henical stand-2	ssist lift). TOI liansiers, to be				
	of D70'c 'l ' (	off) side neglect for salety,				
	and also to be watc	hful of [R70's] position of len				
	ankle/foot so it [sic]	does not roll during				
	transfer/weight bea	room, undated, directed staff				
	care sheet in R/US	"one assist" and use "EZ				
	Stand".					
	During observation	on 4/2/2014 at 9:24 a.m.,				
	purging assistant (	NA)-A assisted R / 0 to transier				
	from the wheel cha	air onto the tollet in the				
	the second N	IA_A nositioned a LIKO brand				
	stand-assist lift in f	Front R70's wheel chair. From				
	R70's bed, NA-A	etrieved a large maroon and ness, with an "EZ" insignia on				
20.00	green-colored har	aced the harness behind R70's				
	the label. NA-A pl	ath of each of R70's arms, and				
	u u ahad tho	ands of the harness to the				
	handlohor of the li	ft NA-A also fastened the seat				
		the harness around N/03				
	torso in place N/	A-A positioned R/05 leet on the				
	urri i - ifermo ond il	atormed R/U life int was				
Lave 11	ط مطلبه ال	and bars raised. R/U glasped				
	the handlebar wit	h only her right hand. R70's left				
	hand was near he	er shoulder, positioned as if				
	clutching a book.	During the lift, R70's lower right e bumped up to the padded leg				
	leg and knee wer	70's left lower leg, nor left knee				
	Lunched the lift le	a had The led strap, which				
	I-I hobind	P70's leas was not allached,				
	and was hanging	i on the lift near the loot platform.				
	During the lift an	d transfer, R/0 was not				
	uprig	ht but rather hanging in the my				
	Lile a hornocc	supported R/US weight. Meters				
	us at the lift int	o the hathroom and lowered in a	,			
	ante the toilet	JA-A assisted R/U with toneting,				
	then transferred	R70 from the toilet into the	1		12	continuation sheet
Minnesot	a Department of Health		6899	UXQR11	IT ·	

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innosota	Department of Heal	th	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMPI	SURVEY
ATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING:			
D PLAN OF	CORRECTION	IDENTIFICATION NO.	A. BOILDING			
			B. WING		04/	03/2014
		00313				1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -
		STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
AME OF PRO	VIDER OR SUPPLIER	1801 S	OUTHWEST WILLN	IAR AVENUE		
ICE CARE	CENTER	WILLM	AR, MN 56201			(25)
ICE CARE			ID	PROVIDER'S PLAN O (EACH CORRECTIVE AC	F CORRECTION	(X5) COMPLETE
(X4) ID PREFIX TAG		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	) THE APPROPRIATE	DATE
			2 830			
2 830	Continued From pa	age 18				
	recliner.					
	In an interview on	4/2/2014 at 9:29 a.m., NA-A				
		wore not stranded on the me				
		n, I guess I should." NA-A also nd used for R70's transfer was				
	verified the lift sta	nd also verified the sling used				
	l'outro larc	maroon and green the				
	was an "extra larg	NA-S said "That's what fits				
	[R70] best."					
	-					
	During an intervie	ew on 4/2/2014 at 12:34 p.m.,				
	Live of stated P70	only uses nel fight hand to here				
	1.0 - 1	Franctors DeCause INTO Cont				:
	have be with bo	r loff side " NA-Q Salu you nuu				
	L service auro R7	n's feet were hat on the platerny,				
	so they doesn't t	wist off, as [R70] is "a large said the foot straps on the stand				
4.1	person." NA-Q s	s be used "for [R70]and any				· · ·
	lift were to alway	s be used for [to a] a				· · ·
	resident."					
	R40's diagnoses	s from the annual Minimum Data				
	$0 \rightarrow datad 0/24/$	2013 Included Oslevarum 0000,				
	· · · · · · · · · · · · · · · · · · ·	d anemia The MDS also	4			
	identified R40 a	s mildly, cognitively impance, and				
		a extensive assistance for				
	transferring, wit	h the physical assistance of one				
	person. The C	are Area Assessment (CAA) for 7/2013, identified R40 required				
. <sup>1</sup>		a staff to maintain Dalance during				
the second	U. L. La High	and that R40 Struggles with pairs				
	n uninte/Ada	ntive Equipment, daled 5/1/2019				
	right normal s	tand (a mechanical stand-assist				
		sefore The Calle Silect III 11700				
	room undated	, directed stan to transfer 1040 m				
1	"Two assist" 0	r use "EZ Stand."				continuation shee

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ATEMENT (	Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00313	00313 B. WING		04/03/2014	
			DDRESS, CITY, STATE	, ZIP CODE		
AME OF PR	OVIDER OR SUPPLIER	1801 SO	UTHWEST WILLM	AR AVENUE		
ICE CAR	ECENTER	WILLMA	R, MN 56201		(75)	
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE	
2 830	Continued From pag	ge 19	2 830			
	nursing assistants ( transfer R40 from th wheel chair. A LIKC mechanical stand-a	on 4/2/2014 at 11:34 a.m., NA)-S and NA-Q prepared to be toilet in her room into the D [brand name] stand (a ssist device) was positioned				
	in front of R40, who	rness under her arms, and				
	around the back of	her torso, in a U-shaped			14 A	
	seatbelt buckle, wh ran parallel to and u each of the ends w	ess was secured to R40 with a ich was in place. The harness underneath R40's arms, and ere fastened to corresponding handlebar. NA-S started the				
a a **	lift, and told R40 to moved upward, R4	"hold on." As the handlebars 0 said "it hurts, hurry up." right in the stand, NA-Q				
	adjusted R40's clot out of the bathroon chair. R40 was ob	thing, and NA-S moved the lift n, and in front of R40's wheel served standing upright, and the handle bars. R40 was				
	wearing shoes, an platform, and her l	d both feet were flat on the lift egs were against the leg The leg strap, which would go				
	behind R40's right	and left legs, was not secured, at the side of R40's leg. After into the wheel chair, NA-S				
	unbuckled the safe	ety belt and removed the and R40. NA-Q adjusted the ushed R40 out of the room.				
	Then, NA-S exited	d the room carrying the harness a portable piano near R40's a "EZ" was visible on the green				
	and maroon-color during the transfe	ed harness that was used				
	NA-S said R40 or	ew on 4/2/2014 at 11:42 a.m., ccasionally needed the "EZ nd" (a mechanical stand-assist				

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Minnesota	Department of Healtl	h	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COWF	LETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOTIBER	A. BUILDING.			
			B. WING		04	/03/2014
		00313				
		STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER	1801 S	OUTHWEST WILLM	AR AVENUE		
RICE CARI	E CENTER	WILLM	IAR, MN 56201			(X5)
			ID	PROVIDER'S PLAN C (EACH CORRECTIVE A	CTION SHOULD BE	COMPLETE
(X4) ID		OV MUST BE PRECEDED BT FULL	PREFIX TAG	CROSS-REFERENCED TO	) THE APPROPRIATE	DATE
PREFIX TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	IAO	DEFICIE	NCY)	
А. А.			0.000			
2 830	Continued From page	ge 20	2 830			
2 000	Contanta da Antina	R40 was the "LIKO" brand				
	used for transferring	staff routinely referred to the				
	lift. NA-5 said that	Z stand" lift. [Likko and				
	EZ Chand are two h	rand names of sitting				
	stand accist device	s 1 NA-S said the green and				
	marcon-colored hai	rness with the EZ maight				·
	the are used for	or R40's transfers. INA-0				
	firmed that durin	ng R40's lift and transier from				and a second
	u to the the the whe	of chair, the ley strap on the				
	lift was not fastene	ened" while transferring R40,				
	Lill-ther regident	ke "when using the LZ otang.				
	NA C stated the DI	irpose of the slidp was to heep				
	the standa logo fr	om moving of slipping out of				
	ition when hein	na transferred. INA-3 salu that h				
	interviewe kno	win to "KICK Dack, Hove of our				
- S.	their feet during a	transfer, then "we would put the				
	strap on."					
	During on intervie	w on 4/2/2014 at 12:02 p.m.,				•
	V ad practical	nurse (IPN)-C stated that use				
	r la a strong wher	h transferring a resident on an				
i ang	" acut the add was "s	a matter of salely. Line of				
	i i laha haa "b	hard and seen that the sales				
	i i unara not a	ways used on the EZ stands.				
	and nurses to put	t the legs straps "every time" the ident transfers. LPN-C was				
	lift is used for res	" Stand" brand harnesses were				
	i uith the "Lil	kko" brand lifts. "We always				
	used those [harn	esses], LPN-C stated, "I though	nt			
	they were interch	nangeable."				
	During an intervi	ew on 4/3/2014 at 10:41 a.m.,				
	registered nurse	(RN)-B verified that both R40 stand lifts for transfers. RN-B				
	and R70 utilized	tructions for residents was care				
	said transfer inst	ould expect" nursing assistants	to			
	planned, and ware a Department of Health				If	continuation sheet 21 c
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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROV		h (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMF	SURVEY
	OF DEFICIENCIES - CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
AND LAN OF			в. WING		04	/03/2014
		00313				an ta a ta
NAME OF PR	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
			UTHWEST WILLM	ARAVENUE		
RICE CAR	E CENTER	WILLMA	AR, MN 56201	PROVIDER'S PLAN C	OF CORRECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	COMPLETE DATE
1		04	2 830			
2 830	Continued From page					
	follow the protocol f	or transfers and apply "safety				
	halts and the leas s	trans" during transfers. It is the				
	and acto lift use was part of "an employee's					
	ariantation checklis	t " RN-B acknowledged the				
	facility utilized LIKC	) brand stand lifts, and also				
	used harnesses fro	m "EZ Stand", a different				
	brand. RN-B was unaware of any difference between "EZ Stand" and "LIKO" brand lifts, and					
	the alings or harnes	sses, RN-B said the				
	harnesses out on t	he floor have been used "for a				
	long time."					
	R51's significant cl	hange minimum data set				
	(MDS) dated 2/5/1	4 indicated R51 had dementia				÷
	and was cognitive	bly impaired. R51's care plan				1
	dated, 2/13/14 ind	icated R51 was an extensive with an EZ stand to transfer to				
	the wheelchair and	d to and from bed.				
	During abconvatio	n on 4/2/14, at 8:00 a.m.				
	ing occistant	(NA)-I was assisting Rol with				
	U LUZO meehan	ical standing lift. INA-L used an				
	EZ May dark gree	en color harness and placed the				
	EZ Way harness	behind R51, buckled the				
R Ball	- I deminal strap	and attached to the LINU				
	mechanical stand	ling lift. NA-L pushed the control				
	to raise R51 up o	ut of bed and transferred him to R51's wheelchair. R51 into				
	with the LIKO III	wheelchair and NA-L removed				
	the EZ Way harn	ess from R51.				
	R11's quarterly m	ninimum data set (MDS) dated				
	12/31/13 indicate	ed R11's had severe cognitive				
	impoirmont The	care plan reviewed on	1			
	4/40/2014 indica	ted R11 was an extensive to tota	"			
	assistance for tra	ansfers with 1 or 2 staff and the anical standing lift). A Balance				
	EZ stand (mecha	ed 3/29/14 indicated R11 used a	n			
	Assessment date EZ stand for trar	sfers				
	During observat	ion on 4/2/14, at 9:11 a.m. of				
Minnesota	a Department of Health		6899	UXQR11	lf c	continuation sheet 2
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linnesota	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COME	(X3) DATE SURVEY COMPLETED	
TATEMENT	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00313	B. WING		04	/03/2014
			ADDRESS, CITY, STATE	ZIP CODE		
ame of PF	ROVIDER OR SUPPLIER					
ICE CAR	E CENTER		AR, MN 56201			
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	F CORRECTION	(X5) COMPLETE
(X4) ID PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
			2 830			
2 830						
	NA-L assisted R11 v	vith the LIKO mechanical				
	standing lift. NA-L pl	aced a maroon color sling, tag on the harness behind				
	R11 R11 was buck	led into the harness with the				
	abdominal strap an	d attached it to the LIKO				
	machanical standing	a lift. NA-L pushed the control				
	to raise R11 out of t	he wheelchair and transferred om. When R11 had finished				
	using the bathroom	R11 was moved to the				1999. 1999.
	wheelchair and low	ered into the wheelchair. The				
	EZ Way harness wa	as removed from R11.				
,"s - ,	0 4/0/14 at 12:10	p.m. an interview with NA-R				
1	worified she uses th	e EZ Way harnesses on				
	residents with the L	IKO lift. At 12:28 p.m. NA-L		· · · · ·		1. A.
	stated the mechani	ical standing lifts used in the				
	facility were LIKO	ifts and verified the harnesses harness and not the LIKO				
	harnesses NA-LS	stated that new namesses				
	come with the new	LIKO lifts but they did not				
	have the abdomina	al strap on them that buckled				
	around the residen	IIS.				- 
	During an interview	w on 4/2/2014 at 12:37 p.m.,				
	the physical therat	pist (PT)-A stated in order to				
	use a mechanical	stand lift, a resident would ate "ability to bear weight," have				
	- finiant range of	motion have arm and				
	shoulder strength.	and do so "without pain." The			1	
	DT said a resident	should not look like they re				
	"sitting in a wheel	chair" while using the lift. The or harness should not be				-
•	boaring the weigh	t of a resident. The PT also				
	stated safety prec	autions needed to followed				
	when a resident is	s transferred, and that should				
	include "putting o	n leg straps" during a transfer.				
, i						
	In an interview or	1 4/3/2014 at 9:27 a.m., the				
1	occupational ther	apist (OT)-A stated that she				ontinuation sheet

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ATEMENT (	Department of Health DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	PLETED
		00313	B. WING		04	/03/2014
			ADDRESS, CITY, STAT	E, ZIP CODE		1997 - 19
AME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLN			
ICE CARE	ECENTER		R, MN 56201			(1/5)
(X4) ID PREFIX TAG	(FACU DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pag	e 23	2 830			
	stand-assist lift. Fur instructed staff to "al	g on proper use of the ther, the OT stated, that she lways" lock the seat belt ss, and "always fasten the leg ferring a resident using the				
	by the facility, that in vests/harness's that Sabina standing lift. harness's from other form a sitting position if the resident could a sling that fits under full support. This could the resident was up	I-Service Summary provided included three different type could be used with the LIKO None of these included or companies. A passive lifting on with Sabina form indicated in't stand or cooperate to use or the residents buttocks for build be used infrequently, if hable to bear weight, staff were full body lift with a sling.		•	• •	
	a.m. the LIKO Barr health care ergono been at the facility staff on the use of Sabina), the reside have muscle tone a DHCE stated the la remind the residen DHCE stated the c used on the LIKO are vests that wrag other harness's ar	via telephone April 2, at 9:30 ier Free Access, director of mics (DHCE), stated he had a few years ago and trained the LIKO standing lift (named ant must be able to bear weight, and ability to follow commands. eg strap is an option to use to t not to step off the platform. only harness's that should be lifts, is the LIKO brand, these o around the residents torso, e not made the same way and his particular machine, and is				
	The DHCE provide	ed a LIKO Lift Sign-In Sheet, vith the names of 15 NA's				

# 2830 Provide Care/Services For Highest Well Being

### **Corrective Action:**

Res 152 was discharged from the facility

## Corrective Action - identify other residents:

All residents receiving dialysis services have been identified. Dialysis Educational manual is in each neighborhood for reference of emergency procedures for staff to refer to.

New Dietary form will be used for documentation of fluids after each meal. Information will be given to med nurse at the end of the shift for fluid intake totals. Dietary will have, on patient dietary card, fluid amounts for each meal

E-mar dialysis section has been added to include orders for dialysis patients to individualize care. This will include: care of access site, emergency procedures

## Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding residents receiving dialysis fluid restriction documentation, dialysis educational manual location, & adding nursing orders in the Treatment section of E-mar.

### Monitoring for Compliance:

Audits will be completed by DON &/or Designee weekly for one month then twice a month for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits.

### Date of Completion:

May 8, 2014

# 2830 Free of Accident Hazards/Supervision/Devise

### **Corrective Action:**

Resident # 36, 11, 51, 40 & 70 have all been assessed by RN Clinical Coordinator & Barrier Free Access for safe transfers when using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

## Corrective Action – Identify other residents:

RN Clinical Coordinator in each neighborhood & Barrier Free Access has assessed other residents/patients using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

RN Clinical coordinator will monitor significant changes in resident/patient for the use of Liko Standing Mechanical lift or Hoyer lift. OT/PT Screening will be obtained if RN deemed appropriate.

## Corrective Action to Prevent Reoccurrence:

Education was completed on April 25, 2014 to all nursing staff for the appropriate harness size & style for each resident/patient. Pink card in Long Term Care has been reviewed for accuracy of how resident transfers. Therapy Suites roster identifies how patient is to transfer

### Monitoring for Compliance:

Random audits will be completed by DON or RN Clinical Coordinator for the proper use of Liko Sabina Standing mechanical lift. This audit will continue for 90 days and the results brought to the QA committee for recommendation on the need for further audits.

### Date of Completion:

May 2, 2014

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Minnesota	Department of Healti	<u>n</u>	(X2) MULTIPLE CON	ISTRUCTION (2	(3) DATE SURVEY COMPLETED
CTATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		
AND PLAN OF	CORRECTION				04/03/2014
		00313	B. WING		04/00/20
			DRESS, CITY, STATE,	ZIP CODE	
NAME OF PR	OVIDER OR SUPPLIER	1801 SOL	JTHWEST WILLMA	RAVENUE	
RICE CAR	E CENTER		R, MN 56201	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETE DATE DATE
			2 830		
2 830	signed in, and provi Training Outcomes list included, "Patier including the ability 20% of his weight a upper body control simple commands. unpredictable the S Under, "Vest applie of Sabina Vests m in a seated positio the patient's low b umbilicus. Conne connection approp connection style d	ge 24 ded a LIKO Sabina Lift Check-Off list. The check off int assessment, Patient criteria of the patient to bear about at least on one leg, have some and have the ability to follow If patients weak, confused or SafetyVest should be used." cation and connection, all types ust be applied with the patient n. The vest application is at ack and/or just below the ct the vest using the style of oriate for that vest. The vest liffers with the SupportVest esign and the SafetyVest styles s "D" ring connection."	2 830		
	The director of nureview/revise pol dialysis patients, mechanical lift for staff, and then per compliance. TIME PERIOD F (21) days.	ETHOD OF CORRECTION: ursing (DON) or designee could icies regarding the care of and the proper use of a r transfers. They could educate erform audits to ensure COR CORRECTION: Twenty One 05200 Subp. 2 E. Adequate and	2 855	Refer to attachment for	PoC
	Proper Nursing Subp. 2. Criter proper care. T adequate and p E. Assistance	Care;Oral Hygiene ria for determining adequate and he criteria for determining proper care include: as needed with oral hygiene to n, teeth, or dentures clean. t be used to prevent dry, cracked		and date of completion	
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ATEMENT OF DEFICIE D PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		COMPL	
	IDENTIFICATION NUMBER		A. DOILDING:			
					04/	03/2014
		00313	B. WING			00/2011
ME OF PROVIDER O	R SUPPLIER		ADDRESS, CITY, STATE			
				AR AVENUE		
CE CARE CENTE			AR, MN 56201	PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETE
(X4) ID PREFIX ( TAG F	FAOL DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	DATE
	ued From pag	e 25	2 855			
	leu i iom pag					
lips						
This M	N Requireme	nt is not met as evidenced				
by:	on observatio	on, interview and document				
roviow	the facility fai	led to ensure oral hygiene				
was pr	ovided daily f	or 1 of 3 residents (R 29) who				
neede	d staff assista	nce with oral care.				
Findin	gs include:					
0 1 4 1	13 identified R	S (Minimum data set) dated 29 was cognitively intact, had				
assist	ance of two p	ty and needed extensive ersons for oral hygiene. The daily living care area				
assist	ance with gro	ed R29 needed extensive oming and personal hygiene ance problems.				- 4 4 1 1
The c	are plan date	d 2/21/14 indicated a problem				15. 1
with a	activities of da	ily living related to weakness				
	-lan diracted	ity due to Parkinsons. The staff to provide extensive				
assis	tance for one e resident bec	for dressing and grooming use				
state	d, "They neve ush my teeth	w on 4/1/14 at 1:20 p.m. R29 er brush my teeth, I would like myself but I can't." She stated beth were brushed was when				
she	was staying o	n the therapy unit R29 stated eeth, and is unable to wear he roof of her mouth. She can				
only few	eat chopped teeth on her ι	food because she only has a upper mouth, and wants staff to				
brus	sh her teeth.					
An i assi Minnesota Departme	istant (NA)-K	/1/14 1:28 p.m. nursing said R29 sits on side of the bed				ntinuation sheet

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TATEMENT	<u>Department of Healt</u> OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00313	B. WING		04/03/2014
	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
ANE OF FR	OVIDER OR OOF FEER		UTHWEST WILLMA		
	E CENTER	WILLMA	R, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIEN(	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 855	Continued From pag	e 26	2 855		
	to get dressed and if brushed she will ask	she (R39) wants her teeth			
	NA-I stated R29 sits partially washes her with the rest. NA-I s	on 4/1/14 on 1:48 p.m. with s on the side of the bed and self a little but we help her tated R29 can only get into er wheelchair and staff			
	a.m. to 9:00 a.m. R2 for oral hygiene. At 0 recliner and stated s with brushing her te brush in R29's bath tooth brush remaine	bservation on 4/2/14 6:50 29 was not assisted by staff 6:50 a.m. R29 was in her she did not get assistance eth this morning. The tooth room drawer was dry. The ed dry, and R29 confirmed at ad not been assisted to brush			
	and NA-J both state brush her teeth this she needed assista knew if R29 had de they have never ass	on 4/2/14 at 9:00 a.m. NA-I ed they did not assist R29 to morning, they were not aware nce. Neither NA-I or NA-J ntures or natural teeth, since sisted her with oral hygiene. 4/2/14 at 9:10 a.m. registered		·	
	nurse (RN-A) state	d she was not aware R29 has r teeth brushed, "She never			
	The director of nurs review/revise polici	HOD OF CORRECTION: sing (DON) or designee could es regarding providing oral sidents, educate staff, then nsure compliance.			
		R CORRECTION: Twenty One			

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### 2855 Oral Hygiene

### Corrective Action:

Res 29 oral hygiene is offered to resident every AM/PM . Staff is allowing R29 to continue to be independent with brushing of teeth; electric toothbrush has been provided to help with oral hygiene. Staff will assist if resident is unable.

## Corrective Action - Identify other residents

Oral Hygiene Policy has been reviewed & updated. Refusal of oral care planned and risk/benefit explained to resident regarding lack of oral hygiene. Oral exam is completed by license staff at least quarterly and PRN.

All residents have been identified if they have dentures, partials or own teeth and pink care card updated with this information for staff.

## Corrective action to Prevent Reoccurrence:

Education with all nursing staff will be completed May 8, 2014 reviewing the updated policy of oral hygiene. Pink Care cards reviewed with staff and providing oral hygiene every AM & PM with cares. Staff is to assist with oral hygiene if assistance is necessary. If resident refuses oral care, this will be care planned and risk/benefit explained to resident regarding lack of oral hygiene.

### **Monitoring for Compliance**

Random Audits will be completed by DON or RN/LPN 2 times a week for one month then 1 time a week for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits

### Date of Completion

May 8, 2014

STATEMENT (	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.			04/03/2014
		00313	B. WING		
	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			THWEST WILL	MAR AVENUE	
RICE CARI			, MN 56201	PROVIDER'S PLAN OF CORRECTION	DN (X5) D RE COMPLETE
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE
2 855	Continued From pag	e 27	2 855		
	(21) days.				
2 900	MN Rule 4658.0525	Subp. 3 Rehab - Pressure	2 900	Refer to attachment for P	oC
	Ulcers			and date of completion	
	comprehensive resi	sores. Based on the dent assessment, the director must coordinate the ursing care plan which			1993 1997 1997
	A. a resident wh without pressure s pressure sores unl	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and			
	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	vho has pressure sores ry treatment and services to prevent infection, and prevent eveloping.			
	by: Based on observative review, the facility (R79, R36 and R <sup>2</sup> ) assessed, monito ensure current pro- to provent the details	nent is not met as evidenced ation, interview, and document failed to ensure 3 of 4 residents 150) with pressure ulcers, were red and/or provided care to essure ulcers were healing and velopment of new pressure sed actual harm for R79.			
	Findings include:				
	indicated R79 W	Data Set (MDS) dated 2/19/14 as cognitively intact, but required ance with transferring and			
Minnesota	a Department of Health		6899	UXQR11	If continuation sheet

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TATEMENT (	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY LETED
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		04	/03/2014
		00313	B. WING		04/	03/2014
	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
			UTHWEST WILLM	AR AVENUE		
RICE CARE			R, MN 56201	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
2 000	Continued From pag	ie 28	2 900			
2 900						
	repositioning in bed	and was at risk for pressure nent. The MDS also identified				
-	ulcer (PU) developin	of peripheral vascular				
	disease, neuropath	v and hypertension.				
	The 2/19/14 Pressu	re Ulcer Care Area				
	Assessment (CAA)	identified R79 was at risk for				
	developing pressure	e ulcers, and needed				
	extensive assistanc	e for bed mobility, and had an e to coverage of wound by				
	unstageable PO due	CAA also identified risk				,
	factors of immobility	incontinence, poor nutrition,				
	and recent decline i	in activities of daily living				
	(ADL).					
	The Skin Risk Asse	essment (with Braden Scale)				
	scale dated 3/21/14	4 identified R79 scored an 18,				
	mooning he was at	risk for the development of				
	PU He currently h	ad PU "bilateral to feet, with no				
	new sores." The a	ssessment also indicated he				
	had slight limited fr	nobility, with potential and shearing due to "skin				
	probably slide to so	ome extent against sneets,				
	chair Maintains r	elatively good position in chair				
	or hed most of time	e but occasionally sides down.				
	The interventions i	ncluded pressure relieving				
	devices for bed, ul	cer care, application of				
	dressing/ointments	s and other preventative or e and "prevalon boots." There				
	protective skin car	a turning and repositioning				
	scheduled was im	plemented even though R/9				
	was at risk for PU.	, had limited mobility, and was				
. '	at risk for having f	riction and shearing of his skin.				
	R79's care plan da	ated 2/24/14 identified a				
	problem with fragi	le skin, recurrent skin				
	breakdown circul	atory disease and chronic				
	wounds to lower e	extremities and skin tears easily. ected staff to "Dressing changes			-	
	The second and second s	used atoff to "Dressing changes	1			

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TATEMENT	Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		
		00313	B. WING	-	04/03/2014
			DDRESS, CITY, STATE	, ZIP CODE	
IAME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLM		
	E CENTER		R, MN 56201		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE
TAG	(LOOL				
2 900	Continued From page	ge 29	2 900		
2000		r CNP [certified nurse			
	to open areas as pe	plan also identified he had a			
	dealing in mobility a	nd weakness, with the			
	interventions of "Nu	rsing will provide assistance			
	Line ADI 's and mot	lity per therapy directives.			
	Devoical therapy (P	T) and occupational therapy			
	(OT) five times 2 W	pek for improved mobility,			
	endurance and stre	ngth. There was no mention			
	of a turning and rep	d staff assistance with mobility,			
	though R/9 needed	sure ulcer development and			
	was at risk for pres	ressure ulcers which were not			
	identified on the ca	re plan.			
	During an interview	v on 4/1/14 at 2:10 p.m.		•	
19.991 - 1	nursing assistant (	NA)-L stated she gave R79 a			
5 m a	bath this morning a	and noticed R79, "Had an open so we put Calizone lotion it is			
	spot on the bollon	e area was smaller than an			
	eraser on a pencil				
				с	
	During an interviev	w on 4/1/14 at 2:25 p.m. with			
	registered nurse (	RN)-C unit clinical cool unator			
	stated R79 has so	me open areas on his legs, due			
	to poor circulation	. RN-C did not mention R79			
	had any pressure	ulcers on his buttocks.			
		tion on 4/1/14 from 12:58 p.m.			
	R79 was observa	t 12:58 p.m. R79 was sitting in a			
	regular high back	chair with a cushion asleep with			
	his feet firmly on 1	the floor. R/9 continued to sleep			
	in this same posit	ion until 2:04 p.m. when an			
	unknown NA ente	ered the room and placed his			
	Continues a chair	The unknown NA did not			
	repeationed R79	and only placed his feet onto a			
	chair R79 contin	nued in the same positioned until			
	3:58 p.m. when a	an unknown physical therapy ne room and did exercises with			
	staff came into th	mained in the same chair during			
	K/9 legs. K/9 re	en the exercises were completed			
1	Department of Health				If continuation sheet

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TATEMENT	a Department of Health OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00313	B. WING		04/	03/2014
AME OF PR	OVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		1801 SOL	JTHWEST WILLMA	AR AVENUE		
RICE CAR	E CENTER	WILLMAI	R, MN 56201			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 30	2 900			
2000	the unknown therapy top of the chair as be staff did not offer to a different position. At sit in the same chair	staff, replaced R79's feet on fore. The unknown therapy assist R79 off the chair into a 4:41 p.m. R79 continued to for 3 hours and 43 minutes ioned during this time.				
	had not moved from family member (F)-A interview stated R79 scabbed area on his on 4/1/14 at 4:50 p.r nurse (LPN)-A said I	14 at 4:50 p.m. R79 said he the chair since lunch. R79's who was present during the has a new open area and a buttock. During an interview n. with licensed practical R79's feet were sore so he any more but just sits there.				
	unsure when R79 w NA-DD and NA-S as position. Near R79 open area approxim was a scabbed area cm on R79's right tu 0.8 cm x 0.3 cm on NA-S confirmed the NA-S verified R79 d or repositioning sch	m. NA-DD stated she was as last repositioned and sisted R79 to a standing scrotal area there was an ately 0.3 cm X 0.3 cm. There approximately 0.8 cm x 0.3 berosity and an open area his left tuberosity. NA-DD and id not have a specific turning edule, even though he had rs in the same location.				
	a.m. R79 was in his a regular chair with He remained in this when F-A came to v this chair until 11:00 by NA-Y to ambulat	observation on 4/2/14 at 7:50 room again sitting in room on his feet up on a folding chair. positioned until 9:55 a.m. visit. He continued to remain in a.m. when he was assisted e to the dining room for the of 3 hours and 10 minutes itioned.				

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	a Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:		(X3) DATE COMPI	
		00313	B. WING		04/	03/2014
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
		1801 SOI	JTHWEST WILLN	IAR AVENUE		
RICE CAR	E CENTER	WILLMAI	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 31	2 900			
· ·	manurad the press	sure ulcers on R79 buttocks.				
	There was an open	area that measured 0.9 x 0.5				
	on the right ischeal	tuberosity and 0.7 cm x 0.4				
	cm on the left. The	scrotal area measured 0.6				
	cm X 0.3 cm. RN-E	stated R79 had an open area				
	on the scrotum fron	n "shearing" as well as two				
		n his ischeal tuberosity. R79				
	skin was poor and a	agreed the shearing were				
	considered pressur	e ulcers. She stated the RN cides if a resident needs to be				
	nlaced on a turning	and repositioning schedule,				
	which R79 did not h					
	Review of the facili	ty Progress Notes and Wound		2 C - 1		
	Progress Sheets fro	om 2/20 through 4/1/14 did not				
	identify any pressu	re ulcers for R79's scrotum				
		al tuberosity until 3/27/14, when				
		ss note indicated, "Small open				
	area on scrotum wi	th a small amount of bloody				
	drainage. Possibly	from shearing." There was no eral pressure ulcers on the				
	ischool tuborosity	even though the right ischeal				
	tuberosity was obsi	erved to be scabbed over on				
•	4/2/14 These pres	ssure ulcers had not been				
	reassessed or mon	itored and measured on a				
		termine location, staging, size,				1.1
	exudate, pain, wou	nd bed and description of				
	surrounding wound	l edges even though they were				
	a stage 2 pressure	ulcer (Partial thickness loss of				
		as a shallow open ulcer with a				
	red-pink wound be	d without slough).				
	R79					
		at risk for pressure ulcers				
	development and c	leveloped three separate stage				
	2 pressure ulcers,	one on his scrotum on 3/27/14,				
		cheal tuberosity, unknown				
	date of developme	nt. The facility did not				
	reassessed these I	pressure ulcer, to determine				
	what interventions partment of Health	should be implemented to help				

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STATEMENT	Department of Health	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	•	(X3) DATE COMF	PLETED
AND PLAN OF	CORRECTION	00313	B. WING		04	/03/2014
			DDRESS, CITY, STATE	. ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLM			
	E CENTER		R, MN 56201			
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
0.000	Continued From pag	e 32	2 900			
2 900						
	decrease the risk of	R79 from developing further o there was no indication the				
	prossure ulcers were	e consistently monitored and				
	provided interventio	hs to promote the healing of				
	these pressure ulce	s which caused actual harm				
	for R79.					
	R36's admission Mi	nimum Data Set (MDS) dated				5. [1]
	2/14/14 included s	he was cognitively intact,				1.1
	required extensive t	o total assistance with bed nd toileting and was				
	frequently incontine	nt of bladder. R36 had				
11 - 4 	diagnoses of heart	failure and arthritis, was at risk				
	for pressure ulcers,	and had moisture associated d not have current pressure				
	ulcer.					
	D26's Prossure LIC	er Care Area Assessment				
	(CAA) dated 2/14/1	<ol><li>Iisted R36 had risk factors</li></ol>				
	for development of	pressure ulcers including,				
	requiring extensive	assistance with bed mobility, d bowel incontinence, poor				
	nutrition slides do	wn in bed, requires regular				
	schedule of turning	related to pressure, and				
	moisture associate	d skin damage. The analysis d, "[R36] needs extensive help				
	to make position C	hanges and do any officialing				
	activity she is a CE	eiling lift at present. Has a				
-	brace to her R [rig	ht] leg r/t [related to] knee fx ire planning decision was				
	marked as ves an	id "Proceed to care plan to				
	assist with offload	ing and repositioning, provide				
	thorough cleansin	g."				
	R36 was observe	d in bed, on her back with the				
	boad of bed up ar	proximately 45 degrees, on				
$p_{\rm e} M_{\rm e}$	1/1/14 from 1.00	p.m. until 2:15 p.m. At 2:15				
	p.m. R36's pressu	ire ulcer with registered nurse erved, on R36's buttock which				
	Department of Health				lf cr	ontinuation sheet

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00313	B. WING		04/	03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICE CAR	E CENTER		UTHWEST WILLMA R, MN 56201	AR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pag	je 33	2 900			
	the area. R36 stated quite a while," and c sleeps on her back o breathing and this po comfortable for her.	RN-G stated the nurse aides				
	for meals or therapy repositioning schedu pressure ulcer was f the ceiling lift sling, v	rom shearing from the use of vhich she was no longer				
- 11 - 1 -	placing her at risk fo confirmed they had r	ent the potential shearing of				
	head of bed elevated	n bed, on her back with the d approximately 45 degrees, a.m. until 7:53 a.m. and on n. until 9:00 a.m.				
	assistant (NA)-AA st repositioning schedu when in bed, she wil she gets up for there	n 4/1/14, at 2:15 p.m. nursing ated R36 was not on any ule, she lays on her back I change positions when ever apy or meals. NA-AA stated ently, and didn't always get				* - 44 *
	stated R36 was not of she will mostly lay of	4/2/14, at 7:53 a.m. NA-A on a repositioning schedule, n her back in bed, with head le. However, sometimes R36 heel chair.				
1	"Crack in coccyx are Calazime applied."	dated 2/12/14, included, a, no drainage noted. This area was not identified sure ulcer, or any further				

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STATEMENT	Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
AND PLAN UI	GUNNEDHON	00313	B. WING		04/	03/2014
			DDRESS, CITY, STATE	E, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLM			
	E CENTER		R, MN 56201	÷		
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0.000	Continued From pag	10.34	2 900			
2 900						
	description including wound edges, tissue pain was associated	g size, wound bed, drainage, e surrounding wound, or if any l with it.				
	noted to have small left buttocks measu 0.5 cm." R36's Wou 2/19/14, included a of dermis presenting	on 2/19/14, indicated "Patient area of shearing to middle of ring 2 cm [centimeters] x [by] ind Progress Sheet dated stage 2 (partial thickness loss g as a shallow open ulcer with				
	a red pink wound be	ed, without slough) pressure ound bed, scant amount of ing tissue pink, and wound				
	The progress note skin assessment fo with the following re number "1) Banmc .75 cm." There wa 2/19/14, pressure to	on 3/11/14, indicated, "Weekly r high risk patient completed esults." Under "skin issues," hable [sic] right buttock 1 cm x as no way to determine if the ulcer on the left buttocks had this was the same area as 4.				
	she had been hosp on 3/24/14 had ret hospital return Ski 3/24/14, indicated ulcers or other ski	tes dated 3/20/14, indicated bitalized with pneumonia, and urned to the facility. R36's n Risk Assessment dated she did not have any pressure n issues on her buttocks or				
	assessment (a sca ulcer risk) was cor included risk facto ulcers that include chronic incontiner	asment with Braden Scale ale used to predict pressure npleted on 3/24/14 which rs for development of pressure ed: Cardiovascular disease, nce, abrasions, bruises, steroid use, occasional moist y limited ability to change and				

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If continuation sheet 35 of 46

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMPL	
		00313	B. WING		04/	03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
RICE CAR	E CENTER		UTHWEST WILLM	AR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pag	e 35	2 900			
х. 19 г.						
	wound to coccyx/but 1.75 inches x 3 inches surrounding multiple skin shearing." Ther pain, wound bed, der wound edges or if thi	note, indicated, "Observed tock crease this evening. es, reddened areas small areas of stage 2 or e was no staging, exudate, scription of surrounding is was the same open area gress note or if this was a		· · · · · · · · · · · · · · · · · · ·		1910 - Status 1910 - Status 1910 - Status
	included nursing wou ADL's [activities of da therapy directives." address the risk factor Skin Risk Assessment interventions to help pressure ulcers even	e plan updated 2/20/14, uld provide assistance with aily living] and mobility per The care plan did not ors listed on the CAA and int to determine appropriate prevent the development of though R36 was at risk for PU and currently had a stage				
	house supervisor, re- stated she was not a ulcer at any time. RI 2/12/14, 2/19/14, and had healed during th	n 4/1/14, at 1:55 p.m. the gistered nurse (RN)-E, ware R36 had any pressure N-E was unsure if the d 3/11/14, pressure ulcers e hospital stay, or before or if they did not heal at all.				
	clinical coordinator, F timed repositioning p reposition her when	n 4/1/14, at 2:43 p.m. the RN-C verified there was no blan for R 36, staff would ever she got up for therapy or R36 spent most of the time in				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	COMP	LETED		
ALEMENT C D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
					04	/03/2014
		00313	B. WING		1 01	
		STREET A	DDRESS, CITY, STATE	, ZIP CODE		. ,
ME OF PRO	OVIDER OR SUPPLIER		UTHWEST WILLM			
	CENTER		R, MN 56201			
CE CARE			ID	PROVIDER'S PLAN C	F CORRECTION	(X5) COMPLE
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	) THE APPROPRIATE	DATE
			2 900			
2 900	Continued From page		2000			
	bed on her back due	e to breathing difficulty. There				
	was no toileting plar	i, even though Roos pressure				
	-1	a indicated utiliary				
	incentingnce placed	R36 at risk for development				
	of proceure ulcers	RN-C stated she had no way				
	i lutermaine when t	he "Crack in coccyx area,				
	1	4 had healed, or when or m,				
	the store 2 pressur	e ulcer identilieu on 2000, 14,				
	had boaled or if the	area Identilieu on 4/ 1/ 14,				
	was the same area	as had been identified on				
ŕ.,	2/12/14, 2/19/14, 0	r 3/11/14. RN-C stated R36 eassessed after R36 had				
193 10	should have been r	ospital weaker, and was				
	returned from the n	o in bed				
	spending more time	e in bea.				
	Although P36 Was	at risk for pressure ulcers and				
	had doveloped a p	ressure ulcer on 2/19/14 to				
	present these ulce	ers had not been consistently				
	the section O WO	why basis to determine				
ana di Angela. Angela	Li attan ataging s	ize exudate pain, wound bed				
1	and departmention of	surrounding would edges.				
	AL - comprober	heive assessment hau not been				
	accorded to dete	rmine what interventions should				
	be implemented to	b help decrease the lisk of Roo				
	from developing p	ressure ulcers.				
		the second for prossure ulcers				
	R150's, closed re	cord review for pressure ulcers,				
	indicated R150's	admission MDS, dated 1/23/14,				
	indicated R150 ha	ad no unhealed pressure ulcers				
	and was at risk fo	also indicated the resident				
	ulcers. The MDS	ity for bed mobility and extensive				
	-interned for tra	neters in addition, the MDO				
	assistance for the	ad multiple diagnoses including				
	nneumonia denr	ression, arthritis, and				
	hypertension.					
4						
	R150's skin asse	essment, completed on 1/18/14,				
	indicated the res	ident had a Braden Scale (Scale				
	of pressure ulcer	r risk factors] score of 16,			lf c	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					(X3) DATE S COMPL	
		00313	B. WING		04/0	)3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		1801 SC	UTHWEST WILLM	AR AVENUE		
RICE CAR	E CENTER	WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 37	2 900			
	identifving R150 wa	as at risk for pressure ulcer				
		esident's pressure ulcer Care				
		CAA), dated 1/27/14, identified				
	R150 was in therap	y to improve ability to offload				
	independently.					
		· · · · · · · · · · · · · · · · · · ·				
		lated 1/27/2014, indicated				
		ender area to "L" buttock on				
		to offload from lower surfaces,				
		care plan directed staff to g activities and "Cover				
		with mepilex border and apply			•	
	calazime PRN [as r					
	A review of R150's,	Resident Progress Notes,				
	dated 1/25/14, iden	tified the resident continued to				
		tenderness and discomfort to				
		left inner buttocks which	_			
		ntimeters] by 1.5 cm. The				
		area had "Calmo applied and				
		ex." The resident's progress				
		4, identified that R150				
		ain of discomfort to coccyx pplied various times				
		almo what effective for				
	•	, on 1/28/14, progress notes				
		I an "Area of raised, firm tissue				
		noted to be macerated this				
		l, Calazime applied, and				
		ilex Border." The progress				
		4, indicated the Nurse				
		bserved the resident's				
		was an area of shearing from				
		eated surfaces. The NP				
		o (L) [Left] butt TID [three				
	• • •	t cover with Mepilex border;				· •
	software cushion in	any chair surface he sits in."				
	Although the facility	had identified, on admission,				
	R150 was at risk fo					

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Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
TATEMENT		IDENTIFICATION NUMBER:	A. BUILDING:			
		00313	B. WING		04/03/2014	4
			DDRESS, CITY, STATE,			
AME OF PR	OVIDER OR SUPPLIER		UTHWEST WILLMA			
	E CENTER		R, MN 56201	••••		
			ID	PROVIDER'S PLAN OF CORREC		X5) PLETE
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)		ATE
2 900	Continued From pag	e 38	2 900			
2 300						
	and identified R150	developed a pressure ulcer to				
	the left buttock, after	admission; the care plan reflect the current treatment				
	was not updated to r	e nurse practitioner (NP) to				
	as prescribed by the	d prevent the development of				
	promote nearing and	ulcers. Also, the assessment				
	did not identify what	interventions could be				
	implemented to prev	vent R150 from developing				
	pressure ulcers.					
	When interviewed, o	on 4/3/2014 at 1:26 p.m., the				
	RN-E stated the ma	cerated area on the leπ				
	buttock was a press	sure ulcer. RN-E also stated				
	the care plan was n	ot updated to reflect the				
	pressure ulcer treat	ment ordered 1/29/14 by the				
	nurse practitioner.					
	A policy entitled Sk	in Care, Rice Care Center,				
	dated 3/10 include	d a purpose of, "To maintain				
	skin integrity, preve	ent skin breakdown, and to				
	nromote healing of	non-intact skin. The				
	procedure identifie	d upon admission or hospital				
	return, a skin asse	ssment would be completed				
	within 24 hours; a	comprehensive risk				
	assessment with B	raden scale would e rith a tissue tolerance test (a				
4	completed along w	ng skin can withstand pressure)				
	test to see now ior	ed. If a resident was found to				
	would be complete	preakdown, skin would be				
	monitored weekly	and documented in the				
	progress notes R	esidents with reddened, open				
	areas or ulcers W	ould be entered on the				
	treatment sheet, a	ind documented on weekly to				
	include "treatment	nt given, interventions to				
	prevent further bre	eakdown, size, depth, odor, and				
	drainage " The po	plicy further indicated the				
	physician would b	e consulted with if there was				
	any significant cha	ange in the ulcer. The policy				
	contained a defini	tion of an "Avoidable Pressure				
	Ulcer," which incl	luded, "an ulcer that has				

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### 2900 Treatment/SVCS to Prevent/Heal Pressure Sores

#### **Corrective Action:**

Res 36 Revised comprehensive pressure ulcer risk assessment completed on April 14, 2014. Appropriate interventions to prevent further development of additional pressure ulcers have been added to care plan. Wound progress sheet reviewed and updated. R36 discharged from facility on April 23, 2014 with no open areas.

Res 79 expired at hospital

Res 150 closed record review/discharged

Skin Care Policy reviewed and updated

#### Corrective Action-identify other residents:

All Residents with pressure ulcers have been reviewed for appropriate assessment. Wound monitoring progress sheet reviewed to ensure current pressure ulcers are healing and to prevent the development of new pressure ulcers.

Care plan interventions reviewed for appropriate interventions to prevent the development of new pressure ulcers.

LTC Pink care cards updated with repositioning guidelines, Therapy Suites patient roster updated with heart shape if patient needs assistance with repositioning.

#### Corrective action to prevent reoccurrence:

Education will be completed on May 8, 2014 regarding the Skin Care Policy to all nursing staff. Review of LTC Pink care cards with repositioning guidelines, Therapy Suites patient roster reviewed with heart shape if patient needs assistance with repositioning.

### Monitoring for Compliance:

Audits will be completed by RN Clinical Coordinator &/or DON weekly at Wound meetings in each neighborhood to assure wound monitoring sheets are completed and pressure ulcer is healing and measures in place to prevent the development of new pressure ulcers.

Care plans will be reviewed weekly at wound meeting for appropriate interventions.

High risk residents/patients pink care cards or patient roster will be reviewed for accuracy.

Results will be brought to QA committee for recommendation on the need to further audit.

#### **Completion Date:**

May 8, 2014

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00313	B. WING		04/03/2	014
	ROVIDER OR SUPPLIER	1801 SO	DDRESS, CITY, STA UTHWEST WILL R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES WINT BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE 0	(X5) COMPLETE DATE
2 900	were not done: a res not evaluated, risk fa interventions were no	one or more of the following sidents clinical condition was ctors were not identified,	2 900			
	The director of nursir review/revise policies ulcer prevention and perform audits to ens	IOD OF CORRECTION: ng (DON) or designee could s/procedures for pressure care, educate staff, and then sure compliance. CORRECTION: Twenty One				•
2 910	have a continuous pu management to redu unnecessary use of o	ce. A nursing home must rogram of bowel and bladder ice incontinence and the catheters. Based on the lent assessment, a nursing	2 910	Refer to attachment for I and date of completion	PoC	
	A. a resident wh without an indwelling unless the resident's that catheterization v B. a resident who receives appropriate prevent urinary tract	o enters a nursing home catheter is not catheterized clinical condition indicates				
	This MN Requirement	nt is not met as evidenced				

;

TATEMENT	Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE S COMPL	
ND PLAN OF	IDENTIFICATION NUMBER:		A. BUILDING:		04/0	)3/2014
		00313	B. WING			
	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
			UTHWEST WILLM	IAR AVENUE		
RICE CARI	ECENTER	WILLMA	AR, MN 56201	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	DATE
2 910	Continued From page	ge 40	2 910			
	by:					
	Based on observation	on, interview, and document				
28.5	review the facility fa	ailed to comprehensively				
	assess, and place in	nterventions to improve or ontinence for 1 of 2 residents				
	(R36) reviewed for u	urinary incontinence.				
	Findings include:					
						1997 - 19
	R36's admission Mi	inimum Data Set (MDS) dated				
	2/14/14, included s	he was cognitively intact, assistance with mobility,				
	toileting and hygier	ne. R36 was frequently				
	incontinent of bowe	el and bladder, had a trial				
	toileting program w	ith no improvement, and was ng program. The MDS also				
	on a current tolletin	s of heart failure and arthritis,				
	and received a diu	retic (water pill) daily.				
- -						
	D26's Bladder Ass	essment dated 2/13/14,				
	included risk factor	rs for urinary incontinence,				
	including impaired	mobility with dependent				
	transfers, urine lea	kage on way to bathroom,				
	failure, and use of	suppress, congestive heart a diuretic.				-
		antinongo Care Area				
	R36's Urinary Inco	ontinence Care Area ) dated 2/19/14, included risk				
	factors for urinary	incontinence including,				
	extensive assistar	nce required to toilet, urinary				
	incontinence, moi	sture associated skin damage, obility, urinary urgency, and use				
	of a diuretic. The	type of urinary incontinence				
	was listed as "Fu	nctional (can't get to the tollet in				
	time due to physic	cal disability, external obstacles,				
1	or problems think	ing or communicating." An				

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			LETED		
	00313		B. WING		04/	03/2014		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       1801 SOUTHWEST WILLMAR AVENUE       RICE CARE CENTER     WILLMAR, MN 56201								
RICE CAR				PROVIDER'S PLAN OF CORR	ECTION	(X5)		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETE DATE		
2 910	Continued From pag	e 41	2 910					
	analysis of findings i incontinent of bladde mobility. She is on c chronic, per AL [assi indicated care plann	ncluded, "[R36] is frequently er, compounded by loss of liuretics. Incontinence is sted living]." The form ing would occur, "Proceed to ith toileting and attempt to						
	decline in ADL's r/t [ heart failure], RA [rh weakness, COPD [c pulmonary disease] [fracture]; Here for s return to community "Will regain indepen daily living] to allow Staff were instructed monitor for increase constipation and no physician] if indicate address the risk fac use, or to direct stat or improve urinary i	ed 2/20/14, included, "Recent related to] CHF [congestive eumatoid arthritis], coronary obstructive R [right] patellar [knee] fx hort term stay with desire to ." The goal for R36 was, dence in ADL's [activities of safe return to community." d to, "Assist with toileting, d incontinence and/or tify PCP [primary care ed." The care plan did not tors of immobility, diuretic ff on any program to maintain ncontinence even though the ed these areas of risk for R36.						
	had been assisted assistant (NA)-L an product was dry an NA-AA stated R36 toileting schedule, j R36 calls to get her	on 4/1/14, at 2:15 p.m. she to the toilet by nursing d NA-AA. R36's incontinent d she voided in the toilet. was not on any routine ust when they get her up, or r incontinent product changed. cently and did not always get		-				
	R36 was observed	on 4/2/14, at 7:53 a.m. she						

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TATEMENT	Department of Health DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY LETED
00313		B. WING			/03/2014	
			DRESS, CITY, STATE	, ZIP CODE		
AME OF PR	OVIDER OR SUPPLIER		JTHWEST WILLMA			
	E CENTER		R, MN 56201			
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 910	Continued From pag	e 42	2 910			· · · 2'
	had been assisted fr NA-L and NA-A. R3 toilet at this time, and saturated with urine.	om bed to her wheel chair by 6 was not assisted to the d her incontinent product was NA-A stated R36 does not st gets her pad changed up into the wheel chair.				
	verified the assessm for R36 regarding to of a diuretic with the shortly after taking t did not identify if R3 any indication that h to aid with functiona assessed or evalua determine an approverified R36 had be not get up out of be assist R36 with toile to maintain or improverified When interviewed of director of nursing with interventions s	n 4/1/14, at 2:43 p.m. RN-C hent had not been developed illeting needs for staff, the use e possible need to toileting he diuretic. The assessment 6 had urgency, nor were there her environment was modified al incontinence. RN-C had not ted any voiding patterns to priate toileting plan. RN-C en ill frequently and often did d. There was no plan to eting needs at these times, or pove her urinary incontinence.				
	continence. A policy was reque facility. SUGGESTED ME The director of nur review/revise polic educate staff, and	ested, but not provided by the THOD OF CORRECTION: rsing (DON) or designee could cies on bladder assessments, perform audits to ensure each dividualized assessment to				

# 2910 Assessment Accuracy/Coordination/Certified

### **Corrective Action:**

Res 36 Bowel & Bladder assessment was reassessed on 4/14/04 – 4/16/2014. Assessment accurately reflected the residents care plan that staff are providing

## Corrective Actions - identify other residents:

- The RAI process was reviewed and is current
- All residents with urinary incontinence assessments and care plans reviewed to ensure
- œ interventions are in place to improve or maintain urinary incontinence.

### **Corrective Action to Prevent Reoccurrence:**

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of MDS matches the care plan. Nursing staff are to alert Clinical Coordinator if changes, significant change will be evaluated at that time.

### Monitoring for Compliance:

DON or Designee will audit bladder assessment to ensure resident assessment accurately reflects the care plan. Audits will be done weekly for 4 weeks then 2 times a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.

### Completion Date:

May 8, 2014

### 2910 No Catheter, Prevent UTI, Restore Bladder

#### **Corrective Action:**

Resident 36 Comprehensive Assessment with analysis and interventions put in place to improve or maintain urinary incontinence completed on April 16, 2014

#### Corrective Actions-identify other residents:

All residents with urinary incontinence assessments & care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

#### Corrective Action to Prevent reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of the MDS matching the care plan. Nursing staff are to alert the Clinical Coordinator if there changes, significant change will be evaluated at that time.

#### Monitor for Compliance:

DON or Designee will audit bladder assessment to ensure completion and interventions are indentified on Care Plan to improve or maintain urinary incontinence. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audits.

#### **Date of Completion:**

May 8, 2014

Minnesota Department of Healt STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
		00313			04/03/2014
	OVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE	
			UTHWEST WILLI	IAR AVENUE	
RICE CAR	E CENTER	WILLMA	AR, MN 56201		ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN)	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
2 910	Continued From pag	e 43	2 910		
	maintain or improve				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One			
21800	MN St. Statute144.6	51 Subd. 4 Patients &	21800	Refer to attachment for P	юС
	Residents of HC Fac			and date of completion	
	are legal rights for t stay at the facility or treatment and maint that these are descr written statement of responsibilities set f case of patients adr as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga advocacy and legal residential program accommodations sh communication imp speak a language of facility policies, insp local health authori the written statement to patients, resident chosen representation person consistent	dmission, be told that there heir protection during their throughout their course of tenance in the community and ibed in an accompanying the applicable rights and orth in this section. In the mitted to residential programs in 253C.01, the written of describe the right of a dor older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in s. Reasonable hall be made for those with other than English. Current bection findings of state and ties, and further explanation of ant of rights shall be available its, their guardians or their tives upon reasonable request r or other designated staff with chapter 13, the Data section 626.557, relating to			

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Minnesot	a Department of Healt	h			-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00313	B. WING		04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	4
		1801 SO	UTHWEST WILLN	IAR AVENUE	
RICE CAR	ECENTER	WILLMA	R, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21800	Continued From page	9 44	21800		1
	by: Based on interview a facility failed to provid noncoverage, or gene discontinuation of Me	t is not met as evidenced nd document review, the le the notice of provider eric notice, upon dicare part A services for 1 eviewed for liability notices.			
	Findings include:				
	had been admitted to Medicare part A servi Progress and Discha indicated R23 had me skilled services would There was no indicat notice of provider nor notify the resident of	ssion Record indicated he the facility on 1/13/14, on ces. The Physical Therapist rge Summary dated 2/27/14, et the therapy goals and d be ending on 2/27/14. ion R23 had received a neoverage (CMS 10123) to the right to an expedited Improvement Organization.			
	Medicare part A days				
	A policy was requeste facility.	ed, but not provided by the			
Minnesster	The administrator or on the process of pro	OD OF CORRECTION: designee could educate staff viding liability notices and			
STATE FORM	partment of Health		<sup>6899</sup> U	XQR11	If continuation sheet 45 of 46

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313		B. WING		04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
		1801 SO	UTHWEST WILL	MAR AVENUE	
	ECENTER	WILLMA	R, MN 56201		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21800	Continued From page	e 45	21800		
4	resident appeals righ	ts. The administrator or audit to ensure compliance.			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One			
			<i>a</i> .		
17. 3 4				· · ·	
					· · ·
Minnesota Dep STATE FORM	partment of Health	<u> </u>	6899	JXQR11	If continuation sheet 46 of 46

# 21800 Notice of Rights, Rules, Services, Charges

### **Corrective Action:**

R 23 discharged from facility

## <u>Corrective Action – identify other residents</u>

Effective 4/7/2014 all patients being discharged from facility will be given a 48 hour notice of denial.

### **Corrective action to Prevent Reoccurrence:**

Medicare Denial Completion has been added to the check list to alert Nursing or Social Services to complete Medicare Denial 48 hours before discharge.

Business office personal has developed an internal check list for completion for discharged patients

## Monitoring for Compliance

Random Audits will be completed weekly by the DON or Designee to assure Medicare denials were given. This audit will continue for 90 days and the results brought to the QA committee for recommendations on the need for further audits.

### Date of Completion

April 23, 2014