CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VKFY

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

| PART | I - TO BE COMP | LETED BY T | THE STAT | ΓE SURVEY AGENCY | Facility ID: 00792 |
|---|--|---------------------------------------|-------------------------|--|--|
| MEDICARE/MEDICAID PROVIDER NO. (L1) 245427 2.STATE VENDOR OR MEDICAID NO. (L2) 516240800 | 3. NAME AND AI (L3) BETHESDA (L4) 901 SOUTH (L5) WILLMAR, | NH PLEASAN EAST WILLM | TVIEW | UE (L6) 56201 | 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 09/10/2013 (L34) | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual | IPPLIER CATEGO 05 HHA 06 PRTF | ORY 09 ESRD 10 NF | 02 (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| 8. ACCREDITATION STATUS:(L10) 0 Unaccredited | 03 SNF/NF/Distinct 04 SNF | 07 X-Ray 08 OPT/SP | 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 123 (L18) 13.Total Certified Beds 123 (L17) | Complian1 B. Not in Co. | | gram | And/Or Approved Waivers Of To 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code * Code: A* | 6. Scope of Services Limit7. Medical Director |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 123 | | IID | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) |
| (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAL See Attached Remarks 17. SURVEYOR SIGNATURE | (L42) BLE SHOW LTC CANCI | (L43) ELLATION DATE | <u>;</u>): | 18. STATE SURVEY AGENCY | APPROVAL Date: |
| Karen Aldinger, HFE NE II | | 09/16/2013 | (L19) | Shellae Dietrich, P | rogram Specialist 02/06/2014 |
| PART II - TO 1 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) | 20. COM | BY HCFA RIMPLIANCE WITH GHTS ACT: | | | ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) |
| 22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 02/01/1987 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNA | | 24. LTC AGREEN ENDING DAT (L25) | | 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination | 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement |
| (I 27) | ion of Admissions: Suspension Date: | (L44) (L45) | | 04-Other Reason for Withdrawal | 07-Provider Status Change 00-Active |
| 28. TERMINATION DATE: (L28) | 29. INTERMEDIARY/03001 | CARRIER NO. | (L31) | 30. REMARKS | |
| 31. RO RECEIPT OF CMS-1539 (L32) | 32. DETERMINATION 06/27/2013 | OF APPROVAL D | DATE (L33) | DETERMINATION APPR | ROVAL |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00792

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5427

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we imposed State Monitoring effective May 29, 2013 and we recommended enforcement remedies to CMS RO and CMS RO imposed the following remedies on their letter dated July 3, 2013:

- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013
- Discretionary DOPNA effective July 22, 2013
- Mandatory DOPNA effective July 22, 2013

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A Health PCR was completed on July 24, 2013 and a LSC PCR was completed on July 12, 2013. The LSC PCR found all deficiencies corrected but the Health PCR found three deficiencies uncorrected at a S/S level of E and identified two new deficiencies at a S/S level of D.

As a result of the health PCR, state monitoring will remain in effect and we recommended to CMS RO the following and CMS RO concurred:

- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 will remain in effect
- Mandatory DOPNA effective July 22, 2013 will remain in effect

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A second health PCR was completed on September 10, 2013 and the facility was found in substantial compliance, effective August 30, 2013. As a result, we discontinued state monitoring effective August 30, 2013. We also recommended the following action to the CMS RO and CMS RO concurred:

- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 was discontinued effective August 30, 2013

See attached CMS-2567B from the September 10, 2013 revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5427 February 6, 2014

Ms. Michelle Haefner. Administrator Bethesda Nh Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

Dear Ms. Haefner:

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 August 30, 2013 the above facility is certified for:

123 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 123 skilled nursing facility beds located in rooms You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900

Telephone #: (651) 201-4106 Fax #: (651) 215-9697

Licensing and Certification File cc:



Protecting, Maintaining and Improving the Health of Minnesotans

September 16, 2013

Ms. Norma Brendle, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427023

Dear Ms. Brendle:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013

Also, the CMS Region V Office notified you in their letter of July 3, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint numberH5427017 and H527019 . The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28,m 2013. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. As a result of the revisit findings, we notified you that the

Bethesda Nursing Home Pleasantview September 16, 2013 Page 2

Category 1 remedy of state monitoring would remain in effect.

On August 9, 2012 , this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 remain in effect
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 remain in effect

On September 10, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 24, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 24, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 30, 2013.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 be discontinued August 30, 2013
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

As we notified you in our letter of May 24, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2013.

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.

Bethesda Nursing Home Pleasantview September 16, 2013 Page 3

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Colleen Feach

PO Box 64900

Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) Provider / Supplier / CLIA / Identification Number 245427 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 9/10/2013 |
|--|--|---------------------------------------|-----------------------------------|
| Name of Facility | | Street Address, City, State, Zip Code | |
| BETHESDA NH PLEASANTVIEW | | 901 SOUTHEAST WILLMAR AV | /ENUE |

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

| (Y4) Item | | (Y5) Date | (Y4) Item | | (Y5) Date | (Y4) | Item | (Y | ' 5) | Date |
|---------------|-------------------------|-----------------------------|---------------|-----------------|----------------------|---------|---------------|------------|-------------|-------------------------|
| | | Correction | | | Correction | | | | | Correction |
| ID Prefix | F0225 | Completed 08/30/2013 | ID Prefix | F0226 | Completed 08/30/2013 | | ID Prefix | F0309 | | Completed 08/30/2013 |
| | 483.13(c)(1)(ii)-(iii), | | | 483.13(c) | | | | 483.25 | | |
| LSC | | | LSC | | | | LSC | | | _ |
| | | Correction | | | Correction | | | | | Correction |
| ID Dueffy | F0000 | Completed | ID Duefin | F0400 | Completed | | ID Dueffy | | | Completed |
| ID Prefix | - | 08/30/2013 | ID Prefix | - | 08/30/2013 | | | | | _ |
| | 483.25(I) | | | 483.60(c) | | | Reg. # LSC | | | _ _ |
| | | Correction | | | Correction | | | | | Correction |
| ID Prefix | | Completed | ID Profix | | Completed | | ID Profix | | | Completed |
| | | | | | | | | | | <u> </u> |
| Reg. # LSC | | | Reg. # LSC | | | | LSC | | | _ _ |
| | | Correction | | | Correction | | | | | Correction |
| ID Drofiv | | Completed | ID Drofiv | | Completed | | ID Drofiv | | | Completed |
| ID Prefix | | | | | | | | | | _ |
| Reg. # LSC | | | Reg. # LSC | | | | Reg. # LSC | | | |
| | | Correction | | | Correction | | | | | Correction |
| ID Profiv | | Completed | ID Profix | | Completed | | ID Profix | | | Completed |
| Reg. # | | | Reg. # | | | | ъ " | | | |
| LSC | | | LSC | | | | Reg. # LSC | | | _ = |
| | | | | | | | | | | |
| Reviewed E | By Revie | wed By | Date: | Signature of | f Surveyor: | | | I | Date: | |
| State Agen | cy BF/ | 'sd | 09/16/2 | 13 29 | 9245 | | | | 09 | /10/13 |
| Reviewed E | By Revie | wed By | Date: | Signature of | Surveyor: | | | | Date: | |
| | o Survey Complete | d on: | | Check for any U | nearracted Defi | iolono! | os Was s | Summony of | | |
| | 5/8/2013 | | | | Deficiencies (CI | | | | YES | NO |

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VKFY

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

| PAI | RT I - TO BE COMP | HE STA | TATE SURVEY AGENCY Facility ID: 007 | | | |
|---|---|----------------------------------|-------------------------------------|--|--|--|
| MEDICARE/MEDICAID PROVIDER NO. (L1) 245427 2.STATE VENDOR OR MEDICAID NO. (L2) 516240800 | 3. NAME AND AD (L3) BETHESDA (L4) 901 SOUTHI (L5) WILLMAR, | NH PLEASAN EAST WILLMA | TVIEW | UE (L6) 56201 | 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint | |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) | 7. PROVIDER/SUI | PPLIER CATEGOI | RY 09 ESRD | 02 (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint | |
| 6. DATE OF SURVEY 07/24/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other | | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 | |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 123 (L1 13.Total Certified Beds (L1) | 8) Complianc 1. A X B. Not in Con | | ram | And/Or Approved Waivers Of TI 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: B* | 6. Scope of Services Limit 7. Medical Director | |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 123 (L37) (L38) (L3 | | IID (L43) | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| 16. STATE SURVEY AGENCY REMARKS (IF APPLIC See Attached Remarks | CABLE SHOW LTC CANCE | ELLATION DATE) |): | | | |
| 17. SURVEYOR SIGNATURE Brenda Fischer, Unit Supervis | Date : | 08/09/2013 | (L19) | Shellae Dietrich, P | | |
| PART II - TO | D BE COMPLETED | BY HCFA RE | EGIONA | L OFFICE OR SINGLE ST | ATE AGENCY | |
| 19. DETERMINATION OF ELIGIBILITY _X | RIG | IPLIANCE WITH (GHTS ACT: | CIVIL | 21. 1. Statement of Final2. Ownership/Control3. Both of the Above | l Interest Disclosure Stmt (HCFA-1513) | |
| 22. ORIGINAL DATE 23. LTC AGE OF PARTICIPATION BEGINN 02/01/1987 (L24) (L41) | REEMENT 2- NING DATE | 4. LTC AGREEM ENDING DAT | | 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme | 05-Fail to Meet Health/Safety | |
| A. Susp | NATIVE SANCTIONS ension of Admissions: and Suspension Date: | (L44) (L45) | | 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | OTHER 07-Provider Status Change 00-Active | |
| 28. TERMINATION DATE: (L28) | 29. INTERMEDIARY/C 03001 | | (L31) | 30. REMARKS | | |
| 31. RO RECEIPT OF CMS-1539 (L32) | 32. DETERMINATION O 06/27/2013 | OF APPROVAL DA | ATE (L33) | DETERMINATION APPR | OVAL | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00792

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5427

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we imposed State Monitoring effective May 29, 2013 and we recommended enforcement remedies to CMS RO and CMS RO imposed the following remedies on their letter dated July 3, 2013:

- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013
- Discretionary DOPNA effective July 22, 2013
- Mandatory DOPNA effective July 22, 2013

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A Health PCR was completed on July 24, 2013 and a LSC PCR was completed on July 12, 2013. The LSC PCR found all deficiencies corrected but the Health PCR found three deficiencies uncorrected at a S/S level of E and identified two new deficiencies at a S/S level of D.

As a result of the health PCR, state monitoring will remain in effect and we recommended to CMS RO the following and CMS RO concurred:

- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 will remain in effect
- Mandatory DOPNA effective July 22, 2013 will remain in effect

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

See the CMS-2567B and CMS-2567 from these revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5155

August 9, 2013

Mr. Douglas Dewane, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017, H5427019

Dear Mr. Dewane:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint number H5427017 and H5427019. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. The deficiencies not corrected are as follows:

- F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) (4) -- Investigate/report Allegations/individuals
- F0226 -- S/S: E -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies
- F0309 -- S/S: E -- 483.25 -- Provide Care/services For Highest Well Being

In addition, at the time of this revisit, we identified the following deficiencies:

- F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
- F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 will remain in effect
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effective
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013 will remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of May 24, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2013.

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.

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 Minnesota Department of Health Midtown Square 3333 West Division, Suite #212 Saint Cloud, Minnesota 56301

Telephone: (320) 223-7338

Fax: (320) 223-7348

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 November 8, 2013 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

Mark Weath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

cc: Licensing and Certification File 5427r1_13.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) | Provider / Supplier / CLIA / Identification Number 245427 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 7/24/2013 |
|------|---|--|---|--------------------------------|
| Name | of Facility | | Street Address, City, State, Zip Code | |
| BE | THESDA NH PLEASANTVIEW | | 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201 | UE |

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

| (Y4) Item | | (Y5) | Date | (Y4) | Item | | (Y5) | Date | (Y4 |) Item | | (Y5) | Date |
|-------------|-----------------|--|-------------------------|----------|-----------|---------------|---------|-----------------------------|-------|--------------|------------------|-------|-------------------------|
| | | | Correction | | | | | Correction | | | | | Correction |
| | | | Completed | | | | | Completed | | | | | Completed |
| ID Prefix | F0155 | | _06/28/2013 | | ID Prefix | F0157 | | 06/28/2013 | | ID Prefix | F0241 | | 06/28/2013 |
| Reg. # | 483.10(b)(4) | | _ | | • | 483.10(b)(11) | | | | • | 483.15(a) | | _ |
| LSC | | | - | | LSC | | | | | LSC | | | _ |
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| | | | Correction | | | | | Correction | | | | | Correction |
| ID D f | E0040 | | Completed | | ID D. f. | 50044 | | Completed | | ID Dester | F0000 | | Completed |
| ID Prefix | F0242 | | _06/28/2013 | | ID Prefix | FU314 | | 06/28/2013 | | ID Prefix | F0323 | | 06/28/2013 |
| | 483.15(b) | | _ | | _ | 483.25(c) | | | | | 483.25(h) | | _ |
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| | | | | | | | | | | | | | |
| | | | Correction | | | | | Correction | | | | | Correction |
| ID Prefix | F0353 | | Completed 06/28/2013 | | ID Prefix | F0371 | | Completed 06/28/2013 | | ID Prefix | F0441 | | Completed 06/28/2013 |
| | - | | | | | | | - | | | - | | |
| Reg. # | 483.30(a) | | _ | | Keg. # | 483.35(i) | | | | keg. # | 483.65 | | _ |
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| Rea.# | 483.75(e)(5)-(7 |) | | | Reg. # | | | | | | | | |
| • | | <u>, </u> | - | | LSC | | | | | LSC | | | _ |
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| Reviewed By | , | Reviewed I | Ву | Da | te: | Signature o | | | | | | Date: | · |
| State Agenc | y | MM/BF | | 0 | 8/09/20 |)13 | 2924 | .5 | | | | 07/2 | 4/2031 |
| Reviewed By | <i>,</i> | Reviewed I | Ву | Da | te: | Signature of | f Surve | yor: | | | | Date: | |
| CMS RO | | | | | | | | | | | | | |
| Followup to | Survey Comple | eted on: | | | | Check 1 | for any | Uncorrected | Defic | iencies. Was | a Summary of | - | |
| - | 5/8/2 | 013 | | | | | - | | | | to the Facility? | YES | NO |
| | | | | 1 | | | | | | | | | - - |

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| Ì | rovider / Supplier / CLIA / lentification Number 45427 | (Y2) Multiple Constru A. Building B. Wing | N BUILDING 01 | (Y3) Date of Revisit 7/12/2013 |
|-----------|--|---|--|-----------------------------------|
| Name of I | Facility | | Street Address, City, State, Zip Code | |
| BETH | HESDA NH PLEASANTVIEW | | 901 SOUTHEAST WILLMAR AVENI WILLMAR, MN 56201 | JE |

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 | (Y | 4) Item | | (Y5) | Date |
|-----------------------|---------------|------------|-----------------------------|------|---------------|----------------|------|----------------|------|----------------|------------------|-------|--------------|
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| ID Prefix | | | 05/09/2013 | | ID Prefix | | | 07/08/2013 | | ID Prefix | | | 07/08/2013 |
| Reg. # | NFPA 101 | | | | Reg. # | NFPA 101 | | | | Reg. # | NFPA 101 | | _ |
| LSC | K0020 | | | | LSC | K0029 | | | | LSC | K0047 | | _ |
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| ID Prefix | | | 07/06/2013 | | ID Prefix | | | = | | | - | | |
| _ | NFPA 101 | | | | Reg. # | | | | | Reg. # | | | _ |
| LSC | K0056 | | | | LSC | | | | _ | LSC | | | _ |
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| Reviewed By | , | Reviewed E | | Da | ite: | Signature of S | urvo | wor: | | | | Date: | |
| State Agency | | | -, | | | | | , Joi. | | | | | 12/12 |
| | | PS/sd | D., | | 08/09/1 | | | | | | | | 12/13 |
| Reviewed By CMS RO | | Reviewed E | Э | Da | ite: | Signature of S | urve | yor: | | | | Date: | |
| | | | | | | | | | | | | | |
| Followup to | Survey Comple | | | - | | | - | | | | a Summary of | | |
| | 4/30/ | 2013 | | | | Uncorr | ecte | u Deliciencies | S (C | vio-∠oo/) Sent | to the Facility? | YES | NO |



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5155

August 9, 2013

Mr. Douglas Dewane, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017, H5427019

Dear Mr. Dewane:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint number H5427017 and H5427019. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. The deficiencies not corrected are as follows:

- F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) (4) -- Investigate/report Allegations/individuals
- F0226 -- S/S: E -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies
- F0309 -- S/S: E -- 483.25 -- Provide Care/services For Highest Well Being

In addition, at the time of this revisit, we identified the following deficiencies:

- F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
- F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 will remain in effect
- Federal Civil Money Penalty of \$7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effective
- Federal Civil Money Penalty of \$200.00 per day beginning May 8, 2013 will remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of May 24, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2013.

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.

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 Minnesota Department of Health Midtown Square 3333 West Division, Suite #212 Saint Cloud, Minnesota 56301

Telephone: (320) 223-7338

Fax: (320) 223-7348

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 November 8, 2013 (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

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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.

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

Sincerely,

Mark Weath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

cc: Licensing and Certification File 5427r1_13.rtf

PRINTED: 08/09/2013 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB N | O. 0938-0391 |
|----------------------------|--|--|---------------------|-----|---|--|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | ` | | | | | | R |
| | | 245427 | B, WING | | | 07/ | /24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S1 | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESD | A NH PLEASANTVIEW | | | | 1 SOUTHEAST WILLMAR AVENUE | | |
| | | | · | W | ILLMAR, MN 66201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 000} {F 225} SS=E | An onsite Post Certific conducted on July 22 deficiencies issued as complaint Investigatio H5427019 on May 8, post certification revisively. Allegation of the facility must not elem found guilty of a mistreating residents had a finding entered registry concerning at of residents or misappand report any knowle court of law against an indicate unfitness for several conductions. | cation Revisit was , 23, and 24, 2013, for a result of the survey and n of H5427017 and 2013. As a result of this it survey deficiencies were)(2) - (4) DRT IDUALS Imploy individuals who have busing, neglecting, or by a court of law; or have into the State nurse aide ouse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or se State nurse aide registry | {F 0 | 25} | The facility will ensure that all al violations involving mistreatment neglect, or abuse including injurious and source are reported to the administrator immediately and to state agency per policy. Residents R86, R69, R124, R118, R129 have had bruises of unknown origin fully investigated and report the appropriate state agencies per policy. | leged t, es of he the 3, and vn rted to | 8/30/2013 |
| LABORATORY | The facility must ensulativelying mistreatment including injuries of understanding injuries of understanding injuries of understanding injuries of the additional of the additional of the state survey and certional injuries in progressing attentions are thorough prevent further potent investigation is in progressing in the injuries in progressing in the state of the s | are that all alleged violations of, neglect, or abuse, alknown source and sident property are reported ministrator of the facility and cordance with State law rocedures (including to the fication agency). I evidence that all alleged hly investigated, and must ial abuse while the | 8/27/1 | 5 | Residents R78, R40, R122, R99 and R3 had reports submitted to the state agency and have now had a thorough investigation completed. Policy and procedure for abuse prevention has been reviewed and is current. Management state and professional nurses have been re-educated on conducting full investigation when injuries of unknown origin are found. | e r | (XII) DATE |

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

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

AND A STATE OF THE ST

0-12-10

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

| | OF DEFICIENCIES FOORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|---|--|-------------------------------|--|
| | | 245427 B. WING | | | | R 7/24/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | 112412013 | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| {F 225} | The results of all investo the administrator or representative and to with State law (includicertification agency) y incident, and if the alleappropriate corrective | stigations must be reported his designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified action must be taken. | ₹F 2 | Training regarding investing injuries of unknown original well as behavior managen completed for nursing state CMS Dementia training comodules — we are currently nursing staff on module 1 training will be completed 8/30/2013. The rest of the be completed on a monthly over the next 5 months. | n are found as nent will be ff by 8/30/13. consists of 6 y training all and this by e modules will y schedule | | |
| | This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility falled to ensure allegations of abuse, mistreatment and bruises of unknown origin were thoroughly investigated and reported to the state agency for 5 of 5 residents (R86, R69, R124, R118, and R129) reviewed who had busies of unknown origin. In addition, the facility failed to ensure reports submitted to the state agency included a thorough investigation and/ or were reported immediately to the state agency for 5 of 9 reports made to the state agency for residents R78, R40, R122, R99, and R3. | | The state of the s | Assistant Administrator of be responsible for auditing administrator notification completion of full investig reporting to OHFC per powill be audited x1 month, audits of 3 files will be coweekly x 3 months. Audibe reported to QA commit plans developed as needed | g all files for and gation and licy. All files then random nducted t results will ttee and action | | |
| | the facility which was or reported to the state R86 had diagnosis of quarterly Minimum Da 5/24/13, identified R86 impairment and requir with most activities of | senile dementia. The ta Set (MDS) dated 3 had severe cognitive ed extensive assistance | | R86 - An incident report vand submitted on 8/6/2013 members working in the Munit where R86 resides winterviewed. Investigation completed and submitted Resident does have a histobruising; | 3. Staff Memory Care ere 1 report was on 8/13/2013. | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTIONS | אכ | | SURVEY |
|--------------------------|--|---|--------------------|---|--|--|----------------------------|
| | | o . | A. BOILD | | | | R I |
| | | 245427 | B, WING | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1 | 24/2013 |
| | ROVIDER OR SUPPLIER OA NH PLEASANTVIEW | | | | SS, CITY, STATE, ZIP CODE T WILLMAR AVENUE I 55201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | (EAC | PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E IS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 225} | A facility resident injurdated 7/10/13 indicate calf' measuring 3 cm busies on his left thigh and one measuring 3 left calf measuring 3 left calf measuring 3 cm was "Injuries are consumped on chair. State a chair when he has consumped on chair. State a chair when he has consumped on chair. State chair when he has consumped on the chair when he worked with 1 days to determine if the days to determine if the During interview on 7/2 registered nurse (RN) not match the explana sitting down in the chair chair down in the chair definition of a reportate chair cough investigation. On administrator sent and out an incident report if enough information on one being quite large redid that explain all bruising | itting down in t his thigh and calf on arms own." y/ incident report form d R86 had "bruise on right (centimeters) x 3 cm and 2 measuring 8 cm x 4cm cm x 2 cm and one on his m x 1 cm. The explanation istent with being pinched/ if has seen him bump into ome to sit for meals and in chair." The report did iterviews or names of staff R86 in the past several e bruising came from. 23/13 at 10:00 a.m., A stated R86's bruising did tion regarding the resident ir "hard." She also verified mor origin for R86 was not d and did meet the ble bruise of unknown is was not reported to the mitted an email as part of 7/10/13 at 1:50 p.m. the amail to the nurse who filled including, "I don't have this. Multiple bruising with leeds more investigation. In the email on 7/10/13 at les staff has seen him | {F 2 | and has be members to etc. on obj Walker. Maintenant document observe re legs, etc. of monitoring staff members ombative done for rebehavior a intervention willize who maintenant etc. | ulatory in the Merry Waten observed by multiple to bump his arms, hand jects while in the Merry New interventions were ted including monitoring when staff members esident hit his arms, hand on objects as well as g and documenting when bers observe resident between the best of the best of the second of the sec | le staff, s, legs, | |

| CENTER | O FOR MEDICANE & | MICDIONID SEKAIOES | | | | CIMID IAC | 7. 0830-0381 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULT A. BUILDIN | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 945497 | B. WING _ | | | R | |
| | | 245427 | B. WING _ | | | 07/ | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | \$ | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | • | | 9(|)1 SOUTHEAST WILLMAR AVENUE | | |
| BETHESO | A NH PLEASANTVIEW | | | W | /ILLMAR, MN 66201 | | |
| | OURANAOVAOY | ATTICLE OF BELLIEUMES | | | • | | |
| (X4) ID PREFIX | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA | | (X5) COMPLETION ' DATE |
| TAG | - TOOD HON ON | | TAG | | DEFICIENCY) | | |
| (C OOE) | Castinual From page | .2 | # D | \ | | | , . |
| {F 225} | l | | (F 2 | 20} | | | |
| | | explain all of them. He has | | | | | |
| | | when he has went to sit and | | | | ļ | |
| | has come from both s | ides." | | | | ļ | |
| | | • | | | | | |
| | | lentified R86 had multiple | ļ | | | <i>)</i> | |
| | | rigin, the facility did not | } | | • | . | |
| | | y investigation or report it to | | | | 4 | - |
| | the state agency. | | | | | ļ | |
| | | | | | | | = |
| | | ses of unknown origin | | ļ | DCO An inside the second second | 1.41 | |
| | , , | y which was not thoroughly | | | R69 - An incident report was con | ipietea | |
| | investigated or report | ed to the state agency. | | | and submitted on 8/15/2013. | | |
| | | | | | Investigation report is being com | pleted. | |
| | | cluding dementia. The | | ŀ | Direct care staff members who w | orked | |
| | | 5/10/13 identified R69 had | | | with Resident 69 in the days prior | | |
| | severe cognitive impa | | | | | | |
| | independent with all a | ctivities of daily living. | - | | day of incidents were interviewed | • | |
| | | | | ٠, | Assistant Administrator or interir | n | |
| | | July 2013, did not identify | 1 | ţ | DON. Training regarding | | |
| | the resident had any p | ohysical aggression. | Ì | | investigation when injuries of un | known | |
| | | | | | origin are found as well as behav | | |
| | | dent report form dated | | | | | |
| | | "had a blue fading bruise 7 | | | management will be completed for | or | |
| | | ock, multiple (6) red/ purple | | | nursing staff by 8/30/13. CMS | | |
| | | m (0.5 cm and 0.8 cm), | | į | Dementia training consists of 6 n | nodules | |
| | | asuring 1 cm x 0.8 cm." | 1 | ļ | - we are currently training all nu | | l |
| | | w the injury occurred was | | t | • - | _ | |
| | "Bruise to left buttock | | | | staff on module 1 and this trainin | | |
| | 1 | disciplinary progress notes). | | | be completed by 8/30/2013. The | | |
| | | d bruises to forearm are | | Ĭ | the modules will be completed or | ı a | |
| | | behaviors-hitting and | | | monthly schedule over the next 5 | | |
| | | rowing walkers; see IPN | | | months. Resident died at facility | | |
| | | vestigation did not include | 1 | | • | ŲĮ1 | |
| • | | or did it include who was | | ľ | 8/10/2013. | | |
| | working with the resid | ent when she was | | | | | |
| | combative. | | | | • | | . |
| | | | | | | | |
| | | d 7/5/13, Indicated "At 1400 | | | | 1 | |
| | L resident was found si | tting on her buttocks at the | 1 | | | | i l |

| | OF DEFICIENCIES * F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-----------------------|--|----------|-------------------------------|--|
| | | 245427 | B. WING | | | R 07/24/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW | | • | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST 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 | | HOULD BE | (X5) COMPLETION DATE | |
| {F 225} | foot of the recliner wither, she stated that a recliner to wheelchall R69's IPN notes date indicated "Resident with a staff saying 'you can resident was also king yelling at her to get of supply room" Another Resident injuited and 7/15/13 for R69 "on the left arm a few forearm with a 1.5 cm bruise which are consincluding hitting and a walkers and scooting bumping into things, continues with her lare buttock from her fall of x 1 cm bruise above i left thigh measuring 2 on right hip/ thigh are Consistent with her fat transferring self onto interviews indicated Foruises are from her from the sident and right hip, with sitting on toilet and hitting the edge of it." During Interview on 7 stated R69's bruises state agency. RN-A view of states are recommended. | th her pressure alarm under the was trying to get from her and slipped on the floor." ed 7/9/13 at 11:54 a.m. was up in wheelchair at torning. She was hitting out ant tell me what to do.' cking at housekeeper and ut of the housekeeping ary/ incident report form and incident the resident had small bruises throughout at x 1.5 cm mid forearm elstent with recent behaviors, ticking out at staff, throwing along in her wheelchair and On her back side she ge 10 cm x 7 cm on left ton 7/5/13 along with a 1 cm this one on her inner back of 2 cm x 4 cm. Has one bruise a measuring 4 cm x 2 cm. all on 7/5/13 or from the toilet." The staff RN-C "feels these back side all. This writer toileted all this bruise is consistent and wheelchair too close and all this writer toileted all this bruise is consistent and wheelchair too close and all this writer toileted all this bruise is consistent and wheelchair too close and all this writer toileted all this bruise is consistent and wheelchair too close and all this writer toileted all this writer toile | {F 2 | 225} | | | |

| 1 | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION | | SURVEY PLETED |
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| | | | 7. 60/50/ | | | R |
| | V. | 245427 | 8. WING | | 07/ | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | , | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESO | A NH PLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AVENUE | | |
| | | | | WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE |
| (F 225) | things all the time. SI R69's bruises were exbeing combative and administrator was not incident. Although R69 had munot be explained, and cognitive impairment incombative with care thoroughly investigate the state agency. R124 received bruisin with cares and bruisin held down by staff. The thorough investigation state agency. R124 had diagnoses in disease and psychosi MDS dated 5/10/13 id severe cognitive impairment in the state agency. R124's care plan date had target behaviors of angry at other resident medications. However identify R124 had any combative. | 24/13 at 8:40 a.m. 869 bruising was not 9 stated she bumps into ne also stated she believed kplainable because of her a recent fall. The iffed by email of this Itiple bruising which could the resident had severe and was recently s, the facility did not or report the incidents to g from being combative g of her wrists while being ne facility did not complete a n or report the injury to the ricluding Alzheimer's s. The significant change entified the resident had airment and was an all ADL's. d July 2013, indicated R124 of crying, weepiness, being ats, and refusing care and ar, the plan of care did not | {F 2 | R124 - An incident report we completed and submitted on Investigation report is being Training regarding investigating injuries of unknown origin a well as behavior manageme completed for nursing staff CMS Dementia training commodules — we are currently nursing staff on module 1 are training will be completed be 8/30/2013. The rest of the rebe completed on a monthly over the next 5 months. Direct members who worked with | a 8/13/2013. It completed, ation when are found as int will be by 8/30/13. It is is sists of 6 training all and this by modules will schedule ect care staff Resident | |
| | 7/6/13 indicated R124 right wrist measuring | had bruising on anterior of 2 cm x 2 cm and a bruise | | 124 in the days prior and da were interviewed by Assista Administrator or interim DO | nt | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | • | 245427 | B. WING | | R 07/24/2013 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | 01/24/2010 |
| (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 I CROSS REFERENCED TO THE APPROPRI DEFICIENCY) | 1 |
| {F 225} | was "Resident was b with cares on overnig holding residents wrk staff." The investigat interviews or identify | e 6 of the cause of the bruising eing combative and resistive iht with toileting. Staff ets from hurting herself and ion did not include any staff staff members who was id was "holding the residents | {F 22 | The two alleged perpetrators were interviewed and re-educated by I DON on 8/19/13 and 8/20/13 on Resident Rights, never holding redown, and individualized interve and care for dealing with difficul behaviors. A behavior assessment done for resident on 8/19/13. | nterim esidents ntions t |
| | stated she felt R124's because R124 had be said they needed to h RN-A verified the inve as it did not include a | /23/13 at 10:00 a.m. RN-A s bruising was explainable sen combative and staff had hold her wrists to do cares. estigation was not complete my staff interviews nor did e explain why she should | | | |
| , | administrator stated s residents wrists to do like the bruising was o need to report it. The | /24/13 at 8:40 a.m. the staff should not be holding cares, but, the facility felt explainable so they did not administrator received an ruise of unknown origin on | | | |
| | | | | | |
| - | | unknown origin which the phly investigate or report to | | | |
| | quarterly MDS dated resident had severe o | including dementia. The 4/12/13 Identified the ognitive impairment and sistance with all activities of | | R118 - An incident report was completed and submitted on 8/13 Investigation report is being com | |

| Rande of Provider or Supplier BETHESDA NH PLEASANTVIEW STREET ADDRESS, CITY, STATE, ZIP CODE WILLMAR AVENUE WILLMAR, M. S5201 | | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) MULTIPLI A. BUILDING | ECONSTRUCTION | (X3) DATE SURV COMPLETE | |
|--|-----------|--|---|------------------------------|--|--|------------|
| MAKE OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW O(4) ID PREETX TAG CONTINUED FREGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) RT18's care plan dated July 2013 indicated the resident has a history of skin tears to hands and arms and bruising. The facility provided two Resident Injurylincident report forms for R118, both dated 71/15/13 with the same time of 8:30 p.m. One of the reports indicated the resident had purple bruising to right arm as follows: 8 cm x 4 cm on top of hand, 2 cm x 1 cm on wrist, 2 cm x 1 cm on wrist, 2 cm x 1 cm on wrist, 2 cm x 1 cm on forearm. Purple bruise to left shin 1 cm x 4 cm, and brown bruise to right shin 3 cm x 1.5 cm. The investigation was bruising to right forearm occurred from brumping arm on wheelchair. Bruising to left and right shin occurred from resident legs do touch as they need to for correct use of lift" The second Resident injurylincident report forms for R118 dated 71/17/13 at 8:30 p.m. indicated the resident had purple bruising to fight forearm occurred from pumping arm on wheelchair. Bruising to left and right shin occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears R and L shin bruising occurred from using PAL lift. Transfer has been observed by RN. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules — we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed by a straining wi | | | 245427 | B WING | | | |
| ### SUMMARY STATEMENT OF DEFICIENCIES PRETIX TAG ### SUMMARY STATEMENT OF DEFICIENCIES (#ACH DEFICIENCY MILT BE PRECISED BY YULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### PROPRIED PROPRISED TO THE APPROPRIATE DEFICIENCY TAG ### Direct care staff members who worked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported witnessing any staff members reported witnessing any staff members being rough with resident. While bruising is still unknown, it is suspected by interviews that hand and arm bruising occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears R and L shin bruising occurred from using PAL lift. Transfer has been observed by RN. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for musing staff by 8/30/13. CMS Dementia training consists of 6 modules — we are currently training all nursing staff on module 1 and this training will be completed by \$8/30/20.13. The rest of the modules will standard the presence of the modules will be completed by \$8/30/20.13. The rest of the modules will see the precision of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The rest of the modules will be completed by \$8/30/20.13. The r | MMSOSE | POMPED OR CURRUSE | 210121 | | TREET LIBERTO ANY ATLES TO CORE | 07/24/20 | 173 |
| (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 225) Continued From page 7 dally living. R118's care plan dated July 2013 indicated the resident has a history of skin tears to hands and arms and bruising. The facility provided two Resident Injury/Incident report forms for R118, both dated 7/15/13 with the same time of 8:30 p.m. One of the reports indicated the resident had purple bruising to right arm as follows: 3 cm x 4 cm on top of hand, 2 cm x 1 cm on wrist, 2 cm x 1 cm on forearm. Purple bruise to left shin 1 cm x 4 cm, and brown bruise to right and right shin 3 cm x 1.5 cm. The investigation was bruising appropriate area during use of standing lift. An email sent to the administrator dated 7/17/13, 2 days after the incident report was filled out, indicated "transfer was observed and done correctly; resident legs do touch as they need to for correct use of lift" WILLMAR, MN 58201 Direct care staff members who worked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported writnessing any staff members reported writnessing any staff members reported writnessing any staff members veho vorked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported writnessing any staff members reported writnessing any staff members veho vorked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported writnessing any staff members reported writnessing any staff members veho writensing is still unknown, it is suspected by interviews that hand and arm bruising occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears R and L shin bruising occurred from using PAL lift. Transfer has been observed by RN. Training regarding investigation when injuries of | NAME OF F | ROVIDER OR SUFFLIER | | L | | - | |
| FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (F 225) Continued From page 7 dally living. R118's care plan dated July 2013 indicated the resident has a history of skin tears to hands and arms and bruising. The facility provided two Resident Injury/incident report forms for R118, both dated 7/15/13 with the same time of 8:30 p.m. One of the reports indicated the resident had purple bruising to right arm as follows: 8 cm x 4 cm on top of hand, 2 cm x 1 cm on wrist, 2 cm x 1 cm on forearm. Purple bruise to left shin 1 cm x 4 cm, and brown bruise to right shin 3 cm x 1.5 cm. The investigation was bruising to right forearm occurred from bumping arm on wheelchair. Bruising to left and right shin occurred from resident report was filled out, indicated "transfer was observed and done correctly; resident legs do touch as they need to for correct use of lift" The second Resident Injury/incident report forms for R118 dated 7/15/13 at 8:30 p.m. indicated the | BETHESI | DA NH PLEASANTVIEW | | 1 | | | |
| F 225 Continued From page 7 dally living. | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA | | APLETION] |
| resident had left arm skin tear and brulses. The incident occurred "left arm on lap and forearm was under arm rest and when she pulled arm out skin tear occurred due to bruise already there and fragile skin. The IPN note dated 7/15/13 indicated "while staff was getting resident ready for bed she found a skin tear on left upper forearm that measures 7 cm long that curves at the bottom towards the elbow. The area had fresh blood and arm had been on lap and forearm was under arm rest There is a large bruise on upper forearm to elbow Testident ram skin tear and bruises. The over the next 5 months. 20 random resident transfer audits consisting of any transfer using a transfer belt or mechanical lift including shift, 8 evening shift, and 4 night shift will be completed weekly by LPN or RN staff for 4 weeks. Results will be reviewed to the QA committee and additional action plans developed as needed. | {F 225} | dally living. R118's care plan date resident has a history arms and bruising. The facility provided to report forms for R118 the same time of 8:30 indicated the resident arm as follows: 8 cm cm x 1 cm on wrist, 2 Purple bruise to left sl bruise to right shin 3 c investigation was brui occurred from bumpin Bruising to left and rig residents legs touchin use of standing lift. A administrator dated 7/ incident report was fill was observed and do do touch as they need. The second Resident for R118 dated 7/15/1 resident had left arm sincident occurred "left was under arm rest ar skin tear occurred due fragile skin. The IPN note dated 7/ was getting resident reskin tear on left upper cm long that curves a elbow. The area had been on lap and force | d July 2013 indicated the of skin tears to hands and wo Resident Injury/Incident, both dated 7/15/13 with p.m. One of the reports had purple bruising to right x 4 cm on top of hand, 2 cm x 1 cm on forearm. In 1 cm x 4 cm, and brown cm x 1.5 cm. The sing to right forearm g arm on wheelchair. In the shin occurred from g appropriate area during memail sent to the 17/13, 2 days after the ed out, indicated "transfer me correctly; resident legs it to for correct use of lift" Injury/incident report forms 3 at 8:30 p.m. indicated the skin tear and brulses. The arm on lap and forearm and when she pulled arm out to bruise already there and 1/15/13 indicated "while staff eady for bed she found a forearm that measures 7 to the bottom towards the fresh blood and arm had irm was under arm rest | {F 225} | Direct care staff members who we with Resident 118 in the days priday of incident were interviewed Assistant Administrator or Interir DON. No staff members reported witnessing any staff member being rough with resident. While bruising still unknown, it is suspected by interviews that hand and arm bruing occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears Reshin bruising occurred from using lift. Transfer has been observed a Training regarding investigation injuries of unknown origin are for well as behavior management will completed for nursing staff by 8/2 CMS Dementia training consists modules — we are currently training rursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the module completed on a monthly schedover the next 5 months. 20 random resident transfer audit consisting of any transfer using a transfer belt or mechanical lift in 8 day shift, 8 evening shift, and 4 shift will be completed weekly by or RN staff for 4 weeks. Results reviewed to the QA committee are additional action plans developed | or and by n g ng is sing and L y PAL by RN. when and as 1 be 30/13. of 6 ng all s es will ule s cluding night y LPN will be ad | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | LE CONSTRUCTION | | SURVEY |
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| | | 245427 | B. WING | | 1 . | R /24/2013 |
| | ROVIDER OR SUPPLIER A NH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| {F 225} | where the skin tear is. cm x 5 cm. Multiple is surrounding larger brumultiple bruising all put cm x 4 cm top of hand 1 cm forearm. left shin Right shin 3 cm x 1.5 investigation does not identify of R118 had multiple smexplained. During interview on 7/ administrator stated is straight forward." She of having fragile skin with R118. Although the facility identified bruising which could in | pe and the inside edge is The bruise measures "10 mail .2 cm x .5 cm bruise sise Resident also has urple in color on right arm: 8 d, 2 cm x 1 cm wrist, 2 cm x n 1 cm x 4 cm purple bruise. cm brown bruise" The include any staff interviews on the second report why all bruising which was not 24/13 at 8:40 a.m. the he felt this one "was pretty e stated R118 had a history and bruising is "expected" Jentified R118 had multiple tot be explained, the facility thorough investigation and | {F 225 | 3} | | |
| | the facility which was or reported to the state R129 had diagnoses of psychosis and anxiety dated 7/12/13 indicate | of Alzheimer's disease, . The quarterly (MDS) | | R129 - An incident report of completed and submitted of Investigation report is bein Resident R129 is currently Meeker Memorial Hospital Services due to severe behaviories. | n 8/13/2013. g completed. admitted to Behavioral | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL1 A. BUILDI | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 245427 | B. WING | | · | l | 24/2013 |
| NAME OF F | ROVIDER OR SUPPLIER | <u> </u> | _ | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE | ^ <u> </u> | |
| RETHESI | OA NH PLEASANTVIEW | | | 90 | 01 SOUTHEAST WILLMAR AVENUE | | |
| 5511160 | | | | W | VILLMAR, MN 66201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 225} | R129's current plan of indicated she had mode a secured memory cacare also indicated the and pushes. R129's chas skin impairment mand weakness. R129 her wheelchair she fredesks or residents who lower arms. A facility resident injury 7/5/13 indicated R29 on her right elbow, 3 carm, 1 cm x 1 cm bruicem bruise to top of right bruise on her right had bruise indicated "resided wander in her whoungs herself and has she also has been condestroying belongings will reproach her with (protective clothing) or remove the dermafit at The report Indicated it notified but the state at Review of R129's profindicated at supper residents and to get away from were the door was to into other residents resmash the window to was wondering the directions stating stands to get away from were the door was to into other residents resmash the window to was wondering the directions. | f care dated July 2013 od/behavior issues was on are unit. The current plan of at she curses, hits, kicks care plan further states she elated to decreased mobility has poor vision, when up in equently bumps into tables, leelchairs causing bruises to ry/incident report form dated had a 2.5 cm x 2 cm bruise cm x 2 cm bruise on left ise on left hand, 2 cm x 1.5 ht hand and 2 cm x 1 cm hd. the explanation for the dent has poor vision. She heelchair and she runs and hds and arms on objects. Inhative hitting, scratching, s." The intervention was in putting the dermafit in arms and she does and to wear long sleeves." he administrator was agency was not notified. gress note dated 7/4/13 sident became agitated. taff and refused her he doesn't need that shit her. She was also asking get outside. She was going looms. She stated she would get out. After supper she hing area running into loss." At 5:45 p.m. she was | {F 2 | 25) | Per care plan, resident has poor vision up in wheelchair she freque bumps into tables, desks, or reside wheel chairs causing bruising to I arms. Direct care staff members vision worked with Resident 129 in the oprior and day of incident were interviewed. No staff members rewitnessing any staff members rewitnessing any staff member being rough with resident. Resident receased ASA daily which can increase the severity of bruising. When resident returns to facility, new intervention will include offering resident to whom sleeves and/or Dermafit for protection of her arms. Training regarding investigation when injurunknown origin are found as well behavior management will be completed for nursing staff by 8/3 CMS Dementia training consists of modules — we are currently training nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the module completed on a monthly schedover the next 5 months. | ently ents' ower who days ported lg eives ent ons wear eries of as 30/13. of 6 ang all s es will | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER: | (X2) MULTIPLE A. BUILDING | ECONSTRUCTION | (X3) DATE COMF | \$URVEY PLETED |
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| · | | 245427 | B. WING | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | 240421 | | TREET ADDRESS, CITY, STATE, ZIP COD | | 24/2013 |
| | A NH PLEASANTVIEW | | 9 | MI SOUTHEAST WILLMAR AVENUE VILLMAR, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| {F 225} | (milligram) intramuse her arms down while | e 10 cularly (IM); writer had to hold LPN (licensed practical t due to her swearing, hitting | {F 225} | | | |
| | Nurse Consultant (N does have behaviors chair and strike out. staff should not be he The NC verified as p did not look into the s down as the cause o | 8/13 at 11:09 a.m., with the C)-A who stated that R129 a and will hit the walls, arm of The NC further stated the olding the residents down. art of the investigation they staff holding R129's hands if the bruising. The NC nould have investigated | | • | | |
| | and hands noted after to receive Ativan IM, | te the cause of the bruising. | | R78 - Both NA-F and NA educated regarding Safe P Handling policy and were on following this policy as | atient re-educated | |
| | transferring. The sta | ate agency was not notified a thorough investigation | | individualized resident car Corrective actions were co both NAs on 7/21/13. R7 | re planning. ompleted with | |
| | hip/joint pain. The quidentified the residen | ncluding dementia and uarterly MDS dated 5/3/13, It had severe cognitive led extensive assistance with | | evaluated for transfer abili random resident transfer a consisting of any transfer transfer beit or mechanica 8 day shift, 8 evening shif | udits using a l lift including | |
| | required extensive as belt or a PAL or hove resident strength and | • | | shift will be completed we or RN staff for 4 weeks. I reviewed to the QA commadditional action plans de- | eekly by LPN Results will be nittee and | |
| | The facility submitted | d an incident report to the the | | needed. | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TPLE CONSTE | '. | | | E SURVEY PLETEO |
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| | | 245427 | B. WING | | , . | <u>-</u> · | 1 | R //24/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW | | | 901 SOUT | ADDRESS, CITY, STA THEAST WILLMAR AR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION SHOULD ICED TO THE APPROPRICIENCY) | DBE | (X5) COMPLETION DATE |
| {F 225} | "two staff members of transfer from her red Resident began to fa floor by staff. Abrasiside caused by rubb during fall. No transfalthough the inciden was not reported to to 7/21/13, one day after to the state agency ru"Care plan was not transfer belt was belt transfer belt was belt agency of the state agency rule"Care plan was not transfer belt was belt transfer belt was belt agency rule" | 7/21/13 identifying on 7/20/13 were assisting resident to were assisting resident to welliner to her wheelchair. all and was lowered to the ston present to residents right oing against seat of wheelchair ofer belt used during transfer." It occurred on 7/20/13, this the state agency until | {F 23 | 25) | | | | |
| | included a verbal wa present at the time of During interview on a facility administrator | ficated "Corrective action arning for both staff members of the fall" 7/24/13 at 8:40a.m. the stated she was unsure who ars that were not transferring | To the state of th | | | | | |
| | verified this was not | e plan of care of 7/20/13. She reported immediately to the reported the next day. | | | | | | |
| | administrator stated R78 according to the | 7/24/13 at 9:45 a.m. the i the staff who did not transfer e plan of care on 7/20/13 was wn) nurse as nursing d NA-H, | | \$. | | | | : |
| | | ective action was requested but was not provided by the | | | · · · · · · · · · · · · · · · · · · · | | | |
| | R40 was identified t | by the facility as experiencing | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
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| | | 245427 | B, WING | | | R |
| NAME OF D | ROVIDER OR SUPPLIER | 240421 | | STREET ADDRESS, CITY, STATE | TIRANDE | 07/24/2013 |
| IAMMC OF PI | TO VIDER OR SUPPLIER | | | | • | |
| BETHESD | A NH PLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AV | ENUE | |
| | | | | WILLMAR, MN 58201 | | |
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| | | | - | R40 - Staff member | s that were wo | rking |
| {F 225} | Continued From page | 12 | {F 2 | 25) with R40 at the time | e around the in | cident |
| | staff neglect at the fac | cility on 7/3/13. Although the | | have been identified | and were | |
| | | the state agency, the | | interviewed. CNA | | III.OTO |
| | | omplete as there were no | | 1 | | 1 |
| | | ff identified who had been | | re-educated on TAE | | |
| | working with R40. | | | Interim DON or des | ignee will con | nplete |
| | | | | 10 random audits or | TAB/pressure | e i |
| | R40 had diagnoses in | cluding Alzhelmer's | | alarm checks per we | | |
| | disease. The quarter | ly MDS dated 4/12/13, | | Audit results will be | | |
| | identified the resident | had severe cognitive | | l l | | ' I |
| | Impairment and need | ed extensive assistance with | | committee and action | n pians deveic | pea |
| | all ADL's. | | | as needed. | | |
| | resident was at risk fo | I July 2013 indicated the or falls and the resident had ed and a body pillow and | | | | , |
| | concave mattress wh | | | · | | |
| | identified R40 "was fo | | | | | |
| | The lessestimative serv | and authoritized to the state | | | | |
| | | ort submitted to the state ays after the initial report | | | | |
| | | stated TAB alarm and | | | | ļ |
| | | used while in bed. Care | | , | | Ì |
| | | re not being followed as the | | | • | |
| | | ound to be unplugged when | | " | • | |
| | | ne floor by her bed Staff | | | | |
| | | nformation was inconclusive | | | | |
| | | larm was plugged in the | | | | |
| | | en it became unplugged. | | | | |
| | | e they had the TAB alarm | | | | |
| | | she went to bed but not | 1 | | | |
| | | larm Nursing staff from | | | | |
| | | and reported [R40] removes | | | • | |
| | | also was not sounding | | | | |
| | | the pressure alarm. The | | | | 1 |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
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| | | 245427 | B. WING | | R 07/24/2013 |
| | ROVIDER OR SUPPLIER | , | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | V112412013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| {F 225} | 6:30 a.m. but not sure Staff on all shift will be | ed when night staff left at of the pressure alarm a re- educated." | {F 22 | 5} | |
| • | interviewed or what st the time of the neglect | tere was no further related to which staff were aff were caring for R40 at t. The administrator verified t was submitted on 7/9/13, | | | |
| | incident with R40 was The facility submitted agency regarding neg | arding the 7/3/13 neglect requested but not provided. three reports to the state lect and possible abuse by | | | · |
| | the facility did not sub | 22, R99, and R3. However, mit a thorough investigation agations and pattern of by NA-E. | | | |
| | | dated 5/31/13 identified the ecognitive impairment and stance with all ADL's. | | R122 - Tracking system has bee implemented to identify name or caregiver that is involved in each resident incident in order to determine the care of | f n |
| | details indicated the re NA-E "is mean, he ma than sit in recliner, he | 2 on 5/4/13. The incident esident and wife stated that likes me lay in bed rather wants to put me in my at to sit in my recliner and estime." The date the | | a pattern with a certain caregive occurring with incidents. Reside interviewed. NA-E did resign fracility on 7/3/2013. | ent was |
| | agency regarding the | rt submitted to the state Incident with R122 and days after the initial report. | | • | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | ONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 245427 | B. WING | | | | R 24/2013 |
| | ROVIDER OR SUPPLIER | | | 901 | REET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / 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 |
| {F 225} | prefers to stay in his r when planning his tim of his residents needs to assist [R122] to his [NA-E] went on to tell my residents reside residents were interviregarding NA-E was "light." "[NA-E] is care report did not identify allegations of mistrea resident R99 and R3. R99 annual MDS date resident had no cogniextensive assistance." | cated, NA-E stated "R122 ecliner until after 5:00 p.m e and attempting to meet all s, there were times he had wheelchair at 4:45 p.m writer, I would never hurt nts interviewed" Multiple ewed and the response He is quick to answer call ful with transfers." The that NA-E had a pattern of tment made by two other ed 4/26/13 identified the tive impairment and needed with ADL's. | {F 2 | R iii c r a | 199 - Tracking system has been inplemented to identify name of aregiver that is involved in each esident incident in order to deter pattern with a certain caregiver ccurring with incidents. Residen | mine if is | |
| | R99 indicated the resist throws me into bed and the day and evening was identified as NA-I The investigative reportegarding R99 indicated has been positive. The investigative response regarding Nanswer call light." "[Nansfers." There was regarding the other all maltreatment made both NA-E was interviewed any incident as description of the day incident as descriptions. | ident stated "that one aide and stated this happened in ." The alleged perpetrator The alleged per | | iı | ccurring with incidents. Residenterviewed. NA-E did resign from acility on 7/3/2013. | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | A. BUILU | | | R |
| | | 245427 | B, WING | | 1 | 24/2013 |
| | ROVIDER OR SUPPLIER A NH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP COT 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | N SHOULD BE | (X5) COMPLETION DATE |
| {F 225} | resident had no cogn extensive assistance R3 reported allegatio from NA-E and an invalent testing the state incident details on the 6/4/13 indicated "Dur surveyor that a staff during cares. She all reported this at her la | ted 6/7/13 identified the itive impairment and needed with ADL's. Ins of staff maltreatment vestigative report was a agency on 6/4/13. The ereport to the state on ing survey, [R3] informed person was rough with her so stated that she had lest care conference" The 6/8/13 and this was not | ₹ F 2 | R3 - Tracking system has implemented to identify rearegiver that is involved resident incident in order a pattern with a certain ca occurring with incidents. interviewed. NA-E did refacility on 7/3/2013. | name of in each to determine if tregiver is Resident was | |
| | agency dated 6/7/13 surveyor a staff person Writer Interviewed [R recall informing the stated his fastMultiple resident response regarding hanswer call light." "[N transfers." NA-E was remember any incident There was nothing in the pattern of allegational treatment made halthough the facility in possible neglect and residents R122, R99 complete a thorough | nts were interviewed and the NA-E was "He is quick to NA-E] is careful with Interviewed and does not ent as described by R99. the investigation regarding ions of neglect and | | | | |
| _ | NA-E resigned from | the facility 7/3/13. | | · | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUM | IDEO: | E CONSTRUCTION | (X3) DATE SURVEY |
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| · | A. BUILDING | | COMPLETED |
| 245427 | B. WING | | R 07/24/2013 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | 0712412013 |
| | | 901 SOUTHEAST WILLMAR AVENUE | |
| BETHESDANH PLEASANTVIEW | | WILLMAR, MN 56201 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY I TAG REGULATORY OR LSC IDENTIFYING INFORMA | FULL PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 226} SS=E 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement we policies and procedures that prohibit mistreatment, neglect, and abuse of reside and misappropriation of resident property. This REQUIREMENT is not met as evident by: Based on interview and document review, facility failed to ensure the facility policy was followed regarding investigating and reportion allegations of abuse/mistreatment and bruis unknown origin for 5 of 5 resident with bruis unknown origin reviewed, R86, R69, R124, and R129. In addition, the facility failed to ensure the apolicy was followed regarding submitting resident to the state agency which included a thorous investigation and/or reporting immediately state agency for 5 of 9 reports reviewed the sent to the state agency for residents R78, R122, R99, and R3. Findings include: The facility Abuse Prevention Policy/ Proceedated 5/7/13 indicated "All alleged violation mistreatment, neglect, abuse, injury of unknowingin, and misappropriation of resident prowill be reported immediately to the Administ OHFC (state agency) All alleged mistreat abuse, neglect, injuries of unknown origin be investigated by doing the following Immediately report alleged incident to administrator. Complete a resident incident injury report form and submit report to state | ritten ints ced the is ing sing of ses of R118 abuse eports ugh to the at were R40, dure is of nown perty trator, ment, will | The facility will develop and importation policies and procedures the prohibit mistreatment, neglect, an abuse of residents and misappropriof resident property. Residents R86, R69, R124, R118 R129 have had bruises of unknown origin fully investigated and report the appropriate state agencies perpolicy. Residents R78, R40, R122, R99 and R3 had reports submitted to the state agency and have now had a thorough investigation completed. Policy and procedure for abuse prevention has been reviewed and current. Management staff and professional nurses have been reeducated on conducting a full investigation when injuries of unknown origin are found. Training regarding investigation injuries of unknown origin are for well as behavior management will completed for nursing staff by 8/3 CMS Dementia training consists of modules — we are currently training nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the module be completed on a monthly schedover the next 5 months. | at d dictation , and on ted to when and as l be 0/13. of 6 ag all at the case will |

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| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | · | | ļ | 801 SOUTHEAST WILLMAR AVENUE | |
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| (F 226) | involved staff. Intervie | o 17 colved staff, co-workers of ow involved resident, other ony witnessesThe facility | {F 226 | Assistant Administrator or design be responsible for auditing all file administrator notification and completion of full investigation a | es for and |
| | of the findings to the s working days The re following information a | as available: Name of | | reporting to OHFC per policy. A will be audited x1 month, then ra audits of 3 files will be conducted weekly x 3 months. Audit result: | ndom d |
| | perpetrator or staff res including job title, soci | al security number, date of | | be reported to QA committee and plans developed as needed. | |
| | maltreatment" The | ree, any prior incidents of definition of injury of ne policy was, "An injury | | | |
| | source when both the met: The source of th by any person or the s | s injury of unknown origin or following conditions are le injury was not observed source of the injury could | | | |
| | suspicious because o the location of injury (an area not generally | te resident and the injury is of the extent of the injury or eg. the injury is located in vulnerable to trauma) or the served at one particular | | | |
| | point in time or the inc Physical abuse: Inclu | ident of injuries over time des hitting, slapping, spitting, holding roughly, etc. lling behavior through | | | |
| | R86 had a bruise of u | inknown origin identified by not thoroughly investigated e agency per facility policy. | | R86 - An incident report was con and submitted on 8/6/2013. Staff members working in the Memory | f |
| , | quarterly minimum da Identified the resident | ed extensive assistance | | Unit where R86 resides were interviewed. Investigation report completed and submitted on 8/13 Resident does have a history of bruising; | |
| | R86's care plan dated | July 2013, indicated "staff | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | ECONSTRUCTION | (X3) DATE | |
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| (X4) ID | · SUMMARYST | ATEMENT OF DEFICIENCIES | 10 | PROVIDER'S PLAN OF CORRE | | (X5) |
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| | | | | he is ambulatory in the Merr | | |
| {F 226} | Continued From page | 18 | {F 226 | and has been observed by m | ultiple staff | |
| - | will assist [R86] with a | sitting down in | [| members to bump his arms, | hands, legs, | |
| | | it his thigh and calf on arms | | etc. on objects while in the M | Aerry | |
| | of chair when sitting of | lown." | | Walker. New interventions | | |
| | | and to state and make a 1 feet and | L. Company | implemented including mon | | |
| I | | ry/ incident report form ed R86 had "brulse on right | | documenting when staff men | • | |
| | | ed R86 nad "bruise on right 3 cm and 2 busies on his left | ļ | observe resident hit his arms | | |
| | | x 4cm and one measuring | | | | |
| | | on his left calf measuring 3 | | legs, etc. on objects as well | | . |
| | | anation was "injuries are | | monitoring and documenting | | |
| | | pinched/ bumped on chair. | | staff members observe resid | _ | - |
| i | | ımp into a chair when he | | combative by noting how he | | |
| | | eals and from sitting down | | combative. A behavior asses | | 1 |
| | | eport did not include any staff | | done for resident on 8/12/20 | 13 – the | |
| | the resident in the pa | of staff who had worked with | Ì | behavior assessment include | s a list of |] |
| | · | | | interventions for staff to atte | mpt to | |
| | During Interview on 7 | | 1 . | utilize when R86 becomes c | | |
| • | |)-A stated R86's bruising did | | Maintenance department wa | s notified | |
| | not match the explan- | ation regarding the resident air "hard." She also verified | | on 8/13/2013 to request for 1 | resident's | |
| | the bruteing of unknown | wn origin for R88 was not | | bed to be evaluated. | | 1 |
| | thoroughly investigate | | | | , | i |
| | | ble bruise of unknown | | | | |
| | | his was not reported to the | Į | | | |
| | state agency per faci | lity policy. | | | | |
| 1 | | in the day and the mades | | | | - |
| [| | bmitted an email as part of 7/10/13 at 1:50 p.m. the | | | • | |
| į | administrator sent an | email to the nurse who filled | | | | |
| <u> </u> | out an incident report | | | <u> </u> | | |
| · | | n this. Multiple bruising with | | | | |
| | | needs more investigation. | | | | 1 |
| | | ent bump chair? If so, does | | | | |
| | | ng on both legs and thigh?" | | | | |
| | | in the email on 7/10/13 at | | | | |
| | | Yes staff has seen him | | · · | • | |
| | | en going to sit down for | | | | |
| 1 | I meais and yes it doe | s explain all of them. He has | | · | | <u> </u> |

| | o o o o o o o o o o o o o o o o o o o | | | | | - C171D 11C | 7, 0000 0001 |
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| | | 245427 | B, WING | | | 1 | R |
| | | 240721 | D. 11110 | | | 07/ | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | ı | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESD | ANH PLEASANTVIEW | | | 9 | 01 SOUTHEAST WILLMAR AVENUE | • | |
| | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | ۷ | NILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {F 226} | has come from both s Although the facility ic bruises of unknown o | when he has went to sit and ides." dentified R86 had multiple rigin, the facility did not y investigation or report it to . | {F 2 | · | | | |
| | investigated or report facility policy. R69 had diagnoses in quarterly MDS dated resident had severe owas independent with R69's care plan dated the resident had any page 12. | y which was not thoroughly ed to the state agency per cluding dementia. The 5/10/13 identified the ognitive impairment and all activities of daily living. I July 2013, did not identify ohysical aggression. | | | R69 - An incident report was con and submitted on 8/15/2013. Investigation report is being com Resident died at facility on 8/10/Direct care staff members who with Resident 69 in the days prid day of incidents were interviewed Assistant Administrator or interi DON. Training regarding investigation when injuries of ur origin are found as well as behave management will be completed to | apleted. 2013. vorked or and d by m | |
| · | 7/10/13 indicated R6s cm x 9 cm to left butto bruises to right forear scab to right knee me The explanation of ho "Bruise to left buttock 7/5/13- see IPN (interright knee and bruises with recent behaviors staff/ throwing walker. The investigation did interviews nor did it in the resident when she | disciplinary notes). Scab to a to forearm are consistent to forearm are consistent to forearm are consistent at second and kicking out at second and kicking out at second include any staff clude who was working with a was combative. | | | nursing staff by 8/30/13. CMS Dementia training consists of 6 n we are currently training all nu staff on module 1 and this trainin be completed by 8/30/2013. The the modules will be completed o monthly schedule over the next s months. | nodules rsing ng will rest of n a | |
| | dated 7/15/13 for R69 | ry/ incident report form indicated the resident had small bruises throughout | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI | | | | | (X3) DATE COMP | SURVEY LETED |
|--|--|---------------------|---------|---|------------|---|-------------------|----------------------------|
| | 245427 | B. WING_ | | | | | R 07/24/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | , | 901 SOU | ADDRESS, CI THEAST WIL AR, MN 662 | LMAR AVEN | | • | . |
| PREFIX (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CO | PRECTIVE A | OF CORRECTION CTION SHOULD E O THE APPROPRI NCY) | | (X5) COMPLETION DATE |
| bruise which are consincluding hitting and k walkers and scooting bumping into things. continues with her land buttock from her fall of x 1 cm bruise above the left thigh measuring 2 on right hip/ thigh area Consistent with her fall transferring self onto interviews indicated Fibruises are from her fall consistent and right hip/ | x 1.5 cm mid forearm istent with recent behaviors, icking out at staff, throwing along in her wheelchair and On her back side she ge 10 cm x 7 cm on left on 7/5/13 along with a 1 cm his one on her inner back of cm x 4 cm. Has one bruise a measuring 4 cm x 2 cm. If on 7/5/13 or from | (F 22 | 26} | | | | | |
| During interview on 7/stated R69's bruises value agency per facil resident being "combifor bruising and this sand investigated. During interview on 7/sadministrator stated Freported because the into things all the time believed R69's bruise of her being combative administrator verified state agency per facil. | R69 bruising was not resident stated she bumps e. She also stated she swere explainable because re and a recent fall. The this was not reported to the lity policy. It policy. It persident had severe and was recently | | | | | | | |

| | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|----------------------------|--|--|
| | | , | / Bollon to | | R |
| - | | 245427 | B. WING | | 07/24/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| {F 226} | with cares and staff wrists. The facility did investigation or report facility policy. R124 had diagnoses disease and psychos MDS dated 5/10/13 is severe cognitive impressive assist with R124's care plan date had target behaviors angry at other resider medications. However identify R124 had any combative. | facility policy. Ing from being combative was holding the residents of not complete a thorough to the state agency per sincluding Alzheimer's is. The significant change dentified the resident had airment and was an all ADL's. Indicated R124 of crying, weepiness, being ints, and refusing care and er, the plan of care did not y behaviors of being | {F 226 | | ed on g sident f incident The y Interim on residents |
| | 7/6/13 indicated R124 right wrist measuring on posterior of right h cm. The description was "Resident was be with cares on overnig holding residents wrist staff." The investigati interviews or what stawho was "holding the During interview on 7, stated she felt R124's because the resident staff had said they ne cares. RN-A verified | ident report form dated I had bruising on anterior of 2 cm x 2 cm and a bruise and measuring 7.5 cm x 4.5 of the cause of the bruising eing combative and resistive hit with toileting. Staff on did not include any staff off was working with R124 residents wrists." IZ3/13 at 10:00 a.m. RN-A is bruising was explainable had been combative and eded to hold her wrists to do the investigation was not include any staff interviews | | and care for dealing with diffice behaviors. Training regarding investigation when injuries of origin are found as well as behaviors are found as well as behaviors are found as well as behaviors staff by 8/30/13. CMS Dementia training consists of 6 we are currently training all staff on module 1 and this training be completed by 8/30/2013. The modules will be completed monthly schedule over the next months. | ault unknown avior i for modules nursing ning will he rest of on a |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ECONSTRUCTION | | X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|----------------------|---|--|----------|------------------------------|--|
| | | 245427 | B. WING | _ | | l | R (24/2042 | |
| | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | <u> </u> | /24/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 226} | should have bruising, have been reported to investigation was not a dimensional provided investigation was not a diministrator stated a residents wrists to do like the bruising was a need to report it. Although the facility id R124's wrists to do carelated to it; the facility investigate or report it according to facility possible to the facility did not thorough the state agency per from the facility provided the resident has a history arms and bruising. The facility provided the report forms for R118, the same time of 8:30 indicated the resident arm as follows: 8 cm | embative explain why she RN-A verified this should the state agency and the complete. 24/13 at 8:40 a.m. the taff should not be holding cares, but, the facility felt explainable so they did not dentified staff had to hold res and she had bruising y did not thoroughly to the state agency elicy. Inknown origin which the high investigate or report to acility policy. Including dementia. The large the condition of skin tears to hands and the of skin tears to hands and two Resident injury/incident both dated 7/15/13 with p.m. One of the reports had purple bruising to right x 4 cm on top of hand, 2 | {F 2 | | R118 - An incident report was completed and submitted on 8/13. Investigation report is being comp Staff members working during the | oleted. | | |
| | | cm x 1 cm on forearm. nin 1 cm x 4 cm, and brown m x 1.5 cm. The | | | timeframe of the incident will be interviewed for further details. | | | |

| OLIVILIN | O I OR MEDIOLITE OF | HEDIOLID OF HAIDEO | | | | 011101110 | |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | (X3) DATE COMP | |
| | | , | | | | F | ₹. |
| | | 245427 | B. WING | | | 07/2 | 24/2013 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | \$ | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESD | A NH PLEASANTVIEW | · | 1 | 90 | 01 SOUTHEAST WILLMAR AVENUE | • | |
| DE111.20D | 7.11.11.12.7.01.11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1 | | | W | /ILLMAR, MN 66201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | (D PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X6) COMPLETION DATE |
| {F 226} | residents legs touchir use of standing lift. A administrator dated 7, incident report was fill was observed and do do touch as they need to touch as they need to touch as they need for R118 dated 7/15/1 resident had left arm incident occurred "left was under arm rest askin tear occurred dufragile skin. The IPN indicated "while staff for bed she found a storearm that measure the bottom towards the bottom towards the bottom towards the staff of | sing to right forearm og arm on wheelchair. tht shin occurred from og appropriate area during on email sent to the f17/13, 2 days after the led out, indicated "transfer one correctly; resident legs of to for correct use of lift" injury/incident report forms 3 at 8:30 p.m. indicated the skin tear and bruises. The term on lap and forearm ond when she pulled arm out the to bruise already there and note dated 7/15/13 was getting resident ready | {F 2 | 26} | Direct care staff members who we with Resident 118 in the days priced day of incident were interviewed a Assistant Administrator or Interim DON. No staff members reported witnessing any staff member being rough with resident. While bruising still unknown, it is suspected by interviews that hand and arm bruis occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears Reshin bruising occurred from using lift. Transfer has been observed by Training regarding investigation vinjuries of unknown origin are for well as behavior management will completed for nursing staff by 8/3 CMS Dementia training consists of modules — we are currently training nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the module be completed on a monthly schedover the next 5 months. | or and by g ng is sing and L PAL y RN. when und as l be 0/13. of 6 ng all ses will | |
| | x 1 cm wrist, 2 cm x 1 x 4 cm purple bruise. brown bruise" The include any staff inter why on the second re | cm forearm. left shin 1 cm Right shin 3 cm x 1.5 cm investigation does not views nor does it include | | | | | |
| | administrator stated s | /24/13 et 8:40 a.m. the the felt this one "was pretty a stated R118 had a history | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | ΠPL | E CONSTRUCTION | (X3) DATE | |
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| ANDPLANO | CORRECTION | IDENTIFICATION NUMBER: | A, BUILD | ING. | | | PLETEO |
| | | 245427 | B. WING | | | l | R /24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESE | A NH PLEASANTVIEW | | | | 901 SOUTHEAST WILLMAR AVENUE | | |
| | 1 | | | ¹ | WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (XS) COMPLETION DATE |
| (F 226) | with R118. | and bruising is "expected" | {F 2 | 226) | | | |
| | bruising which could n failed to ensure a com | entified R118 had multiple ot be explained, the facility plete investigation was agency was notified per | | | R129 - An incident report was completed and submitted on 8/13/ | | - |
| | the facility which was or reported to the state | inknown origin identified by not thoroughly investigated agency per facility policy. | | | Investigation report is being comp Resident R129 is currently admitt Meeker Memorial Hospital Behav Services due to severe behavioral | ed to | |
| | psychosis and anxiety dated 7/12/13 indicate | of Alzheimer's disease, The quarterly (MDS) d she was cognitively extensive assistance with | | | concerns. Per care plan, resident poor vision, when up in wheelcha frequently bumps into tables, desiresidents' wheel chairs causing br | ir she s, or | |
| | a secured memory ca care also indicated tha and pushes. R129's o has skin impairment re and weakness. R129 her wheelchair she fre desks or residents who | care dated July 2013 ad/behavior issues was on re unit. The current plan of it she curses, hits, kicks are plan further states she elated to decreased mobility has poor vision, when up in quently bumps into tables, selchairs causing bruises to | And the second s | | to lower arms. Direct care staff members who worked with Resid 129 in the days prior and day of it were interviewed. No staff membereported witnessing any staff membeing rough with resident. Reside receives ASA daily which can income the severity of bruising. When res | ncident ers aber nt rease ident | |
| | 7/5/13 indicated R29 h on her right elbow, 3 c arm, 1 cm x 1 cm bruise cm bruise to top of right bruise on her right han bruise indicated "resid does wander in her wh | y/incident report form dated a 2.5 cm x 2 cm bruise m x 2 cm bruise on left se on left hand, 2 cm x 1.5 at hand and 2 cm x 1 cm d. the explanation for the ent has poor vision. She eelchair and she runs and ads and arms on objects. | 1 | | returns to facility, new intervention will include offering resident to whom sleeves and/or Dermafit for protection of her arms. Training regarding investigation valuations of unknown origin are for well as behavior management will completed for nursing staff by 8/3 | vhen und as | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED | |
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| | | 045407 | | | · · · · · · | ì | ₹ |
| | | 245427 | B. WNG | | | 07/ | 24/2013 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ı | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| RETHESD | A NH PLEASANTVIEW | | | 9 | 801 SOUTHEAST WILLMAR AVENUE | | |
| 22111200 | | | | ١ | WILLMAR, MN 56201 | | |
| (X4) ID | SUMMARYSTA | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | - | (X5) COMPLETION |
| PREFIX TAG | | MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE |
| | | | | | , | | |
| | | • | | | CMS Dementia training consists | | |
| {F 226} | Continued From page | | {F 2 | 26} | modules - we are currently traini | ng all | |
| | | mbative hitting, scratching, | | | nursing staff on module 1 and thi | S | |
| | | ." The intervention was | | | training will be completed by | | |
| | "will reproach her with | | | | 8/30/2013. The rest of the modul | es will | |
| | (protective clothing) o | | | | | | |
| | | nd to wear long sleeves. | | | be completed on a monthly sched | uic | |
| | The report indicated the | | - | | over the next 5 months. | İ | • |
| | notified but the state a | gency was not notified. | | | | | |
| | Paview of P120's prov | gress note dated 7/4/13 | | | | | |
| | | sident became agitated. | | | | | |
| | | if and refused her med's | | | • | | |
| | | ed that shit and to get away | | | | | |
| | | so asking were the door | | | | | |
| | | ne was going into other | | | | | |
| | | stated she would smash | | | | i | |
| | the window to get out. | After supper she was | | | | | • |
| | wondering the dining a | | | | | | |
| ļ | | s." At 5:45 p.m. she was | | | | ٠. | |
| | given Ativan (antianxi | | | | | | |
| | | larly (IM); writer had to hold | | | | | · |
| | | .PN (licensed practical | | | | | - |
| | | due to her swearing, hitting | | | | | |
| | and scratching." | | | | | | |
| | During intendess 7/23/ | 13 at 11:09 a.m., with the | } | | | | |
| | |) who stated that R129 | | | | | |
| | | and will hit the walls, arm of | | | | | |
| | | he NC further stated the | | | | | |
| | | ding the residents down. | | | | | |
| | | rt of the investigation they | | | | | |
| | did not look into the st | aff holding the residents | | | | | |
| ` | | use of the bruising. The | | | , | | . |
| | , | should have investigated | | 1 | | | · 1 |
| l . | further. | | | | | | } |
|] | | | | | · | ĺ | |
| | | ultiple bruises on her arms | | | | ļ | , l |
| | | her hands were held down | | | | l | |
| ∮ | to receive Ativan IM, t | | | | · | ľ | ' [|
| | morougnly investigate | the cause of the bruising or | | | · | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | | | DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------|-----|---|---|----------------------------|--|
| | | 245427 | B. WING | _ | | | R 24/2013 | |
| | ROVIDER OR SUPPLIER | | | . 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 226} | Continued From page report it to the state as policy. The facility did not reptransferring R78 to the or submit a thorough it the staff names according R78 had diagnoses in hip/joint pain. The qualidentified the resident impairment and needed ADL's. R78's care plan dated required extensive as belt or a PAL or hoyer resident strength and The facility submitted state agency dated 7/2" two staff members we transfer from her reciling Resident began to fall floor by staff. Abrasio side caused by rubbin | gency according to facility fort staff neglect in a state agency immediately nvestigation which included ding to facility policy. cluding dementia and arterly MDS dated 5/3/13 had severe cognitive ad extensive assistance with July 2013, identified R78 sist of two staff with a gait lift, depending on the pain level that day. an incident report to the the 21/13 identifying on 7/20/13 ere assisting resident to | {F 2 | 26} | | been cated s ing. d with e re- andom of any ift, 8 II be staff ewed nal | | |
| | was not reported until The investigative reported to the state agency remained in transfer belt was being investigation did not lo | rt dated 7/21/13 submitted garding R78 indicated, | | | | | | |
| , | | members present at the | | | | , | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | | | |
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| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | łG | | LETED | |
| | | 245427 | B. WING | | i i | R 24/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | A4/AV (J | |
| RETHESO | A NH PLEASANTVIEW | | ŀ | 901 SOUTHEAST WILLMAR AVENUE | | | |
| | | | | WILLMAR, MN 66201 | • | | |
| (X4) ID PREFIX . TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | |
| {F 226} | Continued From page | 27 | {F 22 | 26} | | | |
| | the two staff were not to the plan of care of | tated she was unsure who transferring R78 according 7/20/13. She verified this lediately to the state agency, | | | | | |
| · · | administrator stated to R78 according to the | /24/13 at 9:45 a.m. the he staff who did not transfer plan of care on 7/20/13 was n) nurse were NA-F and | | | - | | |
| | Education and correct for NA-F and NA-H but | tive action was requested it was not provided. | | | ٠. | | |
| | staff neglect at the factorial facility reported this to investigation was inconstaff interviews or staff working with the residence of the factorial factor | cluding Alzheimer's ly MDS dated 4/12/13 | | R40 - Staff members that with R40 at the time around have been identified and interviewed. CNA staff re-educated on TAB/presenterim DON or designed 10 random audits on TA alarm checks per week x | und the incident were members were ssure alarm use. e will complete B/pressure | | |
| | all ADL's. R40's care plan dated resident was at risk for | ed extensive assistance with I July 2013 indicated the or falls and the resident had ed and a body pillow and | | Audit results will be repo committee and action pla as needed. | orted to QA | | |
| | identified R40 "was fo | e state agency dated 7/3/13 ound on floor by her bed at sident was incontinent of There was no further | , | | | | |

| CLITICIT | O I OI WILLDION IL O | MCBION NO CENTROLO | | | | | | |
|--------------------------|--|---|--------------------|--|--|-----------|-------------------------------|--|
| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1'' | | DISTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | | A BUILD | NG | | | R. | |
| | | 245427 | B. WING | | | 07 | //24/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | | |
| BETHESD | A NH PLEASANTVIEW | | | | SOUTHEAST WILLMAR AVENUE | • | | |
| | | | <u></u> | WIL | LMAR, MN 58201 | | | |
| (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 COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| (F 226) | Continued From paginformation on the ini | | {F 2 | 26) | | | | |
| | agency on 7/9/13, 6 of indicated, "Care plan pressure alarm to be plan interventions we pressure alarm was f [R40] was found on twas interviewed and as to if the pressure evening before or whe Evening staff did staic clipped to [R40] when sure of the pressure day shift interviewed TAB alarm and that if when she fell nor wa TAB alarm was attacted. | ort submitted to the state days after the initial report stated TAB alarm and used while in bed. Care are not being followed as the ound to be unplugged when the floor by her bed Staff information was inconclusive alarm was plugged in the en it became unplugged. The they had the TAB alarm as she went to bed but not alarm Nursing staff from and reported [R40] removes the pressure alarm. The hed when night staff left at e of the pressure alarm | | | | | | |
| | Staff on all shift will be During interview on a administrator stated investigation available interviewed or what so the time of the negle the investigative report 6 days after the initial Education for staff re- | re re- educated." 1/24/13 at 8:40 a.m. the there was no further e related to which staff were staff was caring for R40 at ct. The administrator verified out was submitted on 7/9/13, | | | | | | |
| | The facility submitted agency regarding ne NA-E for residents R the facility did not su | d three reports to the state glect and possible abuse by 122, R99, and R3. However, bmit a thorough investigation legations of | | Victoria de la constitución de l | | | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------|---|--|---------------|---|--|--------------------|--|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A, BUILDING | | • | COMPLETED | |
| | | 245427 | B. WING | | 1 | ₹ 0.4/0040 | |
| NAME OF D | ROVIDER OR SUPPLIER | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 077. | 24/2013 | |
| | KOVIDEK OK OUT TEEK | | - 1 | 801 SOUTHEAST WILLMAR AVENUE | • | • | |
| BETHESD | ANH PLEASANTVIEW | | 1 | WILLMAR, MN 56201 | | | |
| (X4) ID | SUMMARYST | ATEMENT OF DEFICIENCIES | OI OI | PROVIDER'S PLAN OF CORE | | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | | COMPLETION DATE | |
| {F 226} | Continued From page | e 29 | (F 228 |) | | | |
| | moderate cognitive in extensive assistance A incident report was agency regarding R1 details indicated the NA-E "is mean, he man than sit in recliner, he wheelchair when I was | submitted to the state 22 on 5/4/13. The incident resident and wife stated that takes me lay in bed rather wants to put me in my ant to sit in my recliner and the time." The date the | | R122 - Tracking system has implemented to identify not caregiver that is involved in resident incident in order to a pattern with a certain care occurring with incidents. Finterviewed. NA-E did resifacility on 7/3/2013. | me of n each o determine if egiver is Resident was | | |
| | agency regarding the NA-E dated 5/10/13, The investigation ind prefers to stay in his when planning his tin of his residents need to assist [R122] to his [NA-E] went on to tel my residents were interv regarding NA-E was light." "[NA-E] is care was nothing in the intother allegations of n made by R99 and R3 R99 annual MDS dat resident had no cognextensive assistance | ted 4/26/13 identified the nitive impairment and needed with ADL's. ort dated 5/6/13 regarding | | R99 - Tracking system has implemented to identify na caregiver that is involved in resident incident in order to a pattern with a certain care occurring with incidents. Interviewed, NA-E did residents | me of n each o determine if egiver is Resident was | | |
| | R99 indicated the res | or dated 5/6/13 regarding sident stated "that one aide and stated this happened in | | interviewed. NA-E did res facility on 7/3/2013. | ign from the | · , | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | | (X2) MULTIPI A. BUILDING | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-----------------------------|--|---|
| | | 245427 | B. WING | · | R 07/24/2013 |
| | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 66201 | |
| (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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| {F 226} | was identified as NA- submitted on 5/9/13 r NA-E "work performa residents interviewed interviewed and the r was "He is quick to a careful with transfers investigation regardir neglect and maltreate NA-E was interviewed any incident as descr nothing in the investig other allegations mad facility policy indicate other allegations of al with other residents. R3 quarterly MDS da resident had no cogn extensive assistance An investigative repo allegations of staff m R3 was submitted to The incident details of 6/4/13 indicated "Dur surveyor that a staff during cares. She al reported this at her is survey was exited on reported until 6/4/13. The investigative rep | " The alleged perpetrator E. The investigative report egarding R99 indicated ince has been positive. I" Multiple residents were esponse regarding NA-E inswer call light." "[NA-E] is "There was nothing in the ing the other allegations of ment made by R99 and R3. If and does not remember ibed by R99. There was gative report regarding the if by R122 and R3. The If the report should include lileged staff maltreatment ted 6/7/13 identified the itive impairment and needed with ADL's. It submitted regarding alfreatment from NA-E for the state agency on 6/4/13, on the report to the state on ing survey, [R3] informed person was rough with her so stated that she had ast care conference" The in 5/8/13 and this was not | {F 226 | | of ach etermine if ver is ident was |
| | surveyor a staff pers Writer interviewed [R | on was rough with her 3] on 6/4/13 and she does urveyor that NA-E was | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIN | PLE CONSTRUCTION | (X3) DATE COME | SURVEY PLETED |
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| | | 245427 | B. WING_ | | | R /24/2013 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X6) COMPLETION DATE |
| {F 226} | response regarding N enswer call light." "[N transfers." There was regarding the other all maltreatment made b NA-E was interviewed any incident as descrinothing in the investig other allegations mad Although the facility repossible neglect and residents R122, R99, complete a thorough | ts were interviewed and the IA-E was "He is quick to IA-E] is careful with nothing in the investigation legations of neglect and y R99 and R3. If and does not remember bed by R99. There was pative report regarding the le by R122 and R99. The ported allegations of abuse regarding NA-E with and R3; the facility did not investigation regarding the | {F 22 | 6} | | |
| {F 309} SS=E | NA-E. NA-E resigned from to 483.25 PROVIDE CA HIGHEST WELL BEILD Each resident must reprovide the necessary or maintain the highermental, and psychosolaccordance with the cand plan of care. | RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical, | {F 30 | All residents will receive necessand services to attain the high practicable physical, mental apsychosocial well-being. Resident R129 is currently as Meeker Memorial Hospital Eservices due to severe behave concerns. Resident R86 did have had a profile assessment and new conterventions added to care interventions added to care interventions added to care interventions added to care interventions added to care interventions. | nest and Imitted to Behavioral ioral behavior are plan | 8/30/13 |
| | by: Based on interview a facility failed to comp and provide appropria residents (R86, R124 | and document review, the rehensively assess, monitor ate interventions for 5 of 5 , R69, R129 and R115) d on the memory care unit | | interventions added to care p NAR assignment sheet. Res and R115 will have a behavi- assessment completed and no plan interventions will be ad- care plan and NAR assignment | idents R124 or profile ow care ded to the | - |

| CENTER | S FOR MEDICARE & I | MEDICAID SERVICES | | <u> </u> | OND INC | 7, 0000-0001 |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | , | | | | i | R |
| | | 245427 | B. WING | OTHER TIPE OF THE TIPE OF | | 24/2013 |
| NAME OF PA | ROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP CO | טב | |
| BETHESD | A NH PLEASANTVIEW | | 1 | 901 SOUTHEAST WILLMAR AVENUE | • | |
| | | | 1. | WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| *************************************** | | | | R69 died at facility on 8/ | | |
| {F 309} | Continued From page | 32 | {F 30 | 9) A new behavior manager | | |
| | and who displayed in | appropriate behavior. | | policy and procedure had | | |
| ı | | | | developed to include wee | ekly behavior | |
| | Findings include: | | | meetings to review behav | | |
| | R86 displayed inspor | opriate behavior of hitting, | | effectiveness of new inte | | |
| ! | | ring routine cares, the facility | | Training regarding inves | tigation when | |
| | | entify the cause of these | | injuries of unknown orig | | |
| | | ttempt to determine what | | well as behavior manage | | |
| | | R86's behaviors, and failed | | completed for nursing sta | | |
| | to direct staff on now these behaviors. | to care for him when he has | | CMS Dementia training | | |
| | these behaviors. | | | modules – we are curren | | |
| | R86's diagnosis inclu | ded dementia with conduct | | nursing staff on module | | |
| | | arterly Minimum Data Set | | training will be complete | | Į. |
| | dated 5/31/13, Indicat | | | 8/30/2013. The rest of the | | |
| | cognitive impairment, | | | be completed on a month | | į |
| | | i, had physical behaviors ers, and rejected cares. R86 | | over the next 5 months. | ny somedate | |
| | was frequently incont | | | Seven residents have been | on identified by | |
| | | ent of bowel, and required | | the IDT as having behav | | |
| | | from staff for toileting and | | themselves or others suc | | ļ |
| - | | vioral symptoms care area | | | | |
| | | ated 11/20/12 included, | | hitting out, resisting care | | |
| | | t d/t [due to] progressive cognitive impairment with | | residents have had behave | | |
| | | vision required AEB [as | | completed and new, indi | | |
| | | ring, agitation, and resisting | | interventions have been | | |
| | cares." | | | care plan and NAR assig | | } |
| | | A hata 6040 to alcohold | | If any other residents be | | |
| | | d July 2013, included airment r/t dementia with | | behaviors that are harmf | | |
| | | airment, communication | | or others, the team will o | | |
| | | nosis] of disturbance of | | behavior assessment. The | the state of the s | |
| | conduct. Target beh | aviors: yelling, wandering, | | daily to discuss incidents | | |
| 1 | belligerent with cares | s, refusing cares." A goal | | changes in behavior and | | |
| | | will feel safe and secure | | team will identify the re- | | |
| | | nory care unit]. Interventions | | behavior assessments go | ing forward. | |
| | | ecured memory unit and ement at quarterly care | | | | |
| | I TOTION HOUR FOIL HIGH | orrients are advancement and a | E . | 1 | | |

| | OF DEFICIENCIES FCORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | , | 7. 00,20 | | · · · · · · · · · · · · · · · · · · · | | R |
| | | 245427 | B. WING | | · · · · · · · · · · · · · · · · · · · | 07 | /24/2013 |
| | ROVIDER OR SUPPLIER OA NH PLEASANTVIEW | | , | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL . PREFIX (EACH CORRECTIVE ACTION | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) . COMPLETION DATE |
| (F 309) | conference. Administ antipsychotic medicat antianxiety medication behaviorsAllow time feelings and concerns from staff as needed. divert to activities if ab any cares, leave alone later." | er Seroquel [an ion] and Ativan [an | {F 3 | 109} | DON and DSS or designee will responsible for auditing for behaplans and follow-through on new interventions and completion of behavior flow sheets. Audits with completed on 5 of these weekly weeks, then monthly for 3 mont Audit results will be reported to committee and additional action developed as needed. | vior Il be for 4 is. the QA | |
| | though July 24, 2013 a "resists/combative." A were "upsetting/disrug was listed as "unknow care/provider." Intervolution reassurance, ston one's, leave (if reswhen res calm, attemptions and the series of the seri | showed 26 occurrences of All occurrences showed they office to others," the cause in/unpredictable" or "direct rentions provided included ructured activity/group, one [resident] safe) re-approach of w/different caregiver or to ss of these interventions | | - | | | |
| | R86's June 2013 Beha Sheet showed 32 epla resistive/combative wi outcomes. | | - | , | | | |
| | | vior Occurrence Flow sheet of being resistive/combative entions and outcomes. | | | | | |
| | R86's IPN (Interdiscipling) | | | | | | |
| | arms. Frequently [R8 | story of bruises to his lower 6] is resistive and in the evening. Staff do to protect themselves from | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|--|---|---------|-------------------------------|----------------------------|
| | | 245427 | B. WING | | | | | R 24/2013 |
| | ROVIDER OR SUPPLIER | | | STREET ADORESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | { | PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI DEFICIENCY) | OULD BE | | (X6) COMPLET:ON DATE |
| (F 309) | cares done." 6/7/13 "Resident was with HS cares. Resid kick, bite and knock sigetting him washed up cares. Staff was hold him from hurting hims hit his left knuckles on Resident kicked out a down in bed." | resistive and combative ent was attempting to hit, taff over when staff was of for bed. 3 staff assist with ing onto his wrists to keep elf and staff. Resident did the sliding bathroom door. | { F3· | 09) | | | | |
| | with HS cares this ever resident washed up to form getting punched Resident was kicking, attempting to push sta | s combative and resistive ening. 3 assist to get or bed. Staff held his wrist and from hurting himself. stomping on staffs feet, aff over, attempting to bite this back on the back of the | : | | | | | • |
| | hitting and kicking out and bite staff. Staff re [right] hand on the sid 6/19/13 "CNA [certifie reported skin to be cla this evening[R86] w | this evening. Resident was , attempting to arm wrestle ported that he hit his Rt e of the bathtub." | | | | | · | |
| | with HS cares. He was staff's feet, kicking ou and knock staff over a wrists. Resident refus | combative and resistive as hitting out, stomping on tat staff, attempting to bite and digging nails into staffs sed to let staff change is sen staff would attempt to | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3 | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B, WING | | | | ļ | 07/2 | ₹ 24/2013 |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 58201 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | | | (X5) COMPLETION DATE |
| {F 309} | When staff got him ov kick and hit out. Resi the back of his toilet a | ould straighten his arm. rer to bed, he continued to dent bumped his back on few times." | | 09} | | | | | |
| | with his shower this e resident was hitting, p staff. Staff was holdir | combative and resistive vening. Staff reported that unching and kicking out at a land his hands to keep him self and staff. Will watch for | | | | | | | |
| | of repetitious self agit of his head, and grind bruising on his arms fi | been showing mores signs ation, rubbing his arms, side lng of his teethWatch for rom him bumping them, mple has broken off due to | | | | | | | |
| | cares this evening. R | resistive with HS [bedtime] esident was not letting staff Staff was eventually able | | | | · | , | | |
| | (certified nurse aide) in his R [right] calf meas [by 3 cm, on 2 on his 8 cc [sic] X 1 cm. Bru | resident ready the CNA reported fining bruises on uring 3 cm (centimeters) X L [left] thigh one measuring ises are consistent with e chair. RN was notified rties. | | | | | | | |
| | cares. Hitting, pushing | s resistive with am [morning] , trying to bite staff, and ngers and trying to bend | | | | | | | |
| | | s hitting, kicking, and trying aff to hold him while trying to | | | | • | | | • |

| | OF DEFICIENCIÉS CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | CICIOATIONAII MADED. | | | ULTIPLE CONSTRUCTION LDING | | |
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| | | 245427 | B. WING | | | | | R 24/2013 |
| | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | ζ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE |
| {F 309} | hands and arms." 7/16/13 "Resident wa | e 36 Watch for bruising on s resistive and combative nt was hitting and kicking at | {F 3 | 09} | | | | |
| ٠. | placement include: in repetitive compulsive participation in specia | resent that require MCU acreased wandering, | | | | | | |
| | assistant (NA)-A state combative, we try to that doesn't help we hold him in order to g asked where they ho | /23/13 at 1:20 p.m. nursing ed R86 "can be very redirect him, talk to him, if call in more staff, we have to et the cares done." When id him at, NA-A stated on his o keep us from "getting hit.". | | | · | | | |
| | trained medication ai becomes combative have 3-4 staff take of hit staff or hurt himse arms down, will hold | /23/13 at 2:00 p.m., the de (TMA)-B stated R86 with cares, so they usually are of him, so that he doesn't if, they have to hold his him by the hands, R86 will t them trying to get out of the ain. | | | | | Α | |
| | stated R86 can beco "we have to get more calm down, we have keep from getting hit | //23/13 at 2:08 p.m., NA-B me combative with cares, people if we can't get him to to hold onto his hands to " NA-B stated holding onto im down, but the cares can | | | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF | СОМ | (X3) DATE SURVEY COMPLETED | |
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| | • | 245427 | B. WING | | I | R /24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 12-112-10 |
| BETHESD | A NH PLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROPRIES OF THE | LD BE | (X5) COMPLETION DATE |
| {F 309} | stated, R86 will start to more help to hold him | 23/13, at 2:11 p.m., NA-C o hit and "you have to get so we can get the cares | { F 30 | 9} | ÷ | |
| | if resisting, "we do wh cared for." Having 3- | he cares are important and lat we have to get them 4 staff member hold onto of calm him down, but they e for him. | | | · | |
| | stated, "if staff are rea settle down, have to le and re-approach later | 24/13, at 8:35 a.m. NA-D al patient with [R86], he will eave him in a safe place and he will usually ated it takes R86 a long time | | | • | |
| | to process information you are going to do w "digest" the information approached really cal | n, so need to tell him what ith him, give him time to on. "He needs to be mly, he needs short | | | | |
| | information, stating th to be cheerful, calm, o | a.m. NA-D provided further e approach with R86 "needs giving him time to absorb help him with, if his jaw | | | , | |
| | tightens/twitches, he ineed to back off and of make his bed, just give usually cooperate." N | s getting agitated and you come back later, maybe e him time, and then he will IA-D indicated there have | | • | | |
| | tries to walk around the and no pants, and have him, while 2 more was pants on him quickly. | has had soiled pants and ne unit with a soiled bottom we had to get 2 staff to hold sh him up and get a pad and But typically, if staff e won't have the behavior | | | | |
| | stated a couple of we toilet R86 we had to h | 24/13 at 9:37 a.m., NA-I eks ago we were trying to ave several staff hold his et him. He was trying to hit | , | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B: WING_ | | R | 1040 | |
| NAME OF D | ROVIDER OR SUPPLIER | 240421 | D. WING _ | STREET ADDRESS, CITY, STATE, ZIP COE | 07/24/2 | 1013 | |
| | OANH PLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) XMPLETION DATE | |
| {F 309} | Continued From page us he was holding and members hands. | 38 d squeezing another staff | (F 30 | 9} | | | |
| | 7/24/13, at 9:45 a.m. trying to work with state ensuring residents where the state of the state | no are being combative are they are safe, and aff should not be holding e for them. For R86, staff safe place, re-approach, or er. When asked why 3-4 providing care, RN-A stated that many caregivers would may agitate him further. If not consulted with direct avior Occurrence Flow what approaches work om becoming combative, or ht calm him down. RN-A es have frequent bruising shaviors. RN-A stated the | | | | | |
| | facilities Consultant N 10:40 a.m. for the Hea | summary provided by the urse (CN) on 7/24/13, at alth Care Academy training are regulred to complete, | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | NSTRUCTION | | SURVEY PLETED |
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| | | | A. BUILDING | | R | | |
| | | 245427 | B. WING | | | 07 | /24/2013 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | 72772010 |
| DETUEON | A NH PLEASANTVIEW | | | 901 8 | OUTHEAST WILLMAR AVENUE | | |
| BEINESD | A NR FLEAGAN I VIEW | | | WILL | LMAR, MN 58201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD 8E | (X5) COMPLETION DATE |
| {F 309} | Continued From pa | ge 39 2, "If the client is combative | {F 3 | 09} | | | |
| | or violent, stand to reach. You may ne other staff. Howeve | their side and out of their ed to get assistance from er, you should remember that | | | | | - |
| | the client." The pro avoid a resident's "d | ay be overwhelming in itself to gram also gave tips on how to catastrophic reaction," and | | | | | |
| | (SSD) on 7/24/13, a has multiple behavicompulsive things self; wandering and assessment had no these behaviors and direct staff on how to behaviors, other that agreed, staff should as he is safe and resometimes it is need then it takes 3-4 state one staff would hold get his cares done. happening, but had prevent R86 from he had she attempted to | essary to get cares done and ff to care for him. SSD stated l each hand, and two would SSD was aware this was not come up with any way to aving behavior problems, nor to determine how to care for twe behavior problems. SSD | | | | | |
| | Even though R86 has problems, the facility identification of cause prevent behavior profit they occurred. R8 3-4 staff persons to could be performed and R86 frequently | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | Į. | TPLE CONSTRUCTION | | | SURVEY PLETED |
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| | : : | 245427 | | B. WNG | | | R /24/2013 |
| ı | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | • | | S, CITY, STATE, ZIP CODE WILLMAR AVENUE 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EAC | ROVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD FREFERENCED TO THE APPROPE DEFICIENCY) | BE | (X6) COMPLETION DATE |
| {F 309} | R86, had ideas on ho prevent escalation of not been consulted so could be used by all s A facility policy on ma | w to approach R86 to behaviors, but NA-D had o that these approaches | {F 3 | 09} | | | |
| | resistive and combati failed to attempt to de behaviors from occurr | ropriate behaviors of being ve with care's and the facility termine how to prevent the ring, or provide direction to ge the behaviors when they | | | | | |
| | The significant chang identified R124 had so showed inattention are was short tempered at had physical behavior which interfered with behaviors had worser assessment dated 2½ extensive assistance living (ADL's). The beincluded "Has neede | evere cognitive impairment, and disorganized thinking, and easily annoyed. R124 is directed toward others resident care. These ned since the previous 21/13. R124 required with most activities of daily chavior CAA dated 5/17/13 d more cues and reminders is upset with staff when they | | | | | |
| | "Mood/Behavior impa Disease with moderal slight communication environment. Target weepiness, being ang | e cognitive impairment, impairment, new Behaviors: crying, | | | • | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | INSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | • | | | 07 | R //24/2013 |
| | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | ··· | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECT CROSS-REFERENC | PLAN OF CORRECTION TIVE ACTION SHOULD DED TO THE APPROPR FICIENCY) | BE, | (X6) COMPLETION DATE |
| {F 309} | was listed as; "Reside MCU [memory care u to be easily re-directe Interventions listed in unit; allow time to verion mood/behavior, if a monitor/supervise who needed. "Monitor befowel movement] an MD/CNP [physician o | ent will feel/secure within nit]. Resident will continue d during wandering." cluded; secured memory balize needs, staff to chart unable to redirect her, ereabouts. Re-approach as navior of playing in BM d wandering Update r nurse practitioner] as e plan failed to address | (F 3 | (09) | | | | |
| | 1 through July 24, 20 "combative/resistive vimes." The cause of unknown or direct car calm reassurance, dis with talks, cueing, reoursults of the interven | w/ [with] cares occurred 28 the behavior was listed as e. Interventions included; straction/redirection, assist rientation, or toileting. The tion were listed as either hin 5 minutes, decreased | and contemporaries and the second sec | | | | | |
| - | Sheet indicated 209 of on the night shift, intersame, but they were r R124 being combative not begin until May 23 occupancies all on the | e night shift for the rest of ions had either decreased | | | | | | |
| | residents right upper | he following: urple bruises noted to arm, medial side; consistent needed to get resident out | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A, BUILDI | | E CONSTRUCTION | (X3) DATE | SURVEY PLETED |
|--------------------------|--|--|------------------------|------------------------------|--|-----------|------------------------------|
| | | | 17, 50,125. | | | | R |
| | • | 245427 | B. WING | | | 07/ | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| BETHESD | A NH PLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AVENUE | | | |
| | | | | 1 | WILLMAR, MN '56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) - COMPLETION DATE |
| (F 309) | reports that CNA need out of the bathtub last | 42 g following her bath. LPN ded assist to get resident evening, LPN assisted on consistent with the extra | {F 3 | 109) | | | |
| | | | | | | | |
| | | s resistive and combative staff and digging her nails | | | | | |
| | | resistive and combative s hitting and pushing staff. to be redirected." | | | , | | |
| | tonight waiting for her resident came up to h patting her on the arm pushed herself away f | sitting at thee dinner table meal, when another er and was talking and i. [R124] got upset and from the table and slapped the L side of the face by the | | | | | |
| | was attempting to take evening. She had gra cuff cord and started to re-approached her lat staff backwards, sayling reached over to the rectioner and was part of the rectioner. | er and she started to pushing "No, No". She then esident sitting next to her in bushing on her feet." | | | | | |
| | bruise on R upper arm | (left) wrist 3 x 1.75 cm and n 2 x 1.5 cm. [Resident ary resistive with cares | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | AG | | (X3) DATE SURVEY COMPLETED | | | | |
|---|--|--|---------------------|----------|--|-------------|---|-------------|----------------------------|
| | | 245427 | B. WING_ | | | <u> </u> | | 1 | R /24/2013 |
| | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | | 901 SOU | ADDRESS, CIT ITHEAST WIL AR, MN 5620 | LMAR AVENU | | <u>, vi</u> | 12412010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CO | RRECTIVE AC | F CORRECTION TION SHOULD THE APPROPR CY) | BE | (X6) COMPLETION DATE |
| {F 309} | and clothing being s baths. She hits and unable to talk and be residents at times. S certain residents d/t | ge 43 It to be toileted d/t [due to] bed oaked. Also is resistive with pushes staff. [R124] is ecome angry at both staff and She is kept at a distance from [R124] striking out at them. Im combativeness with | (F 30 | . | | | | | |
| | at bath time" | s bruisers on both arms noted as resistive with tolleting, | | | | | | | |
| | | at were charted on 6/20/13 24] had bruise on L upper arm | | | | | | | |
| , | 6/28/13 "[R124] doe behaviors-combative many times a day)." | s have e-resistive with care (daily- | | | | | | | |
| | 7/6/13 "Resident wa with toileting, hitting | s resistive and combative at staff." | | | | | | | |
| | on there [sic] Rt hand and resistive on over hitting out at staff. S from her hurting hers Bruise 1 is on the an side). Measures 2 x of Rt hand. Measure 7/14/13 "Husband d | d that resident had bruises d. Resident was combative r night cares. Resident was taff was holding her wrists self and staff this morning. terior of Rt wrist (thumb 2 cm. Bruise 2 on posterior es 7.5 x 4.5 cm." id call back and he was and he states that he does | | | | • | | | , |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | grab her arms to help | | | | | • | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | ONSTRUCTION | | ľ | (X3) DATE COMP | |
|---------------|--|--|------------------------|-----|---|-------------------------------------|---------|-------------------|--------------------|
| | 245427 NAME OF PROVIDER OR SUPPLIER | | | | | | | f | ₹ • |
| | | 245427 | B. WING | | | | | 07/: | 24/2013 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, | STATE, ZIP CODE | | | |
| BETHESD | A NH PLEASANTVIEW | 4 | | 901 | SOUTHEAST WILLM | AR AVENUE | | | |
| | , | • | | WIL | LMAR, MN 56201 | • | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | (D | T | PROVIDE | R'S PLÀN OF CORR | ECTION | | (X5) |
| PREFIX TAG | | 'MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | | | ECTIVE ACTION SI ENCED TO THE AP | | | COMPLETION DATE |
| IAG | NEOODH ONE | | TAG | Ì | CHOOSINGIEN | DEFICIENCY) | FROFRIA | - | |
| - | | <u> </u> | | | *************************************** | | | | |
| {F 309} | Continued From page | . 44 | {F 3 | 001 | | | | | |
| () | • • | husband was notified of | 1 11-3 | OOI | | | | | |
| | bruises to her arms he | | | | | | | | |
| | | holding her upper arm to | J | 1 | | • | | | |
| | help her get out of her | | | | | | | • | |
| | ger en ei | W. W. W. | | | | | | | |
| | 7/17/13 *[R124] is res | sistive with cares." | | | | | | | |
| , | | | | | | | | | |
| | During interview on 7/2 | 23/13, at 1:20 p.m. NA-A | | | , | | | | |
| | stated the afternoon s | hift has more trouble with | ļ | } | • | | | | |
| | R124 having behavior | problems, R124 has been | <u> </u> | | • | • | | | |
| | cooperative with care: | s on the day shift. | | | | | | | |
| | | | | | | | | - | |
| | | 23/13, at 1:50 p.m. TMA-A | | | • | | | | |
| | | making a fuss," TMA-A will | | | at . | | | | j |
| | · · · · · · · · · · · · · · · · · · · | y to approach later, this | | - | | | | : | - 1 |
| | usually helps. | • | | | • | | | • • | |
| | During interview on 7/ | 23/13, at 2:08 p.m. NA-B | | 1 | | | | 1 | |
| } | stated if R124 gets co | | | 1 | | - · · | | | + |
| | | her, so that cares can be | | | | | | | |
| | completed. | · | - | | | | | j | |
| | - | | | | | | | | |
| | | 23/13, at 2:11 p.m. NA-C | | | | | | . | |
| | | to leave R124 alone if she | | | | | | | |
| | gets combative and th | | | | | | | | } |
| | | e to get the cares done, NA- | | | | | | | |
| | | hold her so cares can be | | | | | | | |
| | completed. | | | | | • | | | |
| | During intentious on 7/ | 24/13 at 11:30 a.m. RN-A | | | | | | | |
| | | w the cause of R124's | | | • | | | , | |
| | resistive/combative be | | | | | | | | |
| | consulted with the dire | • | | | | • | | 1 | |
| | | ger, or what works to calm | | | | | | - | |
| | | ed R124 had been mostly | | | | , | | | |
| | | t shift and had just in the | | | | - | | | |
| | | vernight incontinent brief, | - | | | | | | |
| | so that staff would not | need to interrupt R124 very | | - | | | | ĺ | |
| | often at night due to a | wet bed. RN-A had not | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|---|-----------------------------|--|------|-------------------------------|--|
| | | 245427 | B. WING | | | <u></u> | 0.7 | R //24/2013 | |
| | ROVIDER OR SUPPLIER | : | STREET ADDRESS, CITY; STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | 1 | 124120 (3 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECT ECTIVE ACTION SHOU ENCED TO THE APPRO DEFICIENCY) | LDBE | (X5) COMPLETION DATE | |
| {F 309} | during other cares, or staff had not instructe transfer techniques, o belt to avoid bruising | 4 becomes combative during a bath. In addition, | {F 3(| (9) | | | | | |
| | and other residents, v assess for what preci | al behaviors towards staff which the facility failed to pitates behaviors, or direct e behaviors when they | | | | | | | |
| | dated 5/16/13, indicat impairment, had no be performed ADL's with staff. The Behavioral 7/18/13 included "Du | s. R69's quarterly MDS ed severe cognitive ehavior problems and only set up assistance from Symptoms CAA dated ring the reference period, aviors that including [sic] ff, self-transferring, | | | | | | | |
| | history of anxious/wor worrying about laundi becoming upset about questions, looking for R69's goal was listed comfortable within he Interventions for staff antianxiety medication secured unit. The car physical behaviors R6 towards others. | ehavior impairment /r/t risome behaviors i.e. ry not being done & t it, pacing, asking frequent lost newspapers, etc." as [R69] will be calm and r surroundings." included, to administer an n, redirect, and placement in re plan did not address any se displayed directed | | | | | | | |
| | R69's Behavlor Occur | rrences Sheet(s) Indicated | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | ONSTRUCTION | | TE SURVEY MPLETED |
|---|---|---|------------------------|--|--|----------|----------------------|
| | • | 246427 | B. WING | | | i | R 7/24/2013 |
| | ROVIDER OR SUPPLIER ANH PLEASANTVIEW | | | 901 | REET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES "MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | | IO PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| (F 309) | started June 25, 2013 between June 25 and Interventions off the o reassurance, one to o remove to quiet place | , Refusing ADL's" had and recorded 60 episodes | {F 3 | 09} | | | |
| | and agitated around s alarm multiple times, and down. At 20:10 room to talk to res to just increases agitatic approach res she yell 7/7/13 "She went out | nt] started acting restless supper timesetting off bed is getting up and down up [9:10 p.m.] Staff go into see what she needs but this in and when staff try to is at them and hits staff." front door x 3 and not easily ag at staff with her fist and hold of the door and | | All the same of th | | | |
| | 7/8/13 "12:30 a.m. re to self-transfer. Toile combative when aide transfer back to bed. alarms, wanting to go screaming. Brought west end dining area. Alivan [antianxiety mout. Possible bruisin wheelchair and kickin furniture." | tried pulling clothes up and Upset with door open, home and started out to nurses station and Refused food, attempted edication] and resident spit it g due to ramming her ig and hitting staff and | | NATIONAL PROPERTY OF THE PROPE | | | |
| ! | 7/9/13 "Resident was change of shift this a staff saying, "you car | m. She was hitting out at | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|---|--|-----|-------------------------------|--|
| | | 245427 | 8. WING | | | i i | R - 24/2013 | |
| | ROVIDER OR SUPPLIER | | | 9(| TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 58201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 309} | yelling at her" 7/10/13 "Resident wa Ativan at 1:00 a.m. for transferring, and push | king at housekeeper and s given a PRN [as needed] | {F 3 | 09} | | | | |
| | | orearm are consistent with uding hitting and kicking out valkers." | | | | | : | |
| | escalating over the las resident was upset an | ift. Behavlor has been it month. Tonight at dinner | | - | | | | |
| | | she started grabbing at while siting by the bird | | | | | | |
| | arms, hips, buttocks a bruises are consistent including hitting and ki | with recent behaviors, | | | | | | |
| | care unit. "She pulled staff shirt, trying to get She grabbed a staffs v toward her and then tv | ated a move to the memory hard on one of the kitchen ther to take her out of here. wist, was pulling it down wisted her wrist and finger, aff with her wheelchair." | | | | | | |
| | 7/21/13 "Resident wa foot before lunch." | s kicking another resident | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | ECONSTRUCTION | (X3) DATE | SURVEY |
|--------------------------|--|---|------------------------------|-------------|--|-----------|---|
| : | | | A. BOILUI | A. BUILDING | | | R |
| | | 245427 | B. WING | 8. WING | | | 24/2013 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | Ş | STREET ADDRESS, CITY, STATE, ZIP CODE | | _ ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| BETHESD | A NH PLEASANTVIEW | • | 901 SOUTHEAST WILLMAR AVENUE | | | | |
| | | | | 1 | WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 309} | 7/24/13 at 9:45 a.m., I new to the memory catreated for a possible were going to see if the behaviors, but it did not made to determine catetermine what may what not updated R69's physical behaviors. R129 had behaviors of during routine cares, to identify the cause of failed to attempt to determine to determine to determine what may what had not updated R69's physical behaviors. | registered nurse (RN)-A on RN-A had stated R69 was are unit. R69 had been urinary tract infection, staff hat helped with her but. No other attempts were use of the behaviors, or to work to prevent them. RN-A is care plan to include If hitting, kicking, pushing he facility failed to attempt if these behaviors, and termine what helps to shaviors and failed to direct or her. | {F 3 | 09} | | | |
| | psychosis, anxiety and (MDS) dated 7/12/13, cognitively impaired at assistance with (ADL) indicated she had physymptoms, verbal symwandered daily. R129 CAA dated 4/12/13, in wanders around the scintrude on the privacy behaviors: disrobing, wandering, tearing up rudeness, bumping int scratching staff and coand rejection of cares, behavior, ensure her screproach [slc] at a later | nd needed extensive 's. The MDS further sical and behavioral aptoms and that she b's behavioral symptoms acluded "[R129] frequently ecured MCU and it does or activity of others. Target yelling, hitting, aimless incontinent pads, cursing, to other resident's, ombativeness, with caresif unable to redirect eafety and leave her alone, r time." | | | | | |
| | R129's current physici | an orders dated July 1, | | | | ٠ | |

| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 . | | | | | SURVEY PLETED |
|---|--|--|---|---|--|---|---|
| | | | NG | · | | | R · |
| | 245427 | B. WING | | | | | |
| | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | | |
| (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | ID PREFI) TAG | | (EACH CORRECTIVE CROSS-REFERENCED | ACTION SHOULD BE TO THE APPROPRIA | | (X5) COMPLETION DATE |
| 2013, included Ativar intramuscularly (IM) e | n 1 milligram (mg) oral or very twelve hours as | {F 3/ | 09) | | | | |
| mood/behavioral issu- dementia with behavioral placement on secured care plan goal indicate nursing home placementicuded to administer | es due to Alzheimer's or disturbance. Requires of memory care unit. The ed R129 will adjust to ent. The interventions | | | | | | |
| (antidepressant), Bus Gabapentin (for anxie indicated for staff to m crying, shredding, disr kicking and pushing, indicated to have staff people in hall, television they are her neighbors until 10:00 a.m. to 11:0 being in nursing home | par (treat anxiety) and ty). The care plan also conitor target behaviors, robing, negatism, hitting, The care plan further inform her when she hears on and talking with her that a, allow resident to sleep 00 a.m., do not refer her as . The care plan did not | | | | • | | |
| was observed to be or the nurses desk no be R129's Behavior Occu May, June & July 2013 May 2013: kicking, hit and shredding did not Negative- occurred 20 unknown and intervent one to one and return indicated decreased in June 2013: | the memory care unit by haviors were observed. Irrence Flow Sheet for B indicated the following: ting, pushing, disrobing, occur. times cause was listed as litons calm reassurance, to room. The results tensity/improved behavior. | | | | | | |
| | ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCY REGULATORY OR LEACH DEFICIENCY OR LEAC | ANH PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 2013, included Ativan 1 milligram (mg) oral or intramuscularly (IM) every twelve hours as needed for anxiety and agitation. R129's care plan dated July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing home placement. The interventions included to administer Trazadone (antidepressant), Buspar (treat anxiety) and Gabapentin (for anxiety). The care plan also indicated for staff to monitor target behaviors, crying, shredding, disrobing, negatism, hitting, kicking and pushing. The care plan further indicated to have staff inform her when she hears people in hall, television and talking with her that they are her neighbors, allow resident to sleep until 10:00 a.m. to 11:00 a.m., do not refer her as being in nursing home. The care plan did not address the use of Ativan. During observation 7/24/13, at 9:00 a.m. R129 was observed to be on the memory care unit by the nurses desk no behaviors were observed. R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following: May 2013: kicking, hitting, pushing, disrobing, and shredding dld not occur. Negative- occurred 20 times cause was listed as unknown and interventions calm reassurance, one to one and return to room. The results indicated decreased Intensity/Improved behavior. | ROVIDER OR SUPPLIER AN HY PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 2013, included Ativan 1 milligram (mg) oral or inframuscularly (IM) every twelve hours as needed for anxiety and agitation. R129's care plan dated July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing home placement. The interventions included to administer Trazadone (antidepressant), Buspar (treat anxiety) and Gabapentin (for anxiety). The care plan also indicated for staff to monitor target behaviors, crying, shredding, disrobing, negatism, hitting, kicking and pushing. 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June 2013: | ROVIDER OR SUPPLIER ANH PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 2013, included Ativan 1 milligram (mg) oral or inframuscularly (IM) every twelve hours as needed for anxiety and agitation. R129's care plan dated July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing home placement. The interventions included to administer Trazadone (antitdepressant), Buspar (treat anxiety) and Gabapentin (for anxiety). The care plan further indicated for tastif to monitor target behaviors, crying, shredding, disrobing, negatism, hitting, kicking and pushing. 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The results indicated decreased intensity/improved behavior. | ROYNDER OR SUPPLIER 245427 ROYNDER OR SUPPLIER ANNING STREET ADDRESS, CITY, SYATE, 901 SOUTHEAST WILLMAR, MIN 65201 EACH DEFICIENCY MUST BE PRECISED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 2013, included Ativan 1 milligram (mg) oral or intramuscularly (IM) every twelve hours as needed for anxiety and agitation. R129's care plan dated July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing inome placement. The interventions included to administer Trazadone (antidepressant). Buspar (freat anxiety) and Gabapentin (for anxiety). The care plan also indicated for staff to monitor target behaviors, crying, shredding, disrobing, negalism, hitting, klcking and pushing. The care plan did not address the use of Ativan. During observation 7/24/13, at 9:00 a.m. R129 was observed to be on the memory care unit by the nurses desk no behaviors were observed. R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following: May 2013: klcking, hitting, pushing, disrobing, and shredding did not occur. Negative- occurred 20 times cause was listed as unknown and interventions calm reassurance, one to one and return to room. The ressults indicated decreased intensity/improved behavior. June 2013: | ROWIDER OR SUPPLIER 245427 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 91 SOUTHEAST WILLMAR AVERUE WILLMAR, MIN 8502. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 2013, included Aftivan 1 milligram (mg) oral or intramuscularly (MI) every twelve hours as needed for anxiety and agitation. R129's care plan dated 'July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement. The interventions included to administer Trazadone (antidepressan), Buspar (freat anxiety) and Gabapentin (for anxiety). The care plan durine indicated to have staff inform her when she hears people in hall, television and talking with her that they are her neighbors, allow resident to sleep until 10:00 a.m. of 10:00 a.m., do not refer her as being in nursing home. The care plan did not address the use of Ativan. During observation 7/24/13, at 9:00 a.m. R129 was observed to be on the memory care unit by the nurses desk no behaviors were observed. R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following: May 2013: kicking, hitting, pushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, pushing, disrobing, and afterdung to room. The results indicated decreased intensity/improved behavior. June 2013: | A BUILDING 248427 8. WING TREET ADDRESS, CITY, STATE, 2P CODE 301 SOUTHEAST WILLIMAR AVENUE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST RE PRECEDED BY PULL REGULATORY OR U.SC IDENTIFYING INFORMATION) COntinued From page 49 2013, included Ativan 1 milligram (mg) oral or inframuscularly (IM) every twelve hours as needed for anxiety and agitation. R129's care plan dated July 2013, indicated mood/Dehavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing home placement. The inforventions included to administer Trazadone (antidepressant), Buspar (freat anxiety) and Gabapentin (for anxiety). The care plan also indicated for staff to monitor target behaviors, crying, shredding, disrobing, negatism, hitting, kicking and pushing. The care plan did not address the use of Ativan. During observation 7/24/13, at 9:00 a.m. R129 was observed to be on the memory care unit by the nurses desk no behaviors were observed. R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following: May 2013: kicking, hitting, pushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, pushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, cushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, cushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, cushing, disrobing, and shredding did not occur. May 2013: kicking, hitting, cushing, disrobing, and shredding did not occur. May 2013: kicking and pushing, disrobing, and shredding did not occur. May 2013: kicking and pushing, disrobing, and shredding did not occur. May 2013: kicking and pushing, disrobing, and shredding did not occur. May 2013: kicking and pushing, disrobing, and shredding did not occur. May 2013: kicking and pushing disrobing and shredding did not occur. May 2013: kicking and pushing disrobing and shredding did not occur. |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | | | SURVEY . |
|--------------------------|---|--|---|-----|--------------------------------------|---|--|----------------------------|
| | • | 246427 | B. WING | | | | | R /24/2013 |
| | ROVIDER OR SUPPLIER A NH PLEASANTVIEW | | STREET ADDRESS, CITY, STATE, ZIP CODE \$01 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | - 011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIA IENCY) | | (X5) COMPLETION DATE |
| | remove to quite place, environment, leave if resident calm, toilet, refluid object to hold. The interventions were not Hitting-occurred 10 tin interventions calm real activity/group, one to call the quite place, assist with environment, leave if the resident calm, toilet, refluid object to hold. The interventions were behold unknown, the interventions were behold unknown, the interventione, distraction, remove tasks, modify environment, to hold and fluid object to Negative-occurred 46 unknown. The interventione, distraction, remove tasks, modify environment, to food and fluid object to resumed behavior with decreased intensity and Disrobing and shredding occurred three altered routing, visitor of intervention indicated services. | s calm reassurance, up, one to one, distraction, assist with tasks, modify safe reproach when aturn to room offer food and the results of the resistive. These cause unknown, assurance, structured one, distraction, remove to tasks, modify safe reproach when aturn to room offer food and the results of the avior continued. The cause is tions were calmed activity/group, one to the to quite place, assist with the to quite place, assist with the cause all listed as antions tried were calmed activity/group, one to to quite place, assist with the control of the cause is the cause all listed as antions tried were calmed activity/group, one to to quite place, assist with the control of the country of the countr | (F 3 | 09) | | | | |
| | different caregiver. The | | | | | | | - |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A, BUILDI | TIPLE CONSTRÚCTION ING | (X3) DATE SURVEY COMPLETED |
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| | | 245427 | 8. WING | | R 07/24/2013 |
| | ROVIDER OR SUPPLIER A NH PLEASANTVIEW | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE COMPLETION |
| (F 309) | care or provider, intenstructured activity/grot remove to quite place, environment, leave if resident calm, toilet, refluid object to hold. Pushing- occurred 13 care provider intervenstructured activity/grot remove to quite place, environment, leave if resident calm, toilet, refluid object to hold. Recontinued. Negative- occurred 38 listed as unknown. The reassurance, structur one, distraction, remove tasks, modify environment, tood and fluid object to behavior continued. Disrobing and shreddi R129's interdisciplinar the following: 6/22/13- resident wander bumps her hands and island, med cart and 6/27/13- resident incresident incresid | mes, cause listed a direct ventions reassurance, up, one to one, distraction, assist with tasks, modify safe reproach when eturn to room offer food and times cause listed as direct tions calm reassurance, up, one to one, distraction, assist with tasks, modify safe reproach when eturn to room offer food and esults were behavior times. The cause was a interventions calm ed activity/group, one to we to quite place, assist with nent, leave if safe reproach offer or hold. Results were and did not occur. The progress notes included wanting to go home, staff Ativan 1mg IM was given, bruise on R129's wrist and is in her wheelchair and arms on tables, chairs | {F3 | 09} | |
| | 6/28/13-Resident wen Behavioral Health- Me | t to Center for Senior eker Memorial 11/28/12. | ļ | | |

| | DPLAN OF CORRECTION INDENTIFICATION NUMBER: | | 1 | JLTIPLE CONSTRUCTION DING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|---------------------------|-------------------------------------|----|-------------------------------|--|
| | | | | | | | R | |
| | 1 | 246427 | B. WING | | | 07 | /24/2013 | |
| NAMEOFP | ROVIDER OR SUPPLIER | | , | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| BETHESO | A NH PLEASANTVIEW | | 901 SOUTHEAST WILLMAR AVENUE | | | | | |
| | | | | W | ILLMAR, MN 66201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | | (X6) COMPLETION DATE | |
| (F 309) | Residents behaviors started increasing again. On 2/20/13 physican ordered Ativan 1 mg every 12hrs for severe agitation. Physican here and he also wrote order to give Ativan IM as needed. 6/30/13- resident up wandering, bumping into things. 7/1/13- resident bumping into things. 7/4/13 at 7:56 p.m resident becoming increasingly agitated, going into other residents rooms, trying to destroy belongings. Staff attempted to redirect all attempts failed. Writer gave Ativan IM. 7/4/13 at 8:39 p.m Resident was given Ativan IM at 5:45 p.m. had to hold her hands down while | | {F 3 | 09} | - | | | |
| | | | | | · · · · · | | | |
| • | | | | | | | 7.7.7.7.1.1 | |
| | and scratching. 7/5/13- noted bruises of left hand. 7/9/13- resident was w | e to her swearing, hitting on right hand and wrist and randering in her wheelchair | and the state of t | | . · | | | |
| | hands and arms on ch 7/11/13- Attempted PF | RN Ativan X3 with no ven at 5:30 p.m. behaviors ves wandering and | | | | | | |
| | 7/13/13- resident was home. Redirection wa IM was given at 4:55 p eat supper. | yelling and wanting to go s difficult as needed Ativan .m Resident refused to | | | | | | |
| 100 H | 7/14/13- Resident start staff change her clothe 7/15/13- Resident was Ativan 1mg given at 7: 7/15/13 at 9:40 a.m R she has been running i 7/16/13- Resident start | upset and agitated this am 20 a.m tesident up wandering and into objects. ied behaviors early | | | | | | |
| | afternoon with running residents. Unable to rehome. Resident was g | edirect and wanting to go | | | • | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|------|--|-------------------------------|----------------------------|
| | | | 11. 50.25 | #10_ | | | ₹ |
| | • | 245427 | B. WING | | | 1 | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | - |
| BETHESD | A NH PLEASANTVIEW | | | 91 | 01 SOUTHEAST WILLMAR AVENUE | | |
| DETTILOP | ANIII KEAVAIII IIKII | | | W | VILLMAR, MN 56201 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 309} | agitated. She kept sit bed setting off her ala Ativan 1mg IM was giventervention was used 7/19/13 at 9:52 a.m I upset and yelling and metal of the heat regis wanting to break the vishe has been throwing Difficult to redirect. Sitear. Called certified I order for Ativan 1mg or given per order. She pound on the end of Bigrabbing at the house staff interventions use 7/21/13- Resident star | resident has been very ting up on the edge of her rm. Difficult to redirect, ven also one to one staff . Resident continues to be swearing she ripped off the ster in the bathroom and vindow so she can go home g things at the window, ne did receive a 1.5 cm skin Nurse Practitioner for new to 1 stat. Ativan IM was continues to yell, swear, -hall door and and was keeping cart, one to one d. rted escalating behaviors | {F 3 | 609) | | | |
| | p.m. 7/22/13- noted bruise top right hand. 7/22/13- Resident yell 1 mg x3 at 2 p.m. and Ativan IM 1mg given a her from the area with One on one done until 7/23/13- resident up in change of shift, she w wanting to go home. p.m. During interview 7/24/ who stated when he n sit with the residents, s | as restless, agitated and Ativan 1 mg given at 11 13 at 9:37 a.m. with NA-I otices behaviors he tries to sometimes there behaviors | | | | | |
| | they don't get hurt, I treexplain to them where | hold their hands down so y to talk to them and they are. "Last Friday trol and we had to hold her | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | NSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|---|----------------------|---------------|---|------|----------------------------|
| | ; | 245427 | B. WING | | | | R |
| | ROVIDER OR SUPPLIER | | | STRE 901 S | ET ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE MAR, MN 58201 | 1 07 | /24/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | 8E | (X5) COMPLETION DATE |
| {F 309} | yelling at us telling us Around 2:30 p.m., the | day this week she was to get her out of her house. re was four staff in her ing her hands and some | (F 3 | 309) | | | |
| | Pharmacy Consultant facility last week and s nurse manager that th cause and specific inte | erventions for each nd that it was not being | | | | | |
| | the facility failed to atte causes, potential inter behavior problems or l occurred. There was | how to handle them if they several times staff had to n attempt to her Ativan IM | | | | | |
| | MDS dated 6/14/13, id severe cognitive impai assist with all activities | ed dementia. The annual lentified the resident had liment, was an extensive of daily living (ADL's), and tion of care 1-3 days in the | | | | | |
| | | | | | | | |
| | resident had behaviors | July 2013, indicated the softrying to leave without ng, hitting and yelling. The fifty the resident was | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | | (X3) DATE SURVEY COMPLETED | |
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| | · | 245427 | B. WING_ | | | | | R /24/2013 |
| NAME OF P | RÖVIDER ÖR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP | CODE | | · |
| BETHESD | A NH PLEASANTVIEW | | | 901 | SOUTHEAST WILLMAR AVENU | JE · | | |
| | | | | WIL | LMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X6) COMPLETION DATE |
| {F 309} | Continued From page resistive with cares no approach resident if re | or did it identify how to | {F 30 | 09} | · | | | , |
| | During observation of | R115 on 7/23/13, at 9:45 erri-walker walking around | | | | | | |
| | Review of R115's facil progress Notes (IPN) | | | | | | | |
| | and combative with ca grabbing and swearing 6/20/13-"Resident was grabbing at staff this n | g with cares this a.m." s yelling, swearing and norning," | | | | | | |
| • | and combative during was trying to wash res resident started to swe 6/28/13- "Resident wa ADL's, swearing at sta 6/29/13-"Staff reports with cares this a.m." | ear, yell, and hit out at NA." s combative with morning | | | | | | |
| | staff this morning whe Resident told staff to g 7/8/13- "Staff reports t with toileting this a.m." 7/11/13- "Staff reports and combative with ca yelling, swearing, telling, swearing, telling them and was kicking more cooperative. 7/15/13- "NA reports to swearing, and attempt cares this a.m. 7/16/13- "Resident was | n getting ready for the day. get the hell out of here." hat resident was resistive that resident was resistive ares this a.m. He was ng staff he is going to kill at staff. After cares he was hat resident was yelling, ling to hit at the NA during | | | | | | |

| (EACH DEFICIENCY MUST BE PRECEDED BY FULL BREEK (EACH CORRECTIVE ACTION SHOULD BE COMP | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|------------------------------|--|-----------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW (X4) ID PREFX TAG (X4) ID PREFX REGULATORY OR LSC IDENTIFYING INFORMATION) (F 309) (F 30 | • | · . | 245427 | B. WING _ | | | /2013 | |
| RECH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 309) Continued From page 56 He wanted to stay in bed. Nursing assistant (NA) washed him up, got him dressed and then laid him down again." 7/20/13- "Resident was combative with a.m. cares today yelling, swearing, and hitting out at staff." 7/21/13- "Resident has been more sleepy this a.m. He ate no breakfast he was sleeping in his wheelchair at breakfast table." The most recent summary of R115's current psychotropic medications and behaviors dated 6/28/13 in the IPN notes indicated the following: "Currently (R115) receives the following psychotropic medications: Trazadone 50 mg every HS (hour of sleep). Seroquel 12.5 mg every HS. Target behaviors include: trying to leave without authorization, yelling/ screaming (2 days in June), hitting (2 days in June), cursing and swearing (9 days in June). Staff administers Trazadone per MD (Doctor) orders and monitor for effectiveness" | | | | 901 SOUTHEAST WILLMAR AVENUE | | | | |
| He wanted to stay in bed. Nursing assistant (NA) washed him up, got him dressed and then laid him down again." 7/20/13- "Resident was combative with a.m. cares today yelling, swearing, and hitting out at staff." 7/21/13- "Resident was resistive with a.m. cares, yelling, swearing, and calling staff names." 7/23/13- "Resident has been more sleepy this a.m. He ate no breakfast he was sleeping in his wheelchair at breakfast table." The most recent summary of R115's current psychotropic medications and behaviors dated 6/28/13 in the IPN notes indicated the following: "Currently [R115] receives the following psychotropic medications: Trazadone 50 mg every HS (hour of sleep). Seroquel 12.5 mg every HS. Target behaviors include: trying to leave without authorization, yelling/ screaming (2 days in June), hitting (2 days in June), cursing and swearing (9 days in June), and urinating in appropriate places (0 days in June). Staff administers Trazadone per MD (Doctor) orders and monitor for effectiveness" | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFI) | ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. | SHOULD BE | (X5) COMPLETION DATE | |
| stated R115 can be combative with morning cares because "he doesn't like to get up in the morning" but NA-F stated "once you get him up he's pretty good." NA-F stated staff usually gets R115 up around 6:30 a.m., although sometimes the staff will leave him sleep until 8:30 a.m. and then it seems like R115 is "not as upset about getting up." NA-F was unsure why staff woke R115 up so early in the morning. During interview on 7/24/13, at 12:15 p.m. LPN-A | (F 309) | He wanted to stay in washed him up, got him down again." 7/20/13- "Resident w cares today yelling, s staff." 7/21/13- "Resident w yelling, swearing, and 7/23/13- "Resident ha a.m. He ate no break wheelchair at breakfa. The most recent sum psychotropic medical 6/28/13 in the IPN no "Currently [R115] recepychotropic medical Trazadone 50 mg ex Seroquel 12.5 mg ev Target behaviors inclauthorization, yelling hitting (2 days in Junedays in June), and ur (0 days in June). Staper MD (Doctor) order effectiveness" During interview on 7 stated R116 can be cares because "he dmorning" but NA-F she's pretty good." NA R115 up around 6:30 the staff will leave his then it seems like R1 getting up." NA-F was R115 up so early in the staff up a so early i | bed. Nursing assistant (NA) aim dressed and then laid as combative with a.m. awearing, and hitting out at as resistive with a.m. cares, d calling staff names." as been more sleepy this stat he was sleeping in his ast table." amany of R115's current tions and behaviors dated ates indicated the following: believes the following tions: very HS (hour of sleep). For HS, and the trying to leave without a screaming (2 days in June), e), cursing and swearing (9 cinating in appropriate places aff administers Trazadone ers and monitor for and monitor for a supset about as unsure why staff woke the morning. | {F 3/ | 09} | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | (X3) DATE | SURVEY PLETED |
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| | | 245427 | B. WING_ | · · | 1 | R /24/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY) | OULD BE | (X6) COMPLETION DATE |
| {F 309} | being combative with not aware if staff was morning, but stated th | report to her about R115 morning cares. LPN-A was waking R115 up in the ey should walt for him to efore attempting cares. | (F 30 | 09} | | |
| | stated she wakes R11 NA-A stated R115 bed he's not ready to get u stated if R115 is not re morning staff will get h | comes combative "when up in the morning." NA-A | | | | |
| | stated she does montl behaviors, although st times of day for R115. R115 behaviors are w | 24/13, at 12:25 p.m. RN-A nly summaries of resident ne did not look at specific RN-A verified many of ith morning cares, and this possibly decrease R115 | | | | |
| F 329 | | vide any further information issessments for R115 when | E 20 | | | |
| | UNNECESSARY DRU Each resident's drug re unnecessary drugs. A drug when used in exc duplicate therapy); or t without adequate mon indications for its use; | egimen must be free from in unnecessary drug is any ressive dose (including for excessive duration; or itoring; or without adequate or in the presence of s which indicate the dose discontinued; or any | F 3: | All residents drug regime v from unnecessary drugs. An unnecessary drug is any drug in excessive dose (including therapy); or for excessive du without adequate monitoring adequate indications for its u presence of adverse consequindicate the dose should be rediscontinued; | g when used duplicate ration; or ; or without ise; or in the ences which | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/09/2013 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | OWB NC |). 0938-0391 | |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER: | 1 | PLE CONSTRUCTION IG | (X3) DATE COMP | |
| | | 1. | | | F | ₹ |
| | · · · · · · · · · · · · · · · · · · · | 245427 | B, WING_ | | | 24/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | • |
| BETHESD | A NH PLEASANTVIEW | | | 801 SOUTHEAST WILLMAR AVENUE | | |
| | | | | WILLMAR, MN 66201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X6) COMPLETION DATE |
| F 329 | resident, the facility r who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral intervention | ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical swho use antipsychotic if dose reductions, and | F3 | or any combinations of the above. Resident R129 is currentle Meeker Memorial Hospita Services due to severe behavior managent policy and procedure had be developed to include week meetings to review behavior including non-pharmacologinterventions. | y admitted to l Behavioral avioral nent process been behavior ors and the ventions gical | |
| | by: Based on interview a failed to identify spefi oral or IM (intramuse medication) for beha- non-pharmacological residents (R129) rev Ativan for behaviors. | F is not met as evidenced and record review, the facility icle parameters for giving ularly) Ativan (antianxiety viors or provide Interventions for 1 of 1 lewed who received iM | | Training regarding invest injuries of unknown origin well as behavior managem completed for nursing staff. CMS Dementia training comodules – we are currently nursing staff on module 1 training will be completed 8/30/2013. The rest of the be completed on a monthly over the next 5 months. | are found as tent will be f by 8/30/13. Onsists of 6 y training all and this by modules will | |
| | psychosis, anxiety ar Minimum Data Set (M Indicated severe cog needed extensive as MDS further indicate behavioral symptoms she wandered daily. | nitive impairment and sistance with (ADL)'s. The d she had physical and s, verbal symptoms and that | | Seven residents have been the IDT as having behavio themselves or others such hitting out, resisting cares; residents have had behavio completed and new, indivi- interventions have been ad care plan and NAR assigns | rs that affect as yelling, these seven or assessments dualized lded to their | |

[R129] frequently wanders around the secured

| OLIVILIV | O I ON WEDIOMINE OF | MEDICAID SEVAICES | | | ONB NO | <i>J.</i> 0938-0391 | |
|--------------------------|--|--|------------------------|--|---|----------------------------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | COME | (X3) DATE SURVEY COMPLETED | |
| | | 245427 | 8. WING | | 1 | R /24/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | · | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| BETHESD | A NHPLEASANTVIEW | | | 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 329 | of others. Target behabiting, aimless wander pads, cursing, rudener resident's, scratching with cares and rejection redirect behavior, ensuratione, reproach [sic] at R129's physician order included an order for Amililgram (mg) oral or twelve hours as needed with an origination data not specify when to give R129's progress notes R129 went to the Centification of the continuous started increased and the continuous started increased and the continuous continuous and the continuous c | de on the privacy or activity aviors: disrobing, yelling, string, tearing up incontinent ss, bumping into other staff and combativeness, on of caresif unable to ure her safety and leave her at a later time." It is dated July 2013, Alivan (antianxiety) 1 intramuscularly (IM) every ad for anxiety and agitation e of 5/22/13. The order did are for Senior Behavioral brial on 11/28/12. Residents easing again. On 2/20/13 an 1 mg every 12 hrs for ilcan here and he also wrote if as needed in May 2013, not give staff parameters or all medication versus IM edication administration and July revealed the ved oral Ativan three times ved oral Ativan eight times, seed oral each | F | If any other residents begin of behaviors that are harmful to or others, the team will complehavior assessment. The Hadaily to discuss incidents, far changes in behavior and this team will identify the resident behavior assessments going DON and DSS or designed we responsible for auditing for the plans and follow-through on interventions and completion behavior flow sheets. Audit completed on 5 of these weeks, then monthly for 3 m. Audit results will be reported committee and additional act developed as needed. | o themselves olete a OT meets lls, and is how the ats needing forward. vill be behavior new a of s will be kly for 4 onths. I to the QA | | |
| | iviay, Juite a July 2013 | mulcated the following: | | | · | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | |
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| | | 246427 | B, WING | | 07/24/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| DETUESD | A NH PLEASANTVIEW | . * | 90 | 1 SOUTHEAST WILLMAR AVENUE | | |
| DE HIEOD | MHILLWAOMIIAIRI | | .] w | ILLMAR, MN 56201 | | |
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| F 329 | May 2013: Kicking, hitting, push pad did not occur. No cause was listed as calm reassurance, of the results indicated decreased, intensity | ning, disrobing, and shredding legalive- occurred 20 times unknown and interventions ne to one and return to room, I the behavior had | F 329 | | | |
| | unknown, interventic structured activity/gr remove to quite place environment, leave resident calm, toilet, fluid object to hold. interventions were in Hitting- occurred 10 interventions calm reactivity/group, one to quite place, assist wenvironment, leave resident calm, toilet, fluid object to hold. interventions were be Pushing- occurred 1 unknown. the interventions, intervention, remassurance, structione, distraction, remassurance, struction, and fluid object Negative- occurred a unknown. The intervensurance, structione, distraction, remassurance, structione, distractione, distracti | ot resistive. times. cause unknown, teassurance, structured o one, distraction, remove to th tasks, modify if safe reproach when return to room offer food and The results of the ehavior continued. 5 times. The cause is entions were calm ured activity/group, one to ove to quite place, assist with ment, leave if safe reproach toilet, return to room offer | | | | |

| | OF DEFICIENCIES FCORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| ľ | | • | A. BOILDI | /G | | R | |
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| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | | //24/2013 | |
| 1438.2011 | TO TIDE! | | | 901 SOUTHEAST WILLMAR A | | | |
| BETHESD | A NH PLEASANTVIEW | 1 | WILLMAR, MN 56201 | | | | |
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| F 329 | Continued From pa | ge 61 | F | 329 | | | |
| | _ | avior with in 15 minutes to | , | 12.0 | | | |
| | decreased intensity | | | | • | | |
| | Disrobing and shredding dld not occur. | | | | |] | |
| | | | | | | | |
| | July 1st thru July 24th 2013: Kicking- occurred three times, cause listed as | | | | | | |
| | | | | | | | |
| | | or or other resident, the | | - | | i | |
| | | ed staff left resident alone and | | | | | |
| | | esident calm and attempt with | | | | | |
| | different caregiver. The result behavior continued. | | | | • | | |
| | | times, cause listed a direct | | | | | |
| - | | erventions reassurance, | | | | | |
| | | roup, one to one, distraction, | | | | 1. | |
| | | ce, assist with tasks, modify | | | | | |
| | | if safe reproach when | | | : | | |
| - | | , return to room offer food and | | | | . [| |
| | fluid object to hold. | | | | | | |
| | | 3 times cause listed as direct | | • | | | |
| | | entions calm reassurance, | | | | | |
| | | roup, one to one, distraction, ce, assist with tasks, modify | | | | | |
| | | if safe reproach when | | | | | |
| | | , return to room offer food and | | | | | |
| | | Results were behavior | | | | | |
| | continued. | | | | | | |
| | | 38 times. The cause was | | | | 1 | |
| | | The interventions calm | | , | | | |
| | | ured activity/group, one to | | | | | |
| | | nove to quite place, assist with | | | | | |
| | | nment, leave if safe reproach , toilet, return to room offer | | | • | | |
| | | t to hold. Results were the | | | | | |
| | behavior continued. | | | | | | |
| | | lding did not occur in July. | |] | | <u> </u> | |
| | | | | | ı | <u> </u> | |
| | During interview on | 7/24/13, at 12:05 p.m., | | | • | | |
| | registered nurse (Ri | N)-A on the memory care unit | | | • | ļ l | |
| | stated, "we try to giv | /e [R129] Ativan oral first, if | | | | 1 | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | ······································ | | | | R 24/2013 |
| | ROVIDER OR SUPPLIER A NH PLEASANTVIEW | | • | 901 | REET ADDRESS, CITY, STATE, ZIP CODE I SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | ··· - | | |
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| F 329 | give her Ativan IM. It practitioner to do som everything. We curred involved with her and since June. Her behave had to give her Atiafter she received. Ati | ctive and wont take it, we alked to the nurse ething different we tried | F | 329 | | | | |
| | facility consultant nurs do not indicate when to should have. The CN oral and assuming if the control they probably of form. The CN further attempting to do some get so bad that they he in the IM form and ver | 24/13, at 1:00 p.m. the se (CN) verified the orders o give Ativan oral or IM and stated the staff give the ne behaviors get out of give the medication in IM stated they should look into thing before her behaviors ave to give the medication ified they have not looked its behaviors and should | | | | | | |
| F 428 SS=D | Pharmacy Consultant facility last week and s nurse manager that the cause and specific interestdents behaviors at done on the memory of consultant also stated holding the residents IM and they should have IM medications. | erventions for each and that it was not being care unit. The pharmacy the staff should not be nands down to give Ativan we parameters in giving oral | F | 128 | | | | |

| CLIVICI | O I ON MEDICANE & | MEDICVID SELVICES | <u> </u> | | OIAID IA | C. 0300-0381 | |
|--------------------------|---|--|----------------------|--|------------|--|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
| | | · | | | | R | |
| | | 245427 | B. WING _ | | 07 | /24/2013 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
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| | | | | WILLMAR, MN 56201 | | 1 · · · · · · · · · · · · · · · · · · · | |
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| | | | - | The drug regimen of each res | | 8/30/13 | |
| F 428 | Continued From page | | F 4. | ²⁸ be reviewed at least once a n | nonth by a | | |
| | | each resident must be | | licensed pharmacist. | | | |
| | pharmacist. | e a month by a licensed | | | | | |
| | pricitivation | | | The pharmacist must report a | | | |
| | | report any irregularities to | | irregularities to the attending | | | |
| | the attending physicia | | | and the director of nursing, a | ind these | | |
| | nursing, and these re | ports must be acted upon. | | reports must be acted upon. | | | |
| | | | | Resident R129 is currently a | dmitted to | | |
| | | | | Meeker Memorial Hospital 1 | | | |
| | | | | Services due to severe behav | | | |
| | This REQUIREMENT | is not met as evidenced | | concerns. | , | | |
| | by: | | | · | | | |
| | l . | review and interview the | | All other residents with orde | ers for IM | | |
| | | t falled to inform the facility y specific parameters of | | Ativan have had these orders | | | |
| | | tivan IM (intramuscularly) or | | discontinued and behavior p | | | |
| | | consultant pharmacist also | | being implemented per asses | | | |
| | | cility need for identifying the | • | | • | | |
| | cause of her behavior who received IM Ativa | s for 1 of 1 residents (R129) | | If PRN psychotropic medica | tions have | | |
| | Mun received livi Wilds | ₹ [], | | not been used in the past 3 n | | | |
| | R129 had diagnoses | of Alzheimer's disease, | | have been discontinued by the | • | | |
| | psychosis, anxiety and (MDS) dated 7/12/13 | d dementia. The quarterly indicated she was | - | provider. | | ì | |
| | cognitively impaired a | | | DON and Consultant Pharm | aciet have | | |
| | assistance with (ADL) | | | met and discussed need to re | | | |
| | indicated she had phy symptoms, verbal syn | | | unnecessary drugs, proper re | | | |
| | wandered daily. | representation distriction | | use, and parameters for use. | | } | |
| | · | | | pharmacist recommendation | | | |
| | | ian orders indicates that she | | followed up on by the DON | | <u> </u> . | |
| | receives Ativan 1 milli intramuscularly (IM) e | | | designee. | υ, |]. | |
| | | d agitation dated 5/22/13, | , | anni Enda! | | | |
| | The order did not indic | | | | | | |
| | | or IM or provide specific | | | | | |
| · ' | parameters as to which | h one to give | | | | 1 | |

| | CENTER | S FOR MEDICARE & | MEDICAID SEKVICES | | | | OM CIMO | . 0000-0001 |
|---|--------------------------|---|---|----------------------|-----|---|--------------------------------|----------------------------|
| S | TATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | | LETED |
| | | | 245427 | B. WING | | • | | ₹. 1412042 |
| _ | | O The on Alleria | IAFOFA | 0. 11110 | | TREET ADDRESS, CITY, STATE, ZIP CODE | 0/// | 24/2013 |
| | NAME OF PR | ROVIDER OR SUPPLIER | | | i - | 01 SOUTHEAST WILLMAR AVENUE | | |
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| | F 428 | indicated R129 went in Behavioral Health- Min Residents behaviors on 2/20/13 Dr. Fuglet every 12hrs for sever here and he also wroth needed in May 2013. | gress notes dated 6/28/13 | F | | Random audits of 5 residents curron psychotropic medications will completed monthly for 3 months. Audits will entail looking for parameters for use, appropriate diagnosis and appropriate target behaviors. Case managers or desare responsible for completing the audits. Audit results will be brouthe QA committee and action pladeveloped as needed. | be signee ese eght to | |
| | | record (MAR) for Jun following: June 2013-R129 rece and R129 received A | ived oral Ativan eight times, | - American | | | | |
| | | indicated R129's med 5/20/13, and 6/18/13, problem or irregularity medication regimen r written. The pharmac medications on 7/23/potential problem or in medication regime written. The pharmac | | | | | | |
| | | facility Consultant Ph at the facility last wee | /13 at 9:00 a.m., with the armacist stated that she was sk and specifically informed that they need to identify the | | | | | |

| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING | × | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | | | F 07/2 | R 24/2013 |
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| F 428 | pharmacy consultant not be holding R129 I IM and they should h or IM medications. Although there was n Ativan oral or IM and | which was not being mory care unit (MCU). The also stated the staff should nands down to give Ativan ave parameters in giving oral o parameters for giving the facility lacked identifying that its property of the consultant | F 428 | | | | |
| | | | | | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VKFY

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

| | PART I | - TO BE COMP | PLETED BY T | THE STAT | ΓE SURVEY AGENCY | Facility ID: 00792 | | |
|---|--|--|--|-------------------------------|--|--|--|--|
| MEDICARE/MEDICAID PROVIDER NO. (L1) 245427 2.STATE VENDOR OR MEDICAID NO. (L2) 516240800 | (L1) 245427 STATE VENDOR OR MEDICAID NO. (L4) 901 (L2) 516240800 (L5) WII | | DDRESS OF FACI ANH PLEASAN EAST WILLM AMN | NTVIEW | UE (L6) 56201 | 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint | | |
| 5. EFFECTIVE DATE CHANGE OF OWNERS (L9) | HIP | 7. PROVIDER/SU | PPLIER CATEGO | ORY 09 ESRD | | 7. On-Site Visit 9. Other 8. Full Survey After Complaint | | |
| 6. DATE OF SURVEY 05/08/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 | | |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 12.Total Certified Beds | - | Complian1. X B. Not in Co. | | gram | And/Or Approved Waivers Of Th 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: B * | 6. Scope of Services Limit 7. Medical Director | | |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 123 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| 16. STATE SURVEY AGENCY REMARKS (IF See Attached Remarks 17. SURVEYOR SIGNATURE | APPLICABI | E SHOW LTC CANCE | ELLATION DATE | 3): | 18. STATE SURVEY AGENCY A | APPROVAL Date: | | |
| Jessica Sellner, HFE NEII | | | 06/20/2013 | (L19) | Colleen B. Leach, Pro | gram Specialist 06/25/2013 (L20) | | |
| PART 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participat 2. Facility is not Eligible | | 20. COM | BY HCFA R MPLIANCE WITH GHTS ACT: | | 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : | | | |
| OF PARTICIPATION 02/01/1987 (L24) 25. LTC EXTENSION DATE: 27. | A. Suspension | | 24. LTC AGREEM ENDING DATA (L25) (L44) (L45) | | 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | 05-Fail to Meet Health/Safety o6-Fail to Meet Agreement | | |
| 28. TERMINATION DATE: (L: 31. RO RECEIPT OF CMS-1539 | 28) | 03001 2. DETERMINATION | | (L31) DATE | Posted 6/27/2 | 2013 ML | | |
| (Li | (2) | | | (L33) | DETERMINATION APPR | OVAL | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: VKFY Facility ID: 00792

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5427 Page #2

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we are imposing State Monitoring effective May 29, 2013 and we are recommending the following enforcement remedies to CMS RO:

- A Civil Money Penalty (CMP) effective May 8, 2013 for the deficiency cited at F225
- A CMP effective May 8, 2013 for the deficiency cited at F226
- Optional DOPNA effective July 8, 2013 (60 days rather than 90 days)
- Discretionary Termination of the provider agreement effective October 8, 2013 (Five months rather than 6 months)

Please note the facility is also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

Please refer to the CMS 2567 along with the facility's plan of correction.

Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2944

May 24, 2013

Ms. Michelle Haefner, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017 and H5427019

Dear Ms. Haefner:

On May 8, 2013, an extended survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the May 8, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5427017 and H5427019.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 8, 2013 extended survey the Minnesota Department of Health completed an investigation of two complaints number H5427019 and H5427017 that were found to be substantiated.

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

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 8, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

Telephone: (320)223-7338 Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

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

• State Monitoring effective May 29, 2013. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F225. (42 CFR 488.430 through 488.444)

Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethesda Nursing Home Pleasantview is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 8, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Oliver Potts, Chief 330 Independence Avenue, SE Cohen Building, Room G-644 Washington, DC 20201

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved 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.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SECOND OR FIFTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **July 8, 2013** (**two 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 optional denial of payment 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 optional denial of payment is in addition to any remedies that may still be in effect as of

Bethesda Nursing Home Pleasantview May 24, 2013 Page 6 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 8, 2013** (**five 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring PO Box 64900

Colleen Feach

Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

ADDENDUM TO PLAN OF CORRECTION

Provider Identification Number 245427

BETHESDA NH PLEASANT VIEW

901 Southeast Willmar Avenue

Willmar, MN 56201

F 155 Page 1 addition:

Beginning the week of June 24, 2013, residents/family members will be assured at care conferences that they have a right to refuse any care and/or treatment they may wish to. If a resident refuses, it will be documented in the IPN, plan of care and the refusal will be honored. During the interview audit, one of the questions is, "Have you ever refused any care or treatment and if so what happened?" As of June 18, 2013 during the interviews no resident has identified that they have refused care or treatment or that they had wanted to.

F 157 Page 6 addition:

The DON will monitor the 24 hour boards daily, Monday through Friday and RN charge nurse will monitor them on weekends to assure that physicians/physician extenders and family members are notified per Bethesda Pleasant View policy and procedure.

F 225 Page 14 addition:

Incident/fall/unknown injury reports are reviewed by the falls team daily Monday through Friday. The administrator or designee reviews reports daily and is responsible for compliance with regulation requirements.

F 226 Page 74 addition:

R137: An incident report was completed and submitted on 5/30/2013. Investigation report was completed and submitted on 6/3/2013.

Wallshed accepted

F353 Page 131 addition:

R133/74: On Bethesda's roster received from MDH, there is no R133 listed; according to Bethesda's roster, this resident is listed as R74. R133/74: An incident report was completed and submitted on 6/10/2013. Investigation report was completed and submitted on 6/13/2013.

F441 Page 148 addition:

Infection control is being monitored daily Monday through Friday for compliance and is currently being audited by DON/ADON at least weekly.

F496 Page 156 addition:

Nursing assistant registry was reviewed to ensure compliance.

Date of correction change to June 28, 2013.

Administrator Signature: McWellescefner Date: 6-20-13

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | (X3) DATE SURVEY COMPLETED | | |
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| F 000 | as your allegation of Department's acceptottom of the first properties to be used as verificated. Upon receipt of an arrevisit of your facility validate that substate regulations has been your verification. A standard recertification that went into an examplaint investigatime of the survey. H5427017 and H54 both were substantial Deficiencys had been better that the survey of the survey. | of correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will | F 00 | Preparation, submission and implementation of this Plan of Corredoes not constitute an admission of agreement with the facts and concluset forth in the statement of deficier All deficiencies listed on this 2567 ar under appeal. This Plan of Correction prepared and/or executed as a mean continuously improve the quality of to comply with all applicable state a federal regulatory requirements and constitutes the facility's allegation or compliance. All completion date | or asions acies. e n is ns to care, and f |
| F 155 SS=D | 483.10(b)(4) RIGHT ADVANCE DIRECT The resident has the refuse to participate and to formulate an specified in paragra. The facility must conspecified in subpart related to maintaining procedures regarding requirements include provide written inforced concerning the right or surgical treatments. | e right to refuse treatment, to in experimental research, advance directive as uph (8) of this section. I of part 489 of this chapter ng written policies and ng advance directives. These de provisions to inform and mation to all adult residents to accept or refuse medical nt and, at the individual's | Sold for the State of the State | BPV respects the rights of residents refuse treatment. On admission resident given a booklet entitled, Your Rights are also discussed with them. month, during resident council, one rights are reviewed with examples. Employees are oriented to resident at new employee general orientation annually. Resident, R177, died in the hospital in November 2012. Staff will be re-educated June 3, 4, a by the DON and ADON and 6 th by the about the residents' right to refuse and/or treatment. For staff who are | idents ghts. Each /two rights n and e nd 5, e NHA care |
| LABORATOR | Y DIRECTOR'S OR PROVI | DER/SUPPLIER REPRESENTATIVE'S SIG | SNATURE | TITLE | (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 deficiencles are cited, an approved plan of correction is requisite to continued program participation.

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| F 155 | Includes a written depolicies to impleme applicable State law. This STANDARD is Based on document facilities failed to en (R177) had the righ pharmacological interfered with persuactivities and social using a wheelchair | a advance directive. This escription of the facility's not advance directives and of the facility's and advance directives and of the facility's and interview, the escret of 1 resident's family at to refuse specific erventions. Bered Ativan (a medication by) after the family specifically did not want this medication eaken this medication in the eactions. | F15 | attend an independent study tool utilized. Staff receiving specific information about a resident refureport it to the nurse, who then not the clinical manager is aware and documents as appropriate. An integrated will be completed with 5 resper week by social services staff to weeks. Results will be reported to committee for further direction with NHA accountable for action items social services director will be resto monitor that residents will have right to refuse. The NHA is respondented to refuse with resident rights. | sal are to lakes sure erview idents or 8 of the QA ith the The consible ef the | |
| | According to nurse | s progress notes, (on the day | 1 | | | |

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(X3) DATE SURVEY

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| F 155 | regarding R177's an noted the family repativan at the previothis had the opposite According to a progress very upset and An order for lorazer hours, either orally thru 11/15/12 was redication on 5:00. On 5/2/13 at 3:41 properties in the facility contacte order for Ativan, and to R177 without commembers or honori FM-A stated they to R177's admission to R177's admission to R177's admission to R177's and they do mother. During an interview registered nurse can was unaware of the use of this medication on the medication of the place of the use of this medication on the medication of the place | 'family "was contacted gitation The documentation ported resident had received tus long term care facility and "te affect on her". gress note of 11/13/12, R177 a physician was contacted. Coam (Ativan) 1 mg every 8 or IM (intramuscular injection) received. R177 was given this p.m on this date. I.m. during a telephone mily member (FM)-A stated d a physician, obtained an d administered this medication insulting with any family ing their request of no Ativan. Old the facility on the day of that Ativan had been used at care facility with opposite if not want it given to her on 5/6/13 at 2:55 p.m., are manager (RN)-B stated she is family request regarding the ion. She reported that when a faction like this from a family, a ced in the front of the medical dication administration record stated that during the admission of document this family's eace. She further stated that if ted this family's request, it onored and the resident would | F | 155 | | | |

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| F 157 SS=D | A facility must imm consult with the resknown, notify the reor an interested far accident involving injury and has the pintervention; a sign physical, mental, o deterioration in heastatus in either life clinical complication significantly (i.e., a existing form of tre consequences, or treatment); or a dethe resident from the status in either life clinical complication significantly (i.e., a existing form of tre consequences, or treatment); or a dethe resident from the status in either life clinical complication in the resident from the status in either life consequences, or treatment); or a dethe resident from the status in either life consequences, or treatment); or a dethe resident from the status in either life treatment in the facility must all and, if known, the resident rights und regulations as specthis section. The facility must rethe address and pilegal representative. This REQUIREMED by: Based on interview assets and interview a | clark of Changes E/ROOM, ETC) ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in cotential for requiring physician ificant change in the resident's r psychosocial status (i.e., a aith, mental, or psychosocial threatening conditions or ms); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge ne facility as specified in so promptly notify the resident resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update mone number of the resident's e or interested family member. into is not met as evidenced w, and document review the sure that a physicians were | | | BPV staff do inform residents, family members and physicians when there been an accident, a significant change the resident's physical, mental or psychosocial status, and a need to a treatment significantly. Nurse practs aw R122 on 5-10-13. She reduced metoprolol to 25 mg with orders to monitor and inform her of vital significant of the data she then reduced dose to 12.5 mg on May 13, 2013. The physician visited 5-15-13 and made further changes. No further episode syncope or fainting have occurred. Will be educated on when to contact physician and/or physician extended by the contact of the physician has be reviewed and revised. Wital signs are taken by NA's and LPI are to be reported to the RN if they within normal limits. Staff will be expectations. All other resident vital have been reviewed by the clinical managers and appropriate actions we taken: re-take the vital signs and/or contact the physician. The pressure protocol was reviewed and revised. Specific attention was paid to address the location, staging, size, exudates description of wound bed and wouredges, supplies to be utilized, and a december of the physician of wound bed and wouredges, supplies to be utilized, and a | e has ge in Iter 7/8/2013 |

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F 157

Continued From page 4

notified of changes in a residents condition which included fainting spells during transfers, abnormal vital signs and development of a pressure ulcer for 1 of 1 residents (R122) who had a change in condition that needed physician intervention.

Findings include:

R122 since 12/07/2012, had experienced several episodes of passing out while using the standing mechanical (PAL) lift, had vital signs outside of the normal parameters, and developed a pressure ulcer on 3/29/13. R122 physician was never notified of these changes in R122 condition.

R122 had diagnosis including hypertension and heart disease. R122's quarterly minimum data set (MDS) dated 3/1/13 identified the resident had moderate cognitive impairment, needed extensive assistance with all activities of daily living, was totally dependent on staff for all transfers, and did not have any skin concerns or pressure ulcers.

R122's medical record, interdisciplinary progress notes (IPN) identified the following episodes of R122 "passing out" when using a mechanical (PAL) lift for transferring.

12/7/12- "Family is aware that he does have a spell and 'pass out' when in lift; PLEASE assist him to meet his tolleting needs..."
1/21/13- "This afternoon staff had resident standing in standing PAL lift. They were changing his pad. He had a spell. His face got red and his body went faint. Staff put him down

specific protocol to follow. The DON is responsible for wound care management. The documentation for any/all other pressure ulcers has been addressed. Audits of the documentation for each resident with a pressure ulcer will occur weekly for 4 weeks. Policy/procedure reviewed and revised for outlier vital signs. The results will be reported to the QA committee for further direction on frequency and number of audits/week.

Facility ID: 00792

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| F 157 | Continued From pa | ge 6 | F1 | 57 | | | |
| | of the normal range Clinic identifies a "n 120/80" and "heart 60-100 beats per m consistently lower of dizziness or light consult your physic current physician of the following medic Metoprolol tartrate hypertension (high Lisinopril/ HCTZ 10 hypertension. Lasix 40 mg twice a Zaroxylin 2.5 mg da Upon review of R12 Tracker under "Resthe following: 2/26/13- Blood presthe following: 2/26/13- Blood presthe following: 3/15/13- B/P and pulse they were accurate improved. 3/5/13- P-49. There reading. 3/12/13- B/P-55/96. of this reading. 3/15/13- B/P- 53/99 recheck of this reading. 3/19/13- B/P- 97/55 recheck of this reading. | /12.5 mg everyday for a day for edema (swelling). ally for edema. 22's vital signs charted in Care sident Vitals Chart" indicated ssure (B/P) 95/57 pulse (P) 45. were not rechecked to ensure or if the B/P and pulse e was no recheck of this P-41. There was no recheck P-44. There was no ding. F-46. There was no | | | | | |

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| F 157 | reading. 4/16/13- B/P- 100/8 recheck of this reading. 4/23/13- B/P- 76/3 recheck of this reading. 4/30/13- B/P- 92/54 recheck of this reading. During interview or assistant (NA)-O si assistants do the viange they are supnurse in charge. No having out of range 120/80, pulse 70-96 During interview or practical nurse (LP or pulse is "out of reporting the vital sclosely monitored, physician. LPN-A sthe vital signs the Nois the it is responsil nurse if there are volumedications can effout was unaware of signs. During interview or reviewed the vital sign rechecked, reporte physician notified. If physician or NP visital sign or NP visital or N | re was no recheck of this 7. P-45. There was no ding. 8. P-46. There was no ding. 4. P-49. There was no ding. 5/7/13 at 1:00 p.m., Nursing ated that the nursing ital signs and if they are out of pose to report them to the A-O was unaware of R122 outal signs (blood pressure) | F 157 | | | |

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| F 157 | record lacked evide signs were not follow physician. Upon review of R12 | A verified that R122's medical nce that the abnormal vital wed up on or reported to the 2's interdisciplinary progress | F1 | 57 | | |
| | ulcers: 3/29/13- "Coccyx is calmoseptine. Notif 3/31/13- "Resident I bottom. Calmosept continue to monitor. 3/31/13- "Resident I hours and Calmose area on his bottom. 4/1/13- "Resident ha One on right upper buttocks. Stage on- been applying Calm cares, however, the Assisted staff with of Applied skin barrier Calmoseptine over Mepilex dressings, 4/11/13- "Per RN re wound/ sore open to Will continue to mon 5/1/13- "Resident co areas on bottom. Of close to butt crease drainage. It appear previously recorded healed and is a stage | nas red open area on his ine cream applied. Will " was repositioned every 2 ptine was applied to his open ." as two open areas on bottom. buttocks and one on left upper e with no drainage. Staff have roseptine to area daily with y have not minimized. cleansing buttocks area. prep. Let dry. Applied both open areas. Applied both open areas. Applied one to each open area." quest leave residents bottom o air dry. Please apply calmo. | | | | |

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| F 157 | 5/3/13 indicate, "In stage one/ stage two bottom near his but followed out wound stage one to the rig centimeters (cm) x near the crease that The left buttocks hat that measures 3 cm the center which measures are on bottom" | on the pressure ulcers on April it was noticed he had a to pressure areas on his t crease. The treatment protocol currently there is a ht buttocks that measures 4 3 cm with a stage two center it measures 0.3 cm x 0.3 cm. as a stage one near the crease in x 3 cm and a stage two in easures 0.2 cm x 0.2 cm. and purple colored skin noted | F | 157 | | | | |
| • | stated although star pressure ulcer at the nurse practitioner of pressure ulcers unta after the facility ider ulcer). RN-A verifies | 5/7/13 at 11:50 a.m. RN-A ff were aware of R122's e end of April, the physician or were not notified about the il 5/3/13 (about one month atified R122 had a pressure ed staff should have notified diately of any new open areas | | | | | | |
| F 225 SS=K | Policy and Procedu "The physician or n notified of all new w significant change i is not healing" 483.13(c)(1)(ii)-(iii), INVESTIGATE/REI ALLEGATIONS/IND The facility must no been found guilty of mistreating residen | PORT | F 2 | | BPV staff report alleged violations in mistreatment, neglect, or abuse, incl injuries of unknown source and misappropriate of resident property immediately to the administrator. Ti alleged violations are thoroughly | luding | 7/8/2013 | |

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| F 225 | registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and certifications are thoroup revent further pote investigation is in property of the administrator representative and with State law (includent, and if the appropriate corrections). | abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry les. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the entification agency). In the state all alleged up to the entitle abuse while the rogress. It is designated to other officials in accordance adding to the State survey and within 5 working days of the alleged violation is verified the action must be taken. | F 22 | is prevented. The results of the investigation are reported to administrator or his designee officials in accordance with structure able adult abuse policy procedure was reviewed and investigative report form was was trained on May 8 and 9th June 3, 4, 5 by the DON and A June 6 by the NHA. The 'star questionnaire' documents are staff being interviewed about neglect. Audits will be conducted by its staff per week for 8 weeks or requirements of the Vulneral abuse act. DON and ADON we conduct 5 interviews of staff in various situations weekly for Auditing of 5 investigative reweek will be done by the NHA weeks and then two per we weeks. This audit is for complappropriate reporting. Audit of voice, appropriateness of cand location will occur by DO be reported to the QA comm | the e and to other tate law. The vand revised. The servised. Staff h, and on aDON and on aff e the notes of tabuse and reporting ble Adult vill each on what to do for four weeks. Exports each A and SSD for eek for 4 leteness and ts of CNA tone conversation DN. Results will littee. The | |
| | by: Based on interview facility failed to ensi neglect, and injuries | and document review, the ure all allegations of abuse, sof unknown origin were ated and immediately reported | | DON is responsible to assure are done, the NHA is respons that the investigations are co have been reported as requir state/federal laws. | sible to assure emplete and | |

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| F 225 | to the administrator required, for 17 of 3 R57, R55, R137, R R179, R39, R181, F whom allegations or eviewed; and failed unknown origin wer reported to the SA R19, R177, R8, R8 R128, R10, R4, R3 sample who were reunknown origin. The lack of identific protection, and reported in the administrator (not (DON), and the direction were notified on 5/3 immediate jeopardy the residents at a president of identification protection, and reported in the residents at a president of identification of identification and residents in the facility initiated included revision of and training provided prior to any direct realso conducted training education neglect and abuse, | and State Agency (SA) as to residents, (R122, R3, R43, 128, R67, R10, R180, R5, R59, R75, and R117) for f abuse and/or neglect were if to ensure injuries of the thoroughly investigated and for 16 of 35 residents (R115, 6, R109, R15, R51, R68, R98, 7, R120 and R67) in the eviewed with injuries of atton, investigation, resident orting constituted immediate R3, R43, R57, R55, R137, 5, R39, and R117 who he facility. A)-L, the director of nursing ector of social work (LSW)-A in the health and safety of attern level (K). The systemic on, investigation, resident orting incidents of potential the potential to affect most | F 225 | The results of each investigation will found opposite the resident specific statement of deficiencies. | | |

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| F 225 | explain their respondincidents of potential reporting; resident pexternal reporting a revised abuse previous removed on 5/scope and severity harm with a potential harm, pattern. Findings include: R122 who was a cunursing assistant (Nodid not want that nucare of him. The farefalled in the NA continuity resident. R122's allegation of and the NA continuity interview on stated a NA is "very "he swings me back around. I've got a seriound. I've got a seriound. I've got a seriound, and said the never mind, you are nurses he didn't wat take care of him and R122 they would take stated the NA still tanurses "didn't do ar | ge 12 priviewed and were able to sibilities for identification of al mistreatment; internal protection, investigation; and as defined in the facility's ention plan. The immediacy 8/13 at 3:20 p.m., and the was reduced to no actual al for no more than minimal all for no more than minimal arrent resident, told staff a NA) was rough with him and he was reduced to investigate for the NA being rough with him, ed to provide care for the solitity did not investigate for the NA being rough with him, ed to provide care for the soliting at 3:05 p.m., R122 or rough" with him. R122 stated, and forth and pushes me swollen hip and it hurts me." The NA he hurt and it was too NA had responded, "just be OK." R122 said he'd told the not the nursing assistant to ymore and the nurse had told ke care of it. However, R122 akes care of him and the nything about it." R122 no is rough with him as NA-A. | F2 | 225 | Training on the vulnerable adult abubill of rights and Elder Justice Act ocin March of 2013 for all staff. Traini occurred on May 8 and 9 th on the revulnerable adult abuse act and the krights. Residents 122, 3, 43, 57, 55, 128, 67, 10, 180, 5, 179, 39, 181, 59, and 117 each had a report and investigation completed. Any changes/recommendations to their of care are listed below: R122-Interviews of the resident, NA other NA's were completed. NA-A is assigned to this resident; however, assist with two person transfers with resident's permission. Care and tranaudits of 35 people at random occur 4 weeks; now it will continue at 25 people weeks for 4 weeks. Care and transfers were completed by nursing staff. Designed to the CA completes for the reported to the case of the reported to the case of the reported to the case of the resident to the case of the reported to the | curred ng vised oill of 137, 75, 75, 75, 75, 75, 75, 75, 75, 75, 7 | |

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| F 225 | Review of R122's Findicated the follow 4/10/13- "Resident evening and wante this writer arrived ir did not want the matonight or in his roo don't trust him, he sexplain that someo him and that this whimit was explain wife that this would director of nursing of nursing (ADON) During another inte 3:40 p.m., R122 stover an hour ago to stated when NA-A bathroom R122 has because he did not him. The resident swait to see if any of an hour, he stated the bathroom any locall light again for a NA-A came in agait there "anyone else R122 said NA-A has only one here." R1 rough with me. He come in here, but he During interview or stated he knew R1 care of him anymone. | racility Progress Notes ing: was very upset this early do to talk to this writer. When his room he stated that he ale NA working with him m because 'he is a liar and lies about me.' This writer ne else would be working with riter would take care of that for ed to both the resident and be investigated and that the (DON) and assistant director | F 225 | Further direction. | | |

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| F 225 | R122 had put his cand confirmed that light, the resident h NA-A stated when I respond to R122's asked if there was the bathroom. NA-was no other staff a worked full-time an residents to care fo transferred "many r to be a transfer of to other staff did so as "short staffed and the with transfers." During interview on practical nurse (LP reported abuse he to see if it was "vali aware R122 did now know why. LPN-B to anyone because He verified NA-A conduction of the properties | ts to care for. NA-A verified all light on earlier in the day when he'd answered the call ad told him to "just forget it." he went back an hour later to call light, the resident had anyone else to assist him to A stated he'd told R122 there available. NA-A stated he d this was his usual hall of r. NA-A also confirmed he residents" who were supposed wo, by himself. NA-A stated is well because the facility is here is no one else to assist a 4/29/13 at 6:06 p.m., licensed N)-B stated if there was would "talk to the resident first" d." LPN-B stated he was tike NA-A, but really didn't stated he had not reported this "everyone already knows it." ontinues to care for R122. In 5/1/13 at 12:30 p.m., family ated she had talked to a nurse to NA-A no longer provide cares is "rough with him [R122]." urse had told her she would vever, FM-G said NA-A | F | 225 | | | |

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| F 225 | any investigation in was no documenta to R122 more about conversation with N verified the residen reported to the adm. Although the facility NA-A of being roug the NA to provide convestigate his conception of the providing R122's care R122 had also informight because some the bathroom and to in his brief instead. Review of R122's fathe following: 4/10/13- Resident's get him up to the to he states he has to yourself'." During interview on stated, "If I ask to gusually tell me to just clean it up later. I to tell me it's ok, just greally made him fewhen he has to sit. | provide any documentation of to R122's concerns. There tion that the DON had spoken at his concerns, nor NA-A. In addition, the DON t's concern had not been ministrator or SA. I was aware R122 accused the with him and did not want traces for him, the facility did not cerns, nor remove NA-A from are. I med staff he was neglected at the staff refused to take him to cold him to go to the bathroom accility Progress notes revealed as wife stated, "Staff needs to collet or give him a urinal when a go and not tell him to 'wet at 4/30/13 at 3:29 p.m., R122 go to the bathroom at night they lest poop or pee in my pants. It go in my pants and they will call them I don't want to but they go ahead." R122 stated it call bad and it hurts his "bottom" | F | | | | |

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| F 225 | go to the bathroom him to the bathroom not conducted any documented such, shift" to take reside request. The DON to the bathroom in them to the bathroom eglect. The DON a.m., this allegation been reported to the R3 a current reside had been rough will investigated or immadministrator or the R3's annual MDS of was cognitively into at 2:00 p.m., R3 staworks at the facility with her during care reported this at her care conference te anything has been staff member who R3 stated NA-FF s also stated she way with assist of two, I transferred her bed available to assist. Review of the facility notes (IDP) dated 3 Conference was hed did not address the | ing the night shift telling him to in his pad instead of taking in. The DON verified she had formal investigation nor but stated she "reminded night into the bathroom upon verified asking a resident to go their pad and refusing to assist om would be considered verified on 5/713 at 11:50 of potential neglect had not e SA or the administrator. Int, reported a staff member the her which was not nediately reported to the | F | 225 | R3 Report/investigation completed, cares for resident very infrequently resident permission. Staff training of May 8 and 9 th . DON/ADON will hold nservices on June 3, 4, 5, and the Ni June 6 to include resident rights, vulnerable adult abuse and transfer Nursing staff have/will audit thirty-residents care/transfers for 4 weeks residents will be audited for the neweeks. Audits of staff (nursing staff knowing when/what to report will hwith 5 employees weekly for 8 weeks Results will be reported at QA. QA determine continued frequency and | with ccurred decourred decourred decours decou | |

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| F 225 | facility's incident repreports, did not add NA-FF being rough NA-FF being rough reported to the adm by the facility's police. R43 a current reside assistant had been R43's quarterly MDS was cognitively interable to communicat problems. The MDS specific behaviors obut required extensifor all her personal of R43 was interviewe and reported several assistant had been of a shower and dur the nursing assistant clothes and that she nicer to me?" R43 in seemed to get so up the shower room, by clothing." R43 also assistant had showed but there had been R43 stated it made nursing assistant we like it. She stated she these feelings, as she mad at her. A phone interview we have the shower interview we have the shower room. | orts and Vulnerable Adult ress R3 concern regarding with her. R3's allegation of was never investigated, or ninistrator or SA as directed y. ent, reported a nursing rough with her. S dated 2/1/13, indicated R43 ot, had clear speech and was e her needs without any S indicated R43 had no r any symptoms of delirium, ve assistance from one staff | F 2 | R43. NA terminated. Plan and revised. Staff received Vulnerable Adult Abuse act and the Elder Justice Act in Staff were inserviced on redignity on May 8 and 9 th . and vulnerable adult abus occur on June 3, 4, 5 for moderable adult abus occur on June 3, 4, 5 f | d training of the control of the con | on the trights, 013. I ights ing will f the 6 th . ents orted to ion. | |

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| F 225 | she was given by a being undressed in also during the short to the facility about report, had been to would not bathe or mother. The initial report of the State agency or report was filed with same day. The correcurrence of this in assistant was not to assistant was to hat the room. The repoidentified as NA-J. The nurses' progres indicated FM-AA hassistant's behavion ursing assistant wreprimanded. The FM-AA requested the work with her mothed A random review of provided care to RA the documentation system that allows provided to residen had provided cares though NA-J was not for R43. An interview with recompleted on 5/7/1 reported she was not that NA-J not work reported she was used. | arding the rough treatment nursing assistant when was preparation for a shower, and wer. FM-AA said she'd talked this and as a result of the d the identified staff person provide other services to her or a control of the state agency on the rective action taken to prevent acident included the nursing to bathe R43 alone; the nursing we another nursing assistant in the state agency on the rective action taken to prevent acident included the nursing to bathe R43 alone; the nursing we another nursing assistant was associated assistant was "unacceptable" and the could be appropriately progress note indicated his nursing assistant never | F | 225 | | | |

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| F 225 | which specified if N staff person was to indicated she was a restrictions with NA worked with. RN-A work with R43 as no giving R43 a showed have been made as The facility had sub 3/12/13, (complaint regarding multiple at neglect that had be East side of the nurwere not thoroughly reported to the SA by the facility's policy the following: "On 3/6/13 writer worked on the floor was her training pering sick of taking of When a resident for resident to remain done; the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the resident to remain done the NA said and picked the res | A-J showered R43, a second be in the room. RN-A unaware there were any a-J and which residents she areported NA-J continued to eeded, which could include er. RN-A verified she should ware of this situation. In the same and the | | 225 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | E ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 225 | they were suppose residents were drop Related to these into work here." The Investigative reagency (OHFC -off investigations) on 3 original complaint) "Potential issues were the nursing home is resided on the East with some West erpreviously resided residents were interesidents were interesidents were interesidents. Not reports from resident mistreated by staff interviewed, mostly past employees. Staff were neglectforesidents. It has not resident was injure lifestyle altered. At current and former named as people of met with primarily on 3/8/13. Staff we appropriate resident importance to report their education" the SA also identifit to attend, a session 3/22/12, 3/27/12. | to use two staff. These pped into bed as a result cidents, NA-K did not continue eport submitted to the State lice of health facility 8/12/13, (6 days after the | | 225 | | | |

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| F 225 | the facility did not id spoken to regarding who'd allegedly falle there was no indica had been conducted allegations. During interview on DON and LSW-A stacility for only a sharemember specific. The DON and LSW who had specifically allegations. They we documentation of a resident who'd allegup and put into bed stated NA-K only withe facility should have residents had fallent employment to detevalid. The DON stationallegations made by education for the Earesident care, as we staff and residents building. The DON that were offered, a vulnerable adult reproducted in 2012, mandatory retraining again regarding the staff. The DON stationallegations in the last yunable to do it again where the education staff to do this once | lentify any staff they had gother concerns, the resident on was not identified, and tion any further investigation direlated to NA-K's 5/1/13 at 11:15 a.m., the tated NA-K worked at the cort time and could not names of employees or staff. -A stated they were unsure of investigated NA-K's were also unable to provide any investigation regarding the gedly fallen and been picked by a (unknown) NA. LSW-A corked for "a couple days" and are investigated to see which a during NA-K's short termine if the allegation was | F 225 | | | |

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| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | W | g | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES OF THE | BE | (X5) COMPLETION DATE |
| F 225 | mistreatment made interviews alleging general questions a noticed staff being on the East end?" their human resounded the interviewing ups for employee fiftom the facility and interviewed during the DON stated shinvestigations, empany monitoring of expressed concern because she (the Dworking for the facility and interviewed during the DON stated shinvestigations, empany monitoring of expressed concern because she (the Dworking for the facility and investigations of staff registed he had not investigations. A-E staff mistreatment of dynamics" and how A-E stated it appear girls club and he convipers, "meaning halong and were man other regarding missing sw-A provided her 3/25/13, of the alleginvestigation of the NA-LL reported the interview East end interviews many alleging the staff interviews many alleging interviews many alleging the staff interviews alleging the staff interviews and interviews alleging the staff interview | regarding the allegations of by NA-K or from further staff abuse, but rather were asked uch as "Have you ever verbally or physically abusive The DON and LSW-A stated ces staff (HR)-J, who mainly and corrective action write es, was currently on leave | F 225 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | COMPLETED | | |
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| | | 245427 | B. WING | | 05/08/2013 |
| | PROVIDER OR SUPPLIER DA NH PLEASANTVII | €W | | REET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETI |
| F 225 | and investigations of perceived negative East end staff, bein many of their co-wood determine whether truthful. Residents effort to determine mistreated or felt fe were mostly positive were followed up or action process. The determine that furth (Minnesota Departroccur. Staff were extregarding allegation regarding allegation regarding some of determined that no their abilities affects much of what was adjusted distributional staff of substantive resident According to the reallegations of abuse provided information investigations they resident RESIDENT INTER' | re reported to state agency vere conducted Given the working environment by the g unhappy and angry with orkers, it was difficult to all of the allegations were were also interviewed in a whether residents had been arful. The resident interviews e. Some of staff allegations in with staff through disciplinary ough these meetings it was her reporting to MDH ment of Health) did not need to ducated and disciplined is. Of the staff allegations the named residents it was resident was actually injured, ed, or lifestyle altered. Again, shared points to a culture rather than any trabuse." Dort submitted to the SA on 5427019, the facility indicated various residents and staff on nursing home regarding er and neglect. The facility in from the interviews and discompleted as follows: | F 225 | R57. Report and investigation compl Staff interviewed. Resident calls out "owie" during cares no matter how | |
| | R57's- resident inte | rview questions dated 3/2013 | | staff are. Resident responses are no related to situation, for example: sa | t |

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| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | :W | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | SOUTHEAST WILLMAR AVENUE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 225 | treated roughly by s "Sometimes." Ther done or investigation from the resident. During interview on stated she was not interview with R57 t investigation or follor response. R55's a current resident she was impairment. R55's resident inter asked the resident because of the way treated?" R55 resp when I'm alone beckeep it closed." Th investigation regard During interview on DON stated this was conference and R5 wanted her door clo worry about other ro The DON stated the this nor was there a | dent, "Have you ever been taff." The resident answered, the was no further interview in regarding this response. 5/1/13 at 11:40 a.m., SW-A sure who completed this but verified there was no low up for the resident's. dent's, quarterly MDS dated to had severe cognitive. View questions dated 3/2013, "Do you ever feel afraid you or some other resident is onded, "Sometimes at night ause I can't lock my door and there was no further interview or ling R55's response. 5/2/13 at 10:53 a.m., the is talked about at care 5 was not "afraid," she just osed so she didn't have to desidents coming into her room. The ere was no documentation of any further investigation. | F 2 | R5 me eld do ou dis Sh | et those darkies out of my room," idst of the interview. Behavior logarted 5-30-13. Pain monitoring inicelenol QID initiated. 55. Interviewed spouse. Resident emory loss. BPV placement due to openents at home. Resident wan for locked at home so she couldn't it. Was on memory care unit and stressed with other residents wan se was moved to long term care, cores close her door and has adjuste | has ted the t get dering. an and | | |
| | R137's resident inte indicated when ask | e was cognitively intact. erview questions dated 3/2013, ed, "Have you ever been staff?" The resident | | N/ | .37. Report/investigation complet AR no longer works here. Residen nsistent in recall of events. | | | |

Facility ID: 00792

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | COMP | LETED |
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| | | 245427 | B. WING | | 05/0 | 8/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | (| REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE NILLMAR, MN 56201 | ,,,,,, | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | responded, "One m little." R137 was also been rude to you?" member a couple ti was no further inter R55's responses. During interview on stated she had not made regarding a shim and "shaken himust have completed followed up on it. So investigation nor was clarification from the accusations of staff fast with him. R128 a current resident of the identified when ask rude to you?" The inhave happened; 'quand I didn't feel that were no follow up of there was no invest R128, who was continued per the quarted interviewed on 5/3/ at times, the night rand rude when they 4:00 a.m. to check | oved too fast; shaken up a so asked, "Has staff yelled or R137 responded, "One staff mes when getting up." There view or investigation regarding 5/2/13 at 10:53 a.m., SW-A heard of the accusation R137 taff member who had yelled at m up." SW-A stated SW-B ed this investigation and not tw-A verified there was no as there any further e resident regarding the f yelling at him or moving too dent, had a quarterly MDS ated he was cognitively intact. erview questions dated 3/2013, ed, "has staff yelled or been resident responded, "May uestioned why I did what I did t was appropriate." There uestions asked of R128, and | F 225 | R128. Report/investigation completed interviewed other residents on same No abuse suspected. Social services to interview 5 residents each week weeks about resident rights with dareported to the QA committee for fedirection. | e unit. staff for 8 ta | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | · | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW . | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE /ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION SH | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | During interview on stated she had not made regarding nig LSW-A verified their was there any further resident regarding to behaviors of being: STAFF INTERVIEV A staff questionnair NA dated 3/11/13 in any verbal or physic the East end?" The "Your [residents] go shift comes; between BM (bowel movement shift and then was no further interallegation of resident. During interview on DON and LSW-As with any staff or resincident. A staff questionnair 3/7/13 indicated, "For physical abuse to end?" NA-D had rehoyer [lift], the residus on NA put the walthem to walk. The Per NA-D the (unkriday." There was no investigation of this | b/2/13 at 10:53 a.m., LSW-A heard of the accusation R128 tht shift being rude to him. The was no investigation nor er clarification from the she accusations of staff abrupt, rude or harsh. WS: The completed by an unknown included, "Have you witnessed call abuse to any resident on the entrown NA had responded, bring to have to wait until next en 6-6:30 a.m. during report; if eart) feel they have to wait until forget to tell next shift." There wiew or investigation of this | F2 | 225 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245427 | B. WING_ | and the second s | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER | :W | S | STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVENU WILLMAR, MN 56201 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 225 | During interview on DON stated the supincident" and spoke the administrator wanor was the state agabove incident. The the resident was Renot spoken to the reNA-B (identified by allegation of neglectinvestigation of the current resident and she had moderate of A staff questionnair 3/11/13, indicated sidepartment a situat R67 and NA-B, "toke insisted she could, informed ADON and was no further investing interviews with During interviews with During interviews with and stated the admof the incident, nor contacted. A staff questionnair indicated he "Knowdidn't say specifics over there'." There investigation regard. | 5/2/13 at 11:15 a.m., the pervisor had "checked into this on to NA-D. The DON stated as not notified of the incident, gency contacted regarding the eDON verified she believed of, however, stated she had esident or the alleged staff, DON), regarding this tand had no written alleged incident. R67's was a ditheir quarterly MDS indicated cognitive impairment. The done by TMA-A dated he had reported to the nursing ion that had occurred between the R67 to 'walk then' since she Really needs hoyer dishe talked to NA-B." There is stigation of this incident nor the resident. 5/2/13 at 11:15 a.m., the re had been no investigation, inistrator had not been notified was the State agency The done by NA-A dated 3/8/13, as there's issues on East end; but said 'waters a little thicker was no further interview or | F 22 | R67. Report/investigation c Staff interviewed and valida account. Resident is cognit | ted NA-B | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 8/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 225 | A staff questionnair dated 3/8/13 indicar coworkers talked al abuse they or anyoresident?" The ADO"YesVerbal beh 'shit themselves'." or investigation of tinor employee were alleged incident. During interview on DON stated she was alleged incident. A staff questionnair indicated, "Have ar about any verbal or anyone else may he RN-A had respond becoming more fru a resident had told by staff, and it had stated the ADON ir multiple complaints observing a employ resident bed while bathroom. There we investigation of the During interview or DON stated she had | g the statement he made and that it meant. The completed by the ADON ted, "Have any of your cout any verbal or physical ne else may have done to a ON had responded, ind resident's back. Resident There was no further interview he statement, and the resident identified in the above 15/2/13 at 11:15 a.m., the as not aware of the above The done by RN-A dated 3/11/13 any of your coworkers talked physical abuse they or ave done to a resident?" The done to a resident?" The done is a resident? The shower been reported to OHFC; she avestigated. RN-A also indicated her she was left in the shower been reported to OHFC; she avestigated. RN-A also had a for staff using cell phones and the resident was using the as no further interview or see statements. The statements are the statements are statements. | | 225 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | ONSTRUCTION | | TE SURVEY MPLETED |
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| | | 245427 | B. WING | | | 05 | i/08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVII | EW . | | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE .MAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SH BE CROSS-REFERENCED TO TH APPROPRIATE DEFICIENCY | OULD {E | (X5) COMPLETION DATE |
| | A staff questionnair 3/7/13 asked, "Have physical abuse to a RN-B had responde for not doing proper face." There was n investigation of this residents, nor employed proper face." There was n investigation of this residents, nor employed proper face." There was not for any face of the polyent proper face." The polyent proper face. The physical proper face | ge 29 e completed by RN-B dated e you witnessed any verbal or ny resident on the East end?" ed, "Sometimes get after girls care; brush teeth, washing o further interview or statement and neither the oyee were identified. 5/2/13 at 11:15 a.m., LSW-A I the questionnaire completed llowed up on and there was n available regarding any of e completed by NA-GG on R10 fell during a transfer with oack to desk to eat and then the nurse [resident's name] or right away." R10 who is a sir quarterly MDS dated or had severe cognitive 5/2/13 at 11:15 a.m., the ated R10 had fallen and had not been reported to the facility had determined there istreatment which occurred. an interdisciplinary progress of facility identified as their all) for R10 dated 12/20/12, ich happened when NA-C osident. The note identified | F2 | R10 emplago Staf Care wee don nee- mok shee repo tran to b dres not | D. Fall was reported by former ployee and allegedly occurred. Interview/investigation comf training on transfer compliane/Transfer audits on 35 residents and 25 residents for 4 ween. Side rails removed from beds 1-2 persons to assist with boility on 12/18/12. Staff to utilet, allegro pad and the residents, allegro pad and the residents and re-position. Brakes are to be on disfers and re-positioning. Staff e more careful and move slowering, transferring, turning in the surprise her to help preventing. | months inpleted. ince. ints for 4 iks being ed as she bed illize lift int to uring if directed wer when bed, try | |
| - | Resident slid out of a | snower chair at 6:50 p.m. | | 1 | | | 1 |

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| | PROVIDER OR SUPPLIER | ≣W | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTIES OF THE PROPERTIES OF T | D BE COMPLÉTION |
| F 225 | Staff was unhooking resident leaned for and pulled herself it slip to the floor; state groundResident clong abrasion to the Bruising may happ posterior side of leg floor and legs of the have bed bath" After review of the DON on 5/2/13 at 10 the 12/20/12 progres being transferred were sident is supposed staff. There was also regarding the alleg nurse right away of incident should have reported to the SA was not. The DON also provinced and you went to the failed to find a nurse telling the nurse ablaughing." The DOI corrective action is if the allegation is reasonable and you went to the failed to find a nurse telling the nurse ablaughing." The DOI corrective action is if the allegation is reasonable would out; then come backers. | g straps to lift sling when ward and grabbed the lift bar orward. Resident started to ff assisted resident to the does have a 2 cm (centimeter) e left side of her head en to her coccyx area and the gs bilaterally due to hitting the elift Resident proceeded to IDP, during interview with the 1:15 a.m., the DON verified ess note indicated R10 was with only one staff; although the et to be transferred with two so nothing documented ation of NA-C not notifying the the fall. The DON stated this we been investigated and and the administrator, which it rided an Employee Corrective at 3/20/13 for NA-C which at [R10] fell during a transfer enurses' station to eat. You we right away. When you were out the resident fall, you were N stated an employee done for all employees, even | F 225 | R179. Resident was not burned. Envestigation another resident was to have gauze bandaging on both hand up her arms due to multiple sk from falls at home. She was admit | noted nands in tears |

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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR; MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | who was crying was follow up to the reference of the reference of the reference of the resident who had be regarding the allegar call light, however to investigation of the reported to the admitted the remains and in the remains and in the remains and its resident may be referred to and state of the resident neglect or incident had not be DON verified there investigation includinterviews regarding the referred to and state resident neglect or incident had not be DON verified there investigation includinterviews regarding the referred to the referred to and state resident neglect or incident had not be DON verified there investigation includinterviews regarding the referred to the referred to and state resident neglect or incident had not be DON verified there investigation includinterviews regarding the referred to the | age 31 not sure why." The resident is unnamed, and there was no brence of the burns on hands. 5/2/13 at 11:15 a.m., the stated they were unaware of rding a resident with "burns on ot provide the name of a surnt themselves in the facility. R179 had been talked to ations of NA-D turning off her the DON had no documented incident, and it had not been ninistrator. The DON stated in Employee Corrective Action oyee Corrective Action form ded, "You have been strated with a resident. You ent light and walked out and or room with an attitude." The oclarify what "an attitude." The oclarify what "an attitude." The was not a thorough ing employee and/or resident g the allegation. R179 did not able to identify cognition. | F2 | | the gauze bandaging and the NA mithe residents. The report and invest were completed. Resident discharged 11-27-12. NA denied tur off the call light. Staff training about vulnerable adult abuse, resident right the Elder Justice Act occurred in Ma 2013.; May 8 and 9 and again June and 6 th . Call light audits will occur 1 per week for 4 weeks by the NHA ar pager/cell phone audits by the DON occur 10 times per week for 4 weeks will be reported to QA committee for further direction. | ning t nts, and rch 3, 4, 5 5 times d will s. Date | |
| | 3/7/13 indicated, N. and hit her on the bresident, quarterly I the resident had se The facility submitt regarding R5 (above | re completed by NA-E on A-HH and NA-II "changed R5 bum." R5's who was a current MDS dated 1/24/13, indicated vere cognitive impairment. ed a report to the state agency re) on 3/13/13, 6 days after vare of the allegation. The | | | R5. Interviewed. Resident made var scattered comments which had noth do with the alleged incident. Unable determine if the "hit to the bum" oc | ning to e to | |

Social services to interview and ask about a

| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | ļ ' ' | E CONSTRUCTION | COMF | PLETED |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW . | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | facility investigative indicated the follow interview with NA-E NA-E stated that sh that 'blonde girls hit hit on the bum" Their investigation the incident but she about staff mistreat which did not make "DON, ADON met volume in the facility registate agency requestion the facility registate agency requesinterviewed as part other residents voice their care? Was of staff indicated they mistreatment by other on 3/25/13, "35 currinterviewed, some vispecific or substant from residents that mistreated by staff. Interviewed, mostly past employees. Sistaff were neglectfuresidents but this witnessed, just that allegations received were filed with [state The facility interviewed]. | report submitted on 3/13/13, ing: "HR-J completed staff on 3/7/13" During interview the heard resident R5 had said her.' and changed her and the facility indicated as part of ney spoke with R5 regarding a did not have any complaints ment and made remarks sense. The facility indicated with primary East end evening /13- staff were given direction dent care." On 3/25/13 the sted additional information arding the report on R5. The sted, "Were other residents of your investigation? Did he any concerns regarding her staff interviewed? Did had witnessed any her staff?" The ADON replied rent residents were which do have dementia. No lated reports were received they are/ were being 30 staff members were current employees and some ome staff alleged that other if and mistreated some as not reported to have been they had heard about it. All dithrough these interviews e agency]." | | Interview 5 residents per week for 8 Data to be reported to QA for furthed direction. | | |
| | being mean' or 'cha | lleged incident of 'blonde girls anging and hit on the bum';' sked generic questions about | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 245427 | B. WING | | | 05/0 | 8/2013 |
| | PROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | STREET ADDRESS, CITY, STATE, ZIP (901 SOUTHEAST WILLMAR AVEI WILLMAR, MN 56201 | | | |
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| F 225 | care in general at the submitted a report of not complete an invinterviewing other stallegations. In addisubmitted to the stanot include specific by staff and observing directed the facility. A staff questionnair 3/7/13 indicated, The Resident grabbed from armough a staff joked are equipment witnesses [residents] alarms a sanyone else's call linurse on staff" Reavailable to identify. The facility submitted the allegation of R1 NA-F. The facility is to the SA indicated current and former named as people of period of employment of time (May 2012). (NA-K) could not renames but stated so saw them again. We investigation and an notes to determine out as abusive perporcess it was idental a resident may have named resident diesections. | the facility. Although the facility to the state agency, they did vestigation which included staff and residents about R5's lition, the further information ate agency upon request did allegations which were made red which the facility policy to complete. The completed by NA-E on they "Heard [NA-F] hit R180; ther and she punched his ound about catheter ed backflowwould silence and not answer theirs or lightsReported abuse to 180 did not have an MDS | 3-19-1 Vulner expect above Act, Ro the He adult a May 8 4, 5 ar reside service weeks | Investigation/report complete 3. East side staff provided with rable Adult Act, resident rights tations by DON and ADON. In a list staff completed Vulnerable esident Rights and Elder Justice ealth Care Academy in March 20 abuse act and resident right trained 9. Nursing staff will have and all other staff on June 6 th by nt rights, and vulnerable adult es staff will interview 5 resident. Data will be reported to the 6th of the formal of the control of the formal of the fore | h training of and care addition to be Adult Abuse Act training occurs training Juthe NHA of abuse. Soonts weekly f | the use ng in erable rred une 3, n cial for 8 | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | E CONSTRUCTION | |) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 8/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | | 9(| EET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | 8E | (X5) COMPLETION DATE | |
| F 225 | was determined ha wheelchair causing reports of injury/ brown and the facility regarding the allegal identify the allegal identify the allegal employee was initial facility did not compinterviews regarding R180 being hit on the stated "many name interest," there were was there any investigation of this provide regarding the A staff questionnair 3/8/13, indicated, "s R57; 'here's your diapproach to reside investigation of this person identified with R57. During interview on DON and LSW-A vimade but there had completed. R57's condicated the reside impairment. A staff questionnair 3/11/13 indicated, "to R39; she's not the and quit turning on from of R181 to ge | Its during this time period, it ands were bumped while in bruise to appear. No other using to resident." It submitted a report to the SA ation, the investigation did not perpetrator, although the ally identified as NA-F. The olete any further staff g the alleged accusation of the arm. Although the facility is were named as people of the no names submitted nor stigation the facility could his statement. The completed by NA-JJ dated snippy comments made to this statement nor was the staff the made these remarks to a statement nor was the staff the made these remarks to a statement nor was the staff the made these allegations were a been no investigation parterly MDS dated 3/14/13, and had moderate cognitive are completed by NA-G dated [NA-R] verbally inappropriate the only person to take care of lightsstaff would talk dirty in thim to talk dirty." The facility | | | R57. Report and investigation comp Resident calls out "owie" during care matter how gentle the care giver is. Resident intersview responses and comments do not fit the situation, for example: says, "get those darkies of my room" in the midst of the intervi Behavior log initiated. Tyelenol QID pain log has been initiated. | es, no or ut of ew. | | |
| | Had subilificed a 16 | port to OHFC regarding this | } | | R39. Report/investigation complete | d. | | |

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| | | 245427 | B. WING _ | | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | :W | 5 | TREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX - TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 225 | accusation on 3/13/after the facility was Investigative report the following: "Throughout the coninvestigation, a numabuse have surface substantiated any retheir abilities affected much of what we didirection of a dysfur rather than any substantiated any retheir abilities affected much of what we didirection of a dysfur rather than any substantiated any retheir abilities affected much of what we didirection of a dysfur rather than any substantiated any substantiated any substantiated any substantiated any substantiated with East end even staff were given directore" Although the facility abuse to the SA regnot completed, or sinvestigation including members, nor was been interview to provide any MDS available. During interview on DON and LSW-A sinup or investigation in the substantial control of the substantial cont | 13, regarding R181, 2 days aware of the incident. The submitted to OHFC indicated durse of our internal aber of occurrences of alleged ad It has not been esident was actually injured, ad, or lifestyle altered. Indeed, scovered points in the actional employment culture stantive resident abuse sources (HR)-J completed NA-G on 3/11/13 During the ted 'staff would talk dirty in to get him to talk dirty. This is a would have occurred 4/12 when R181 died. Due to egation, DON and ADON met ang nursing staff on 3/8/13-ection on appropriate resident assubmitted the alleged verbal parding R181, the facility had submitted, a thorough in interviews done with staff it clear whether NA-G had ovide names regarding staffing dirty to R181. R181 did not | F 22 | R39 (continued) Resident interviewed with residents with no complaints. NA-R residents with no complaints. NA-R residents with no complaints. NA-R resident resident resident rights occurred Manursing staff will be re-educyulnerable adult abuse, resident rights occurred Manursing staff will be re-educyulnerable adult abuse, resident rights occurred Manursing staff will be re-educyulnerable adult abuse, resident adult abuse, resident rights occurred Manursing staff will be re-educyulnerable adult abuse, resident expectations on June 3 NHA will educate all other sidents. | about NA-R esigned. completed. ADON met They addressed resident rights taff completed ams on dents rights ch 2013. abuse act and y 8 and 9. cated on dent rights and , 4, 5 and the | |

| | AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | COMPLETED | | |
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| | | 245427 | B. WING | | 05/08/2013 | |
| | PROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | 901 | ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| F 225 | quarterly MDS date cognitively intact, the spoken to R39 or No feerbal abuse towereported the allegates as indicated by facilia. A staff questionnai 3/8/13, indicated and (unknown) NA's having to peeR10 overheard NA's contained they just can't questionnaire asked nursing department answered, "Yes; ercomplaint above." if the report was investionned, "Never her follow up; do your During interview or stated she rememble complaint but belie another resident work to the resident work in the resident of the resident work in the res | and 4/4/13 indicated she was the DON verified she had not IA-R regarding the allegations wards R39; nor had she tion to the administrator or SA dilty policy. The completed by RN-B dated nother resident "said a couple complain about R10 always daughter said she'd in mplain they have 13 residents do it anymore." The diff CM-B had ever gone to the to report abuse. CM-B had mailed DON regarding the When asked if she was aware westigated or if she received a nursing department she answered or responded without hink she reads her emails!" 15/2/13 at 11:00 a.m. DON pers "hearing" about this ved the "talk" was coming from the roomed next to R10; so the known) was complaining about to complaining, not the staff. | F 225 | | | |

| AND PLAN OF CORRECTION (AT) PROVIDER/SUPPLIER/CLIA | | | LE CONSTRUCTION | COMPLETED | | |
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| | | 245427 | B. WING | · · · · · · · · · · · · · · · · · · · | 05/08/2 | 2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW . | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
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| F 225 | bloody nose; picked This is all the quest no resident named what LPN-G was red. During interview on DON and LSW-A we follow up or investig allegations made by no follow up interview. A staff questionnair 3/8/13, indicated an with [R180]; would so 'one girl' was walking resident almost fell. The reported resident all department and "was seeing my residents further investigation did not have an MD. Although this question did not have an investion did not have an investion did been no report NA-F's allegations. A staff questionnair 3/11/13, indicated so "doing the bare min checking/ changing put on toilet; turned off | I up tissue don't have time." ionnaire indicated. There was nor was there any follow up of ferring to. 5/2/13 at 11:15 a.m., the erified there had been no ration regarding the y LPN-G, and there had been w with LPN-G. e completed by NA-F dated unknown NA, "Would argue scream at each other heard ig a resident while texting and "NA-F indicated she had | F 225 | R180. Resident died on 3/19/12. | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | ethical standards a to see what's happe several staff name questionnaire, ther up regarding these any follow up staff i the staff identified. During interview or DON and LSW-As investigation, nor a regarding NA-KK's neglect. The DON not spoken to NA-H An undated staff qu LL, indicated the N staff mistreatment bent out of shape a RN supervisor); ne DON" Witnesse screaming at him b late; R59 also talke throws people into getting ready" R5 | entsI'm quitting because my re very high and I can't stand ening" Although there are swritten on the side of the e was no investigation or follow accusations, nor was there nterviews conducted regarding in 5/2/13 at 11:15 a.m., the tated there had been no additional interviews conducted accusations of resident and LSW-A verified they had K regarding the allegations. Lestionnaire completed by NA-A had gone to the DON about to residents but "[DON] got and told to go to nurse (LPN or ver comfortable going back to be dabuse; "R59NA-B because resident keeping hered to nurse; R59 scaredNA-B bed and yells at them while s9's quarterly MDS dated e was cognitively intact. R59 | F | 225 | DON recalls numerous conversation which she re-directed staff to talk to nurse or case manager on their unit instructed them that those persons take care of the issue the staff raise they didn't follow through staff sho come back to her. Some staff did no being re-directed. R59. Report/investigation complete Removed NA-B from schedule while investigation was being conducted. | o the . She could d and if uld ot like | |
| | DON stated she be referring to a situal between NA-B and stated she had no there been a repor stated NA-B had to this" to R59. The D | n 5/2/13 at 11:15 a.m., the elieved the allegation was ion which had occurred IR59 'months ago.' The DON formal investigation, nor had t made to the SA, but the DON old her "she would never do OON stated she had spoken to would have told me" if there | | | Corrective action taken with NA-B. and 4 before staff began work they received training on the revised Vul Adult Abuse act, counseling on tear positive staff interaction, taking tim residents, empathy and considering residents cognitive ability when procare. Nursing staff inservices held J 5 and for all other staff on lune 6 | nerable nwork, e with each viding une 3, | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | SURVEY PLETED |
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| F 225 | was unable to provinvestigation of this allegation should himmediately, then immediately, then immediately, then immediately, then immediately, then immediately, then immediately, then immediated he was not a of staff mistreatmenthe staff and/or residual egations of residual egations (NTS) had allegation MDS dated 1/1/13, intact. The facility submitter for R75 dated 1/1/8/including, "Staff republister on his inner staff applied warm was too hot. Residual entities on his left inner thigh each of the facility's investing sand a blist left inner thigh. Blist caused by a warm resident's left thigh | of abuse. However, the DON ide any documentation of an incident. LSW-A verified this ave been reported to the SA investigated. 15/2/13 at 11:15 a.m., A-E aware of any of the allegations and abuse which came from sident interviews from March diseveral other submitted ent mistreatment which had the state agency. The reports | F2 | | R75. Report/Investigation completed Nursing department training on facil policy regarding warm packs on June and 5 th . Nursing staff are conducting/conducted Care/transfer for 35 residents per week for 4 week then 25 residents per week for 4 week be done. Data will be reported to Quarther direction. | ity 3, 4, audits s and eks will | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 225 | followed when the investigation reveal daughter felt that the of the blister. In tall resident does requereported that resident make the warm packwas obtained from with resident and the source. As stated polister on his left in affected his abilities perpetrator has not been instructed on packs to attempt to incident." The facility also prolinjury Report Form facility had not sent investigation. An arwhich appears to he and the DON dated indicated R75 "Famon his left thigh this packs the resident." Although the facility incident regarding is report was made 1 facility did not subminvestigation includinterviewed, whether warm pack in the president interview had when and who place. | ncident occurred. Internal ed that resident and his e warm pack was the cause king with staff, they report the est warm packs. Staff also ent has requested that staff ck hotter. This information nursing assistants that work ey are considered a credible prior, the resident sustained a ner thigh which has not sor lifestyle. An alleged been identified. All staff have facility policy regarding warm prevent recurrence of the vided the Resident Incident/dated 11/7/13, which the to the SA as part of their itached note from the nurse, ave been addressed to A-L 11/7/12 at 9:32 p.m., hily noted a 3 cm long blister evening that came from warm has been requesting recently." v submitted a report of the R75's blister to the SA, the 1/8/12 (the next day), and the hit complete results of the ing names of staff who were er the resident had used a revious days, whether a ad been completed regarding ed the warm packs, or v staff was warming up and | F2 | 225 | | | |

| | OF DEFICIENCIES DE CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | E CONSTRUCTION | (X3) DATE COMP | E SURVEY PLETED |
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| F 225 | During interview on and LSW-A verified submitted to the SA also verified she was had been any staff to use of warm packs stated R75 was not cognitive problems. R117, a current resirelated to alleged not MDS dated 1/17/13 intact. The facility submitter regarding R117 date transferred from the he fell-he was being but his care plan is The facility's investive 12/17/12, indicated being tolleted and with going to transfer him wheelchair when she was transferring have a second persiplan interventions with the incident occurred during this fallNAwas again made awas signed a correction. During interview on DON and LSW-A sithe above incident with the SA. However, the same staff of the SA. | 5/1/13 at 10:15 a.m. the DON the investigation results were not complete. The DON s not aware of whether there raining regarding the proper following this incident. SW-A onger in the facility but had no while a resident. dent, had experienced a fall eglect of care. R117's annual indicated he was cognitively at an incident report to the SA and 12/14/12, "R117 was being to tollet to his wheelchair when go transferred with one staff, to use two staff with assist." If years are finished, so [NA-I] was are finished, so [NA-I] was an from the tollet back to his his leg buckled and he felling him by herself and did not on to assist, therefore care were not being followed when d. R117 sustained no injuries I is aware of care plan, and ware of the care plan as well | F 225 | R117. Report/Investigation complet terminated. Training on the plan of and following the plan and transfers Transfer/care audits are to be done residents for 4 weeks and then 25 re for 4 weeks. Data to be reported to committee meeting for further actio | care on 35 sidents the QA | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 225 | herself he is a two processive action for The DON and SW-whether NA-I had reducation as identification | "Transferred resident by person assist with transfers. In his bathroom." The rm was completed by HR-A. A were unable to identify eccived any additional fied in the investigative report A 12/17/12, which indicated re-educated to the resident's ON stated that if NA-I had education should have been which would have been and not by HR-A. Although the alleged neglect of health re were discrepancies in the regarding the employee's ing the incident. | F2 | | R57. Report and investigation complete Resident was not interviewable. He responses were unrelated to the discussion, for example, she would say," Get that darkie out of my room There were no persons of color in the room. Frequently calls out 'owie'. Behavior log initiated. Tyelenol QID initiated with a pain log initiated. | r ''. ne | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | EW . | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
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| F 225 | writer she was very received. This write perpetrator is a NA reported this incide another incident wit perpetrator) will not R57 and encourage without a co-worker agency requested r facility asking to proasked if any other rif they had concerns The facility respons NA-MM"No other Staff working with N reported R57's call who informed the reto reposition herT she believed R57 winutes for two star Neither the AP nor | ge 43 upset about care she had er spoke with her The alleged (un-named) When R57 Int to writerR57 had reported th this NA This AP (alleged be scheduled to work with ed not to enter her room c." On 10-16-12 the state more information from the evide the AP's name and esidents interviewed or asked as regarding the AP's cares? The identified the NA as are residents were interviewed. IA-MM were interviewed and light was answered by the AP esident she needed assistance the other staff person reported valued between 5 and 7 If people to return to her room, the other staff person made ing out or that her room door | F2 | 225 | | | |
| | DON stated she was investigation of the NA-MM. She state was not "complete" reported to be interthere any record of There was also no DON stated NA-MM facility and was not she no longer work facility reported the thorough investigat | 5/3/13 at 11:15 a.m., the as not involved in the alleged incident with R57 and d it appeared the investigation as none of the staff who were viewed were named, nor was which staff was interviewed. Interview with NA-MM. The M was still working at the being monitored to ensure ed with R57. Although the allegation to the SA, a ion was not completed and did M did not work with R57, even | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | 901 | ET ADDRESS, CITY, STATE, ZIP CODE I SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | | |
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| F 225 | During interview on stated back in Janu "accusations" of rest A-E stated nothing reported, because a said he'd felt the accurate man girls club" wresident mistreatme. There was no docurate by NA-LL in received allegations NA-K in March 201 NA-K identified wer identified by NA-LL would be best to locallegations. Although the facility allegations of reside facility failed to thor report these allegations which SA, were not comphad all the information whether resident at occurred, or whether to be completed by system in place to report allegations of to, and the facility wresponsible to ensure the state of the | set by NA-MM actions. 15/2/13 at 11:15 a.m., A-E lary 2013, NA-LL had made sident mistreatment by staff. was done at that time, or of the "staff dynamics." A-E cusations were all part of the ith staff accusing other staff of ent to get them in trouble. mentation of these allegations January. Then the facility is of abuse and neglect from 3. Many of the allegations that re "the same" as the concerns is on at that time A-E decided it ok into some of the coughly investigate and/or clons to the administrator and their policy. Also, the in the facility did submit to the rehensive to ensure the SA clon to make a determination of the same and/or neglect had be further investigation needed of the SA. The facility had no ensure staff knew who to for resident abuse and neglect was unable to verify who was ure all allegations were is staff accused of resident | F2 | 225 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | | ٤ | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
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| F 225 | The Bethesda Hom Report Form Evaluation in E | tes Resident Incident/Injury ations, identified the following origin which were not ated, and/or reported to the tate agency immediately: DS dated 3/28/13 indicated pairment and required be from staff with most ing (ADLs) If report noted a bruise on 1/28 centimeters (cm) X 6 cm, 4 cm X 2 cm between the 1/29 of the left hand, 4 cm X 4 da 6 cm X 4 cm bruise on the 1/28 bruises occurred, did not 1/29 ce of injury, no staff were 1/29 ere was no observation of 1/29 if the bruises could have been | F | 225 | Incident reports were completed for resident with bruising. Incident reports were with report reviewed at the daily Falls meeting. Training on May 8 and 9 on the vuln adult abuse act included bruises of unknown origin. Nursing staff traini June 3, 4, 5 and for all other staff or 6th by the NHA will include Vulnera adult abuse act and bill of rights. M 2013 all staff completed vulnerable abuse, resident rights and Elder Just training via Health Care Academy. Random audits by the nursing staff is cares and transfers of 35 residents exweek for four weeks and 25 resident week for four weeks will occur. Resube reported to the QA committee with determine continued auditing needs | erable ng on June ble larch adult ice Act for each ts each llts will | |
| | on 2/20/13, measure forearm, 5 cm X 2.9 2 cm X 2 cm on the incident report indiction when the bruise occasion of the injury determine if bruises care received nor winterviewed. Although the facility unknown origin the | y report noted to have bruises ring 2 cm X 2 cm on left cm on right outer elbow and back of the right elbow. The sated the staff were unsure curred, did not determine the no observation of cares to secould have been a result of were the resident or staff was aware of R115's injury of facility did not thoroughly ediately notify the SA. | | | R115. Resident utilizes a Merry Wal ambulation. Frequently bumps into chairs anything. Receives aspirin the Sleeve protection in place. | walls, | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | | |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | | REET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | R19's quarterly MD severe cognitive im extensive assistance. R19 incident/injury 4/28/13 measuring and 3 cm X 1.3 cm 3.5 cm to left forear indicated R19 was a how it happened or Furthermore, the reunsure when the bright determine the source observation of care have been a result interviews were contained. The incident/injury 3/13/13 measuring upper arm. The incident were unsure when the bruise was constowards the left in hrest. The report did the injury, no obserconducted to determine the suiter of car resident or staff interviews was constowards the left in hrest. The report did the injury, no obserconducted to determine a result of car resident or staff interviews was constituted in the injury on 3/1/13 measuring conducted to determine a result of car resident or staff interviews was constituted in the injury on 3/1/13 measuring 1.5 cm 2 further up the same bruise on top of left indicated the staff versions. | S dated 2/21/13 indicated pairment and required the from staff with most ADLs. Teport noted bruises on 7 cm X 6.5 cm to right hand to right forearm and 5 cm X m. The incident report anable to answer questions on if she had bruises. port indicated staff was uises occurred, did not be of the injury, no sto determine if bruises could of care received, and no staff appleted. Teport noted a bruise on 6 cm X 10 cm on her left dent report indicated the staff the bruise occurred but that sistent with R19 leaning er wheelchair against the arm not determine the source of vation of cares were mine if the bruise could have e received, nor was the | F 225 | R19.Wheel chair armrest padding a May 29, 2013. Resident moves about a great deal. Side rail assessment on 5/30/2013 and removed the same 5/30/13 sleeve type arm protection place. Audits of staff reporting of Vulnerable adult abuse issues will be conducted on 10 employees weekly weeks. Staff training on vulnerable abuse, resident rights, and Elder Just occurred on Health Care Academy is 2013. Vulnerable adult abuse and right training occurred on May 8 and Nursing staff will be trained on June and all other staff on June 6 by the vulnerable adult abuse and resident | ent done ne date. in e for 8 adult stice Act n March resident d 9. e 3, 4, 5, NHA on | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|-------------------|-----|---|-------------------------------|----------------------------|
| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | eW . | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | occasions and indic staff being rough. N completed. R19 incident/injury i | ge 47 ils which she hits on eated the resident denied any to staff interviews were report noted a bruise on 2.1 cm X 7 cm on her lower | F2 | 225 | | | |
| | back. The incident unsure when the bro determine the source staff interviews note portable lift (PAL), F into wheelchair, hitt | report indicated staff were uise occurred, did not be of the injury, but through that when staff do not use R19 "quickly" tries to transfer ing the arm rest with her hips ont was marked as not | | | | | |
| | 1/14/13 measuring breast. The incider were unsure when to is consistent with wand resident rolled to | report noted a bruise on 3.5 cm X 2.0 cm on her right at report indicated the staff the bruise occurred but that it hen staff laid her down in bed and hit her chest on the de rail. No resident or staff inpleted. | | | | | |
| | measuring 2.5 cm X cm X 2.0 cm and 5. side of back and ab report indicated star bruise occurred, that with R19 not sitting and hitting her side denied staff or family observation of care determine if the bruice in the side control of the side determine if the bruice in the side control of the side control | report noted bruises on 1/4/13 K 1.5 cm on right forearm, 4.0 0 cm X 3.0 cm bruises on left domen area. The incident ff were unsure when the at the bruises are consistent up straight in the wheelchair on the arm rest and that R19 ly being rough with her. No is were conducted to ise could have been a result d no staff interviews were | | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILDI | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|-----------------------|-------|---|------|----------------------------|
| | | 245427 | B. WING | _ | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | :W | | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE .MAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | R19 incident/injury in 11/18/12 measuring thigh. The incident runsure when the brainterviewed "though bumped her thigh wand that although the interviewed, the reprecall anyone being recall bumping, pind observation of caredetermine if the bru of care received and completed. R19 incident/injury in 11/12/12 measures shoulder, 2 cm X 1 wrist and 5.5 cm X 2 The incident report when the bruise occupied table and indicated staff did in shoulder injury and scratch my arms or and denied staff or ther. No observation determine if the bruind care received and completed. Although the facility instances of bruises | report noted a bruise on g 5 cm X 6.5 cm on left upper report indicated staff were uise occurred. Staff was tit is possible resident when she was transferring", he R19 was not able to be ort indicates "she does not rough with her, does not ching, scratching herself". No | F 2 | 25 | | | |

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|--------------|-------------------------------|--|
| | | 245427 | B. WING | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | ≣W | | STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 225 | moderate cognitive extensive assistance. R177 incident/injury bruises on 11/26/12 and 3 cm X 1 cm b cm and 2.5 cm X 2 light bruise to back report indicated sta | age 49 MDS dated 10/15/12 indicated impairment and required be from staff with most ADLs. y report noted a scratch and 2, measuring 12 cm (scratch) ruise on left buttock, 1 cm X 1 cm to right buttock, and a of left thigh. The incident of the was unsure when the curred and the bruise on the | F2 | 25 R177. Deceased, hospitalize died there. | 11-28-12 and | | |
| | left thigh was from and the others were from staff. No obse conducted to deter been a result of car interviews were cor | her cushion in her wheelchair e consistent from transfers rvation of cares were mine if the bruise could have re received and no staff | | | | | |
| | of unknown origin, investigate or imme R8's significant cha indicated severe co | the facility did not thoroughly ediately notify the SA. ange MDS dated 1/25/13 angulative impairment and assistance from staff with | | R8. Side rail assessment com 13. Use is appropriate and co | • | | |
| | measuring 2 cm X arm, 1.5 cm X 1 cm and 2.5 cm X 2 cm report indicated that when the bruises obruises were from bed and shin bruise her wheelchair. R8 | eport noted bruises on 1/11/13, 1 cm on upper outside of left on upper inside of left arm on right shin. The incident at although staff was unsure ccurred they stated arm hitting her side rails while in e was from hitting her leg on was deemed non taff was interviewed. | | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1`′ | | | COMPLETED | |
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| ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW . | | | | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION | SHOULD BE | (X5) COMPLETION DATE | |
| Although the facility unknown origin, the investigate or immed R86's quarterly MD severe cognitive imextensive assistant R86 incident/injury 11/20/12. The incid yellow/purple bruise arm but had no mewere unsure when R86 was often resis wrestle staff memb observation of care determine if the bru of care received no interviewed. R86 incident/injury 4/16/13, measuring arm. The incident runsure when the bru was often combativo of cares were conditive could have be nor was the resider. Although the facility unknown origin, the investigate or immediate R109's quarterly MI severe cognitive imextensive assistant | was aware of R8's bruises of facility did not thoroughly ediately notify the SA. S dated 2/28/13 indicated pairment and required be from staff with most ADLs. report noted a bruise on ent report indicated "a large e" on the outside of the right assurements of size, the staff the bruises occurred and that stive to cares and attempted to er "1-2 weeks ago". No is were conducted to asse could have been a result or was the resident or staff were ruises occurred and that R86 we with cares. No observation ucted to determine if the been a result of care received into retaff interviewed. Was aware of R86's bruise of a facility did not thoroughly ediately notify the SA. DS dated 3/14/13 indicated apairment and required be from staff with most ADLs. | F 2 | R86. Resistive to cares routing believed to occur during care protection applied, resident withem on. Nurses are conduct Care/transfer audits on 35 resweeks, and for 25 residents for Data reported to QA committed action needed. | s. Sleeve vill not keep sing sidents for 4 or 4 weeks. see for further | | |
| K109 incident/injur | y report noted a bruise on | | R109. Forcefully seats self in | chairs, on | | |
| | ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Although the facility unknown origin, the investigate or imme R86's quarterly MD severe cognitive im extensive assistance R86 incident/injury 11/20/12. The incid yellow/purple bruise arm but had no me were unsure when R86 was often resis wrestle staff memb observation of care determine if the bru of care received no interviewed. R86 incident/injury 4/16/13, measuring arm. The incident i unsure when the br was often combativ of cares were cond bruise could have to nor was the resider Although the facility unknown origin, the investigate or imme R109's quarterly M severe cognitive im extensive assistance | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Although the facility was aware of R8's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident/injury report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size, the staff were unsure when the bruises occurred and that R86 was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Although the facility was aware of R8's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident/injury report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size, the staff were unsure when the bruises occurred and that R86 was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. R86 incident/injury report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. The incident report indicated the staff were unsure when the bruises occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. Although the facility was aware of R86's bruise of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R109's quarterly MDS dated 3/14/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. | ROVIDER OR SUPPLIER DA NH PLEASANTVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Allthough the facility was aware of R8's bruises of unknown origin, the facility will not thoroughly investigate or immediately notify the SA. R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident/injury report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size, the staff were unsure when the bruises occurred and that R86 was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. R86 incident/injury report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. The incident report indicated the staff were unsure when the bruises occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise occurred and that R86 was often combative with cares. No observation of cares were conducted to deter | A BULDING 245427 B. WING 35TREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR ANY SEQUIT SUMMARY STATEMENT OF DEFICIENCIES (RECAL DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Although the facility was aware of R8's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident/injury report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size, the staff were unsure when the bruises occurred and that R86 was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. R86 incident/injury report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. The incident report indicated the staff were unsure when the bruises occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. Although the facility was aware of R86's bruise of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R109's quarterly MDS dated 3/14/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | W | | ٩ | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPU DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | The incident report unsure when the brisource of injury to be R109 sat down hard of toilet. R109 was in additional staff in Although the facility of unknown origin, tinvestigate or immer R15's quarterly MD severe cognitive immerstensive assistance. R15 incident/injury 11/23/12, measurin 4.0 cm on left hand and 3.4 cm X 3.2 cm report indicated the bruises occurred, a source of injury but to 11/23/12. No obsconducted to determ been a result of car interviewed. Although the facility of unknown origin, investigate or immerstensive | g 12 cm X 3 cm on her back. indicated the staff were uises occurred, but assumed to when an aide reported d and hit her back on the top not interviewable, there were nterviews. I was aware of R109's bruises the facility did not thoroughly ediately notify the SA. S dated 12/7/12 indicated pairment and required to from staff with most ADLs. I was aware of R109's bruises on 19 3 cm X 2.5 cm and 3.5 cm X 1.2.3 cm on left wrist m on right hand. The incident staff were unsure when the 19 nd did not determine the 19 that R15 was combative prior servation of cares were 19 mine if the bruise could have 19 e received nor was staff I was aware of R15's bruises 19 the facility did not thoroughly 19 diately notify the SA. S dated 1/17/13 indicated 19 pairment and was totally with all ADLs. | . F2 | 225 | R15. Resident had history of punch and hitting staff. He was resistive to measuring bruising. He died 1-16-1: |) | |
| | | report noted a skin tear and measuring 6 cm X 2.9 cm | | | | | - 12 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ₹ | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 8/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | ≣W | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | 8E | (X6) COMPLETION DATE |
| F 225 | skin tear on left for bruise surrounding determined the sou boosting resident u lift sheet up. No reinterviews were cor Although the facility of unknown origin, investigate or immed R68's quarterly MD severe cognitive imextensive assistant R68 incident/injury 4/22/13, yellow in a chigh. The incident unsure when the bruing when the b | the area. The incident report tree of injury was from staff p in the chair and sliding the sident or additional staff inpleted. If was aware of R51's bruises the facility did not thoroughly ediately notify the SA. S dated 2/7/13 indicated apairment and required be from staff with ADLs. If we occurred, a bruise on color on the right frontal mid report indicated staff were ruise occurred, no the bruise and that it was sistiveness with cares" during a vation of cares were conducted bruise could have been a wed. No staff or resident | F2 | | R68. Resident is resistive to cares. bruising incident occurred while resishower. The time of his shower will changed to mornings and re-evalua Nursing staff conducting Care/transaudits on 35 residents for 4 weeks residents for 4 weeks. Data reporte committee for further action. | sting a be ted. fer and 25 d to QA | |
| | inner thigh. The inc | uring 1.5 cm X 1.0 cm on right sident report indicated the staff the bruises occurred but | | | R98. Bruising believed to be caused Merry Walker strap. Now, only occasionally uses Merry Walker. | by the | |

| STATEMENT OF DEFICI AND PLAN OF CORREC | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| NAME OF PROVIDER OF BETHESDA NH PL | | w | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| PREFIX (EAC) | 1 DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| presumincontinicares with stale of unknown investig. R128's was cogassistar. R128 in on 9/8/1 the righ indicate occurre bumpin transfer with stale. Although of unknown investig. R128 ir bruises and 1.5 2.0 cm "large breport in bruises." | ent pad is a ere conduct ave been a and staff with the facility norigin, the ate or immediate from state of buttock did the staff with a PAL ff were combined in the facility own origin, ate or immediate of the staff with a PAL ff were combined in the facility own origin, ate or immediated at a occurred, o | e was consistent where her t times. No observation of ted to determine if the bruise result of care received. The vere not interviewed. I was aware of R98s bruises of a facility did not thoroughly ediately notify the SA. DS dated 2/14/13 indicated he act and required extensive aff with most ADLs. I y report noted to have a bruise ng 1.6 cm X 2.4 cm slightly to crease. The incident report were unsure when the bruises the bruise was a result from derails on his bed during a lift. No additional interviews | F | 225 | R128. Side rail assessment complet 5/2/2013. Appropriate and continuuse them. Ambulates with a wheel and bumps into objects routinely. I sleeve type arm protection. | es to chair, | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| 4 | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | of unknown origin, to investigate or immediate or immediate or immediate of the control of the c | was aware of R128s bruises the facility did not thoroughly diately notify the SA. Irrent resident's quarterly MDS ted severe cognitive is totally dependent on staff | F2 | | R10. Re-arranged room. Side rails removed 12/18/2012. Recliner remefrom room. Tried sleeve arm proted did not work due to arm swelling. Fwall by bed with a fall mat. Nursing | tion, added | |
| | both arms on 11/29 cm and 2.0 cm X 2. cm X 2.5 cm bruise cm below left elbow forearm and 3.0 cm forearm. The incide were unsure when the bruising is consisted with transfers. Staff | report noted six bruises on /12, measuring 1.0 cm X 2.5 0 cm on upper right arm, 1.0 by left elbow, 2.0 cm X 3.0 y, 1.5 cm X 2.0 cm on left of X 1.0 cm bruise on lower left on treport indicated the staff the bruises occurred and that on the with where the lift sheet lies was reminded to be careful ever no staff interviews were | | | are conducting Care/transfer audits residents for 4 weeks and 25 resider 4 weeks. Data to be reported to QA committee for further direction. | on 35 its for | |
| | bruises of unknown | was aware of R10's multiple origin the facility failed to investigation or immediately | | | | | |
| | 1/13/13, measuring cm X 3 cm by right thumb to top of left indicated a family m the attention of staft to her and she had also indicated staff | report noted bruises on 4 cm on top of right hand, 2 thumb, 2 cm circle from left hand. The incident report nember brought the bruises to f because they were unfamiliar not been notified. The report were unsure when the bruises If that bruises were "consistent" | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | IG | | COMPLETED | |
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| | | 245427 | B. WING_ | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVI | EW . | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | : | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | JEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY) | HOULD BE | (X6) COMPLETION DATE |
| F 225 | with where table is bedside table is". No conducted to determ been a result of carstaff were not intervalled to the conducted to determ been a result of carstaff were not intervalled to the conduct a thorough notify the SA. R4's quarterly MDS severe cognitive important extensive assistance as a comparison of the comparison of the conducted to | in dining room or where o observation of cares were mine if the bruise could have e received. The resident and | F 22 | R4. Deceased 2-12-13. Was cowith cares as well as resistive. his hand. | | |
| | unknown origin, the investigate or imme R37's quarterly MD severe cognitive imextensive assistance R37 incident/injury measuring 1 cm X a 0.5 cm X 0.5 cm report indicated that | was aware of R4's bruises of a facility did not thoroughly ediately notify the SA. S dated 2/14/13 indicated pairment and required the from staff with all ADLs. report noted bruises on 8/3/12 and on left inner wrist. The incident the the was resistive with cares er shower. R8 was unable to | | R37. Resists cares and shower keep sleeve type arm protection | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING _ | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | ·W | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | Interviewed. Although the facility of unknown origin, investigate or immediately a severe cognitive imextensive assistance. R120 incident/injury on 8/19/12, measurand a 9 cm X 13 cn incident report indiction when the bruises or injury and no staff v. Although the facility of unknown origin, investigate or immediately and reading the severe measurement and reading the facility of unknown origin, investigate or immediately and reading the severe measurement and reading the severe with the source of instaff were unsure wi | was aware of R37's bruises the facility did not thoroughly diately notify the SA. OS dated 3/21/13 indicated pairment and required e from staff with most ADLs. Preport noted to have bruises ing 3.5 cm X 5.0 cm on chest in on her right hand. The ated the staff was unsure courred, the source of the vas interviewed. Was aware of R120's bruises he facility did not thoroughly diately notify the SA. It resident and their quarterly indicated moderate cognitive uired extensive assistance at ADLs. The port noted to have a bruise ing 8.8 cm X 3.3 cm on left side cident report indicated the hen the bruises occurred, but jury was a result of getting belt. No further staff | F 22 | R120. Receives aspirin daily. Was ambulating at that time with a walke when she sat the walker was in from and she may have hit her chest on it Deceased 5-16-13. | t of her | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | R67 incident/injury bruises on 8/2/12, r left forearm, 0.5 cm hand, 1.0 cm X 0.8 0.9 cm on right delt buttocks. The incide were unsure when determine the sourcares to determine a result of care receinterviewed. Although the facility of unknown origin, investigate or immediate of the injuries of unithe "nurses" bring a staff Monday meeting bruising reports. Stremember specificatinguries of unknown investigations were meet the definition should have been rule facility should have been rule facility will represent the definition should have general regulations and federal regulations and federal regulations and federal regulations were and federal regulations and federal | report noted to have multiple measuring 0.9 cm X 1.1 cm on X 0.8 cm on top of right cm on right elbow, 0.9 cm X oid, 0.6 cm X 1.0 cm on left ent report indicated the staff the bruises occurred, did not ce of injury, did not observe if the bruise could have been elved. No staff was was aware of R67's bruises the facility did not thoroughly ediately notify the SA. 5/1/13 at 11:15 a.m. SW-A the above reports were by had no further investigation known origin. SW-A stated all bruising investigations to a mg and the facility reviews the W-A and DON could not ally reviewing the above in origin, but did verify the not complete and they did of injury of unknown origin and eported to the SA. | F2 | 225 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' " | E CONSTRUCTION | COMP | LETED |
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| | | 245427 | B. WING | | 05/0 | 8/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW . | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | 8E | (X5) COMPLETION DATE |
| F 225 F 226 SS=L | as needed (preventivities of exploitation accordance with state accordance with state accordance with state (SA)," 483.13(c) DEVELO ABUSE/NEGLECT | e and/ or counseling services ion mechanism)The facility d incidents of neglect, abuse, ording to state and federal if in all departments are o nursing immediately any njuries and/ or other incidents te any suspected abuse or cannot be explained in ate and federal regulations and tely to the administrator, MDH P/IMPLMENT | , , , , , | BPV has developed and written poli and procedures that prohibit mistreatment, neglect, and abuse o | ; | |
| | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required and instructed staff to complete a thorough investigation of any alleged abuse, neglect and/ or injuries of unknown origin. This directly affected 17 of 30 residents, (R122, R3, R43, R57, R55, R137, R128, R67, R10, R180, R5, R179, R39, R181, R59, R75, and R117) who had allegations of abuse, and neglect reviewed. In addition, the facility failed to ensure bruises of unknown origin were thoroughly investigated and reported to the administrator and State Agency (SA) for 16 of 35 residents (R115, R19, R177, R8, R86, R109, | | To address a state of the state | residents and misappropriation of reproperty. The policies and procedul were revised. Staff were inserviced 8 and 9 about vulnerable adult and resident rights. June 3, 4, 5 and 6 th swill receive training on vulnerable a abuse and resident rights. The DON responsible for the investigation of unknown injuries as well as other possible situations. DON/ADON will audit/interview 10 staff weekly on reporting requirement of the vulneradults abuse act. Social services stainterview 5 residents a week for 8 wand report data to the QA committed further direction. | res on May staff dult is otential rable aff will | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | i | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | | STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVENI WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | n should E appropf | BE | (X5) COMPLETION DATE |
| F 226 | R15, R51, R68, R99 and R67) in the sail bruises of unknown. The failure to devel prevention plan whi protect residents in abuse and neglect, jeopardy for R122, R128, R67, R10, R10, R10, R10, R10, R10, R10, R10 | B, R128, R10, R4, R37, R120 mple who were reviewed with origin. op and/or implement an abuse ch instructed staff on how to the facility against potential constituted an immediate R3, R43, R57, R55, R137, E4, R39, and R117 who the building. The systemic thoroughly investigate all abuse/ neglect, employees' on how to report allegations of eglect, the undeveloped olicy, and the systemic acility's inability to identify who restigating and/or reporting ant mistreatment and or tential to effect all 118 residing in the facility. A)-E, the director of nursing actor of social services (LSW) 5/3/13 at 1:41 p.m., of the residing in the facility. The facility also provided of the abuse prevention plan aff on each shift prior to any act. The facility also provided this in the facility about abuse, or to, and resident rights in are staff, licensed nursing agers were interviewed and a their responsibility for | F: | 226 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW . | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | B€ | (X5) COMPLETION DATE |
| F 226 | The immediacy was p.m., and the scope no actual harm with minimal harm, wide Findings include: The facility's Abuse dated 3/26/12, include: "The facility will represent a providing protective as needed (prevent will report all alleger or exploitation accoregulations. All star required to report to suspected abuse, in Nursing will evaluate physical injury that a accordance with stawill report immediate and CEP The DO review reported inclinvestigation form visubmitted within five will electronically su | ation and external reporting. Fremoved on 5/8/13 at 3:20 Frend severity was reduced to a potential for no more than spread. Prevention Policy/Procedure ded the following: Ort all alleged incidents of exploitation according to state ons. The DON, ADON, case social services will do a ion of the possible neglect or get the appropriate action and/or counseling services ion mechanism)The facility dincidents of neglect, abuse, rding to state and federal fir in all departments are onursing immediately any njuries and/or other incidents. The and federal regulations and tely to the administrator, MDH, and SS will met to idents as needed. An will be completed and a report e working daysThe facility abmit a full investigative report | F: | 226 | | | |
| | health within five we include the following Name of vulnerable | e Minnesota department of orking days The report shall g information as available; a adult. Name and address of s any prior incidents of | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | NG | | COMPLETED | |
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| | | 245427 | B. WING_ | | 0.5 | 5/08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | : | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 226 | of facility investigated recurrence of incided adult: All attempts prevent further abuse implementing the foresident abuse: In the pisode of abuse of acility who have been may be reassigned until the result of the reviewed by the additional abuse or neglect of complaint of concerning the abuse of acility are mandated abuse or neglect of complaint of concerning and in a concerning the acility are mandated abuse of acility are mandated abuse of acility are mandated abuse of neglect of complaint of the reviewed by the additional and inistrator" The policy did not into ensure all allegated abuse of acility are report policy also indicated suspected abuse of explained in according administrator, MDH not define injuries instruct staff on whom who was a construct staff on whom who was a construct staff on whom who are incident and in according to the acid and in acid | se of reported injury. Details ion Action taken to prevent ent Protection of vulnerable will be made by [facility] to se/ neglect of residents by ollowing actions Staff to he event of a witnessed of a mallegation of abuse that the event of a witnessed of a mallegation of abuse that the event of a witnessed of a mallegation is priate, employees of this ten accused of resident abuse to non-resident care duties to a charge nurse trising will immediately notify that to a charge nurse trising will evaluate any rephysical injury that cannot be ance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the lance with state and federal report immediately to the l | F 22 | 26 | | |
| | | ment of residents, as well as ported to and who was | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | · · · · · · | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | W | | STREET ADDRESS, CITY, STATE, ZIP 901 SOUTHEAST WILLMAR AVE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 226 | assistant (NA)-A wanot want that NA-A facility did not inves NA-A being rough, allegation to the adiby the facility's polic for R122 despite R2 R122's quarterly mi 3/14/13 indicated m During interview on stated a NA-A is "vestated, "he swings me around. I've go me." R122 said he'was too rough, and "just never mind, you told the nurses that care of him anymor would "take care of NA-A still takes care do anything about it Review of R122 Fathe following notes: 4/10/13- "Resident evening and wanter this writer arrived in did not want the matonight or in his rood don't trust him, he I explain that someo | stigation. dent, reported nursing as rough with him and he did taking care of him. The tigate R122's allegation of and did not report the ministrator or SA as directed by. NA-A continued to care 122 complaints. nimum data set (MDS) dated to derate cognitive impairment. 4/29/13 at 3:05 p.m. R122 ery rough" with him. R122 me back and forth and pushes to a swollen hip and it hurts do told the NA he hurt and it said the NA had responded, but are OK." R122 stated he he did not want NA-A to take the and they told R122 they it." However, R122 stated to film and the nurses "didn't collity Progress Notes indicated in the said the NA had responded, but are OK." R122 stated the he did not want NA-A to take the and they told R122 they it." | F | Training on the vulnerable bill of rights and Elder Just in March of 2013 for all stroccurred on May 8 and 9 th vulnerable adult abuse act rights. Residents 122, 3, 4 128, 67, 10, 180, 5, 179, 3 and 117 each had a report investigation completed. changes/recommendation of care are listed below: R122-Interviews of the resother NA's were completed assigned to this resident; lassist with two person traresident's permission. Nu Care and transfer audit of random occurred for 4 we continue at 25 per week for is to be reported to the Question. | tice Act occurred aff. Training on the revised tand the bill of 13, 57, 55, 137, 9, 181, 59, 75, tand Any as to their plans sident, NA-A and ed. NA-A is not however, may asfers with the arsing will audit 135 people at eeks; now it will or 4 weeks. Data | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | Market Control of the | 05/ | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, 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 APPRODEFICIENCY) | | D BE | (X5) COMPLETION DATE | |
| F 226 | wife that this would director of nursing (of nursing (ADON). During another inter 3:40 p.m., R122 states over an hour ago to stated when NA-A obathroom R122 had because he did not him. The resident swait to see if any ot an hour, he stated he the bathroom any locall light again for a NA-A came in again there "anyone else R122 said NA-A ha only one here." R1: rough with me. He come in here, but he come in here, but he During interview on member (FM)-G stated the number of the continues to care for During interview on DON stated she was "rough" with him reminded NA-A to poon to poon was unable to any investigation in the continues to care for the continues to c | ed to both the resident and be investigated and that the DON) and assistant director would be notified." rview with R122 on 4/30/13 at ated he had put his call light on go to the bathroom. R122 came in to assist him to the d told NA-A to "just forget it" want NA-A to take care of tated he was going to try to her staff could help him. After ne was unable to wait to go to onger, so had turned on his ssistance. R122 stated when n, he (the resident) asked isn't here who could help me?" d responded, "nope, I am the 22 said, "He hurts me he is so knows I don't want him to e just keeps coming in." 5/1/13 at 12:30 p.m., family ated she had talked to a nurse NA-A no longer provide cares is "rough with him [R122]." irse had told her she would vever, FM-G said NA-A | F2 | 226 | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | COMPLETED | | |
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| | | 245427 | B. WING | | 05/08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | | REET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLÉTION |
| F 226 | continued to care for not being monitored other residents roug verified the resident reported to the admired reported reported residents get him up to the to he states he has to yourself'." During interview on stated, "If I ask to gusually tell me to just clean it up later. I tell me it's ok, just greally made him fee when he has to sit it. During interview on DON stated she was R122 made regarding to the bathroom him to the bathroom not conducted any focumented such, shift" to take residents. | t his concerns, nor IA-A. The DON verified NA-A or R122, and stated NA-A was at to ensure he was not treating ghly. In addition, the DON It's concern had not been hinistrator or SA. The was neglected at night as a him to the bathroom; they to the bathroom in his brief. The was neglected at night as a him to the bathroom; they to the bathroom in his brief. The was neglected at night as a him to the bathroom; they to the bathroom in his brief. The was neglected at night as a him to the bathroom in his brief. The was neglected at night as a him to the bathroom in his brief. The was neglected at night as a him to the bathroom in his brief. The was neglected at night as a him to the bathroom at night they go and not tell him to 'wet The was neglected at night as a him to the bathroom at night they are to the bathroom at night they are poop or pee in my pants. The was neglected at night as a him to the bathroom at night they are to the bathroom at night they are poop or pee in my pants. The was neglected at night as a him to the bathroom at night they are to the bathroom at night they are poop or pee in my pants. The was neglected at night as a him to the bathroom at night they are to the bathroom at night | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | · | 05/0 | 08/2013 |
| | PROVIDER OR SUPPLIER | EW | • | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | to the bathroom in them to the bathroom neglect. The DON verified do 11:50 a.m., that this had not been invest the administrator, of accordance with the R3 a current reside had been rough with investigated or immadministrator or SA policy. R3's annual MDS downs cognitively inta at 2:00 p.m., R3 stated states assistant (NA)-FF at cares. R3 stated states care conference to does not think anyther accusation. R3 cares for her even to being rough. Review of the facility notes (IDP) dated 3 Conference was hed did not address R3 was rough with her incident reports and not address R3's cobeing rough was near the states of the states of the states of the facility notes (IDP) dated 3 Conference was hed did not address R3's cobeing rough with her incident reports and not address R3's cobeing rough was near the states of the | their pad and refusing to assist on would be considered uring interview on 5/713 at allegation of potential neglect tigated thoroughly, reported to reported to the SA in | F2 | 226 | R3 Staff training occurred May 8 and Inservices on June 3, 4, 5, and 6 incluresident rights, vulnerable adult abutransfers. Thirty-five residents care/transfers have been audited fo weeks, 35 residents care/transfers vaudited for the next 4 weeks and 25 residents will be audited for the new weeks. Results will be reported at 0 will determine continued frequency need. | uded se and r 4 vill be kt 4 QA. QA | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 | |
| | PROVIDER OR SUPPLIER DANH PLEASANTVI | EW | | 901 SOUTI | RESS, CITY, STATE, ZIP CO HEAST WILLMAR AVENU R, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION OSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 226 | Continued From pa | age 66 | F 2 | 26 | | | | |
| | assistant was roughot thoroughly invested administrator or stafacility policy. R43's quarterly ME was cognitively into able to communical problems. The ME specific behaviors but required extens for all her personal R43 was interview reported an inciderago, when a nursing with her in preparashower. R43 report rough taking off her the NA, "will you be the nursing assistant incident, but there treatment. R43 stawhenever this nursing and she did not like told anyone about want the staff to get A phone interview 5/7/13 at 11:03 a.m. | ed on 5/7/13 at 11:00 a.m. and not that occurred several months and assistant had been rough tion of a shower and during the ted the nursing assistant was er clothes and that she'd asked enicer to me?" R43 indicated ant seemed to get so upset that in the shower room, by myself, g." R43 also reported this had showered her since the had been no further rough ated it made her nervous sing assistant worked with her e it. She stated she had not these feelings, as she didn't | | and rev Vulnera and the Staff we dignity o and vuli occur of on June Social se per wee | A terminated. Plan of vised. Staff received to able Adult Abuse act, at Elder Justice Act in Nere inserviced on respon May 8 and 9 th . Renerable adult abuse and June 3, 4, 5 for nurse 6 th for all other staff ervices will interviewek for 8 weeks with dommittee for further | training on the resident rights, March 2013. pect and esident rights act training will sing staff and f by the NHA. To residents lata reported to | | |

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW . | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 226 | being undressed in also during the sho to the facility about report, had been to would not bathe or mother. The nurses' progres indicated FM-AA had assistant's behavionursing assistant we reprimanded. The | preparation for a shower, and wer. FM-AA said she'd talked this and as a result of the id the identified staff person provide other services to her ess note dated 2/11/13, and been told the nursing r was "unacceptable" and the ould be appropriately progress note indicated his nursing assistant never | F: | 226 | | | |
| | reported to the SA investigative report same day. The correcurrence of this in assistant was not to nursing assistant was assistant in the roo was identified as N. A random review of provided care to R4 the documentation system that allows provided to resident had provided cares though NA-J was not for R43. An interview with recompleted on 5/7/1 reported she was not that NA-J not work | was filed with the SA on the rective action taken to prevent necident indicated the nursing beathe R43 alone, and the ras to have another nursing m. The reported perpetrator A-J. In finite nursing assistants who as completed by reviewing in Care Tracker (an electronic staff to document services ts). NA-J documented she to R43 on 3/26/13, even ot supposed to provide care registered nurse (RN)-A was at 11:34 a.m. RN-A ot aware of FM-AA's request with R43. In addition, RN-A | | | | | |
| | reported she was u | naware of any reported J or the corrective action, | | | | | |

Facility ID: 00792

| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | | MPLETED |
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| | | 245427 | B. WING _ | | 0.5 | 5/08/2013 |
| | PROVIDER OR SUPPLIER | EW | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X6) COMPLETION DATE |
| F 226 | which specified if N staff person was to indicated she was to restrictions with NA worked with. RN-A work with R43 as n giving R43 a showe have been made at The facility submitted on 3/12/13 identified H5427019, regarding abuse and neglect on the east side of allegations were not immediately reported administrator as directly and the following: "On 3/6/13 writer worked on the floor was her training pering sick of taking of When a resident for resident to remain done; the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and picked the resident to remain done the NA said I and | A-J showered R43, a second be in the room. RN-A unaware there were any and which residents she reported NA-J continued to eeded, which could include er. RN-A verified she should ware of this situation. The da report to the state agency das complaint numbering multiple allegations of that were observed by NA-K the nursing home. These at thoroughly investigated or ed to the state agency and ected by the facility policy. The data and a ware of allegations parding mistreatment of strator (A)-E was informed owing accusations. She as a NA for 3-4 days, which riod A NA said I am so frate of you to a resident. It, a NA was told to allow the on the floor until vitals could be frickin don't have time to wait dent up and put her in bed. It is a would sit at the nurses' the audible call light and would be resident with the light on. Ing to force a resident to eat by the resident. NA-K also said the resident. NA-K also said the resident. NA-K also said | F 226 | | | |

| | | IDENTIFICATION NUMBER: | 1 ' ' | | COMPLETED | |
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| | | 245427 | B, WING | | 05 | /08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | · · · · · · · · · · · · · · · · · · · | | REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 226 | that NA's would use they were suppose residents were drop Related to these income to work here." The Investigative re (OHFC -office of he 3/12/13, (6 days after included: "Potential issues were the nursing home some west empreyiously resided on the East with some West empreyiously resided or residents were interhave dementia. No reports from resider mistreated by staff, interviewed, mostly past employees. So staff were neglectfuresidents. It has no resident was injured lifestyle altered. Aft current and former named as people of met with primarily E on 3/8/13. Staff were appropriate residen importance to reportabuse immediately, staff are not reportir their education" The SA also identified | one person transfers when to use two staff. These ped into bed as a result cidents, NA-K did not continue port submitted to the SA alth facility investigations) on er the original complaint) ere focused on the East end of current residents who end were interviewed along diresidents, some of which on the East side 35 current viewed, some of which do specific or substantiated into that they are being 30 staff members were current employees and some ome staff alleged that other and mistreated some to been substantiated that any and mistreated some interest DON and ADON ast end evening nursing staff re given direction on to care Staff are informed of tany suspected or witnessed at was alarming to hear that any concerns immediately per the investigation submitted to ad staff were offered, and were on vulnerable adult reporting | F 226 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | :W | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | 8E | (X5) COMPLETION DATE |
| F 226 | 3/12/13, the facility had spoken to regaresident who'd allegand there was no in investigation had be NA-K's allegations. During interview on DON and LSW-A st facility for only a shoremember specific in The DON and LSW who had specifically allegations. They we documentation of airesident who'd allegations. They we documentation of airesident who'd allegations had fallen employment to detevalid. The DON statistically allegations made by education for the Earesident care, as we staff and residents obtained in 2012, mandatory retrainin again regarding the staff. The DON statistically allegations to do it again to make to do it again to make to do it again to investigation to do it again to the staff. | submitted to the SA dated did not identify any staff they rding other concerns, the ledly fallen was not identified, dication any further sen conducted related to 5/1/13 at 11:15 a.m., the lated NA-K worked at the lated NA-K were unsure of employees or staff. A stated they were unsure of investigated NA-K's lated investigation regarding the ledly fallen and been picked lated by a (unknown) NA. LSW-A lated for "a couple days" and lated investigated to see which during NA-K's short later in the lated and later investigation was | F2 | 226 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B, WING | | | 05 | 08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | | | 901 | ET ADDRESS, CITY, STATE, ZIP CODE I SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | <u></u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 226 | LSW-A verified the interviewed directly mistreatment made interviews alleging a general questions a noticed staff being von the East end?" Their human resource did the interviewing ups for employee fill from the facility and interviewed during the DON stated she investigations, emplany monitoring of erexpressed concernibecause she (the Doworking for the facility During interview on stated he'd spoken vallegations of staff investigations. A-E staff mistreatment with dynamics and how A-E stated it appear girls club and he convipers," meaning he along and were make other regarding mist according to the rep 3/6/13, regarding HS they'd interviewed vertice the staff mistreatment with the East end of the results and the regarding mist according to the rep 3/6/13, regarding HS they'd interviewed vertice the staff mistreatment with the East end of the results and the regarding mist according to the rep 3/6/13, regarding HS they'd interviewed vertice the staff mistreatment with the East end of the rep 3/6/13 and 100 the rep 3/6/13, regarding HS they'd interviewed vertice the staff mistreatment with the East end of the rep 3/6/13 and 100 the rep 3/6/13, regarding HS they'd interviewed vertice the staff mistreatment with the East end of the rep 3/6/13 and 100 the rep 3/6/13 and | per year. The DON and staff and residents were not regarding the allegations of by NA-K or from further staff abuse, but rather were asked uch as "Have you ever rerbally or physically abusive The DON and LSW-A stated res staff (HR)-J, who mainly and corrective action write es, was currently on leave was not able to be ne duration of the survey. It was not involved in the oyee corrective actions, or inployees because staff had she may shown favoritism ON) had a family member the during that time period. 5/2/13 at 10:55 a.m., A-E with NA-K regarding instreatment to residents but ollowed up or conducted any stated the alleged incidents of | F2 | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245427 | B. WING | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | W | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X6) COMPLETION DATE |
| F 226 | provided information investigations they'd RESIDENT INTER\ R57's a current resi 3/14/13 indicated shimpairment. R57's- resident intel questioned the resid treated roughly by s "Sometimes." Ther done or investigation from the resident. | dent's, quarterly MDS dated he had moderate cognitive rview questions dated 3/2013 dent, "Have you ever been taff." The resident answered, e was no further interview in regarding this response | F 22 | R57. Staff interviewed. Reside "owie" during cares no matter staff are. Says, "get those dark my room". Pain is medicated to Cymbalta and QID Tylenol for open log initiated June 3, 2013. Behavior log started 5-30-13. | how gentle dies out of with one week. | |
| | stated she was not a interview with R57 b investigation or follor response. R55's a current resignation of the state of the way treated?" R55 response when I'm alone because when I'm alone beca | 5/1/13 at 11:40 a.m., SW-A sure who completed this but verified there was no w up for the resident's dent's, quarterly MDS dated had severe cognitive view questions dated 3/2013, Do you ever feel afraid you or some other resident is onded, "Sometimes at night ause I can't lock my door and are was no further interview or ing R55's response. 5/2/13 at 10:53 a.m., the stalked about at care was not "afraid," she just seed so she didn't have to | | R55. Interviewed spouse. Res memory loss. BPV placement elopements at home. Resident door locked at home so she co out. Was on memory care unidistressed with other residents. She was moved to long term cadoes close her door and has ac | due to t wanted the uldn't get t and s wandering. are, can and | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | ONSTRUCTION | | E SURVEY PLETED |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | - | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE MAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | worry about other reaches the DON stated the this nor was there at R137's a current reached the R137's resident interested roughly by a responded, "One mittle." R137 was also been rude to you?" member a couple to was no further interested she had not made regarding a shim and "shaken him ust have complet followed up on it. Sinvestigation nor was clarification from the accusations of staff fast with him. R128 a current resident interested to you?" The have happened; 'quand I didn't feel that | esidents coming into her room. For was no documentation of any further investigation. Seident, quarterly MDS dated awas cognitively intact. For view questions dated 3/2013, ed, "Have you ever been staff?" The resident roved too fast; shaken up a so asked, "Has staff yelled or R137 responded, "One staff mes when getting up." There view or investigation regarding 5/2/13 at 10:53 a.m., SW-A heard of the accusation R137 rtaff member who had yelled at m up." SW-A stated SW-B ed this investigation and not sW-A verified there was no as there any further e resident regarding the fiveling at him or moving too dent's, quarterly MDS dated e was cognitively intact. For view questions dated 3/2013, ed, "has staff yelled or been resident responded, "May resident responded, "May resident responded, "May resident responded, "There uestions asked of R128, and | F 2 | R12 Inte No to in wee | 8. Report/investigation comple erviewed other residents on sam abuse suspected. Social services nterview 5 residents each week eks about resident rights with da orted to the QA committee for f | e unit. s staff for 8 ta | |

| | OF CORRECTION | IDENTIFICATION NUMBER: | 1 ' ' | | DISTRUCTION | COM | APLETED |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVI | EW | | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE MAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | R128 reported at tivery abrupt and rud 3:00 a.m. or 4:00 at R128 stated at time than they need to be buring interview or stated she had not made regarding nit. SW-A verified the was there any furth resident regarding behaviors of being STAFF INTERVIE! A staff questionnal NA dated 3/11/13 in any verbal or physical abuse of DON and LSW-A swith any staff or reincident. A staff questionnal SW-A swith any staff or reincident. A staff questionnal 3/7/13 indicated, "or physical abuse of the staff of the staff questionnal 3/7/13 indicated, "or physical abuse of the staff questionnal and t | wed on 5/3/13 at 2:30 p.m. imes, the night nursing staff are de when they wake him up at i.m. to check for continence. es he feels they are harsher be. In 5/2/13 at 10:53 a.m., LSW-A heard of the accusation R128 ght shift being rude to him. ere was no investigation nor her clarification from the the accusations of staff abrupt, rude or harsh. WS: If a completed by an unknown included, "Have you witnessed ical abuse to any resident on e unknown NA had responded, oing to have to wait until next ten 6-6:30 a.m. during report; if eart) feel they have to wait until forget to tell next shift." There rview or investigation of this | F 2 | 226 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION NG | 1 00 | |
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| | | 245427 | B. WING_ | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANHPLEASANTVIE | W | | STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 226 | hoyer [lift], the resid so a NA put the wal them to walk. The residence of NA-D the (unknown) and investigation of this nor was the alleged this questionnaire. During interview on DON stated the supincident" and spoke the administrator wan or was the SA conincident. The DON resident was R67, he spoken to the resident (identified by DON), neglect and had no alleged incident. R6 she had moderate of A staff questionnaim 3/11/13, indicated she had moderate of the staff and NA-B, "told insisted she could, informed ADON and was no further investiganty interviews with current resident, and indicated she had mimpairment. During interview on DON confirmed the the administrator has a side of the staff and instructions and indicated she had mimpairment. | ent said they wanted to walk ker in front of them and told resident said 'I can't walk.' own) NA was taken off that further interview or allegation of resident neglect; NA perpetrator identified in 5/2/13 at 11:15 a.m., the ervisor had "checked into this into NA-D. The DON stated as not notified of the incident, tacted regarding the above verified she believed the owever, stated she had not ent or the alleged staff, NA-B regarding this allegation of written investigation of the 67's quarterly MDS indicated tognitive impairment. The done by TMA-A dated the had reported to the nursing on that had occurred between I R67 to 'walk then' since she Really needs hoyer I she talked to NA-B." There stigation of this incident nor the resident. R67's was a ditheir quarterly MDS | F 22 | R67. Report/investigation co Staff interviewed and validate account. Resident is cognitiv | ed NA-B | |

| | OF DEFICIENCIES DE CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 245427 | B. WING | | 05/08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 226 | indicated he "Knowdidn't say specifics over there'." There investigation regard. During interview on DON and LSW-A si with NA-A regarding they did not know was they or anyor resident?" The ADO "YesVerbal behi shit themselves'." To rinvestigation of the nor employee were alleged incident. During interview on stated she was not a incident nor was this or state agency. A staff questionnaire indicated, "Have any about any verbal or anyone else may ha RN-A had responde becoming more frus a resident had told he stated the ADON investigation resident and it had be stated the ADON investigation regards. | e done by NA-A dated 3/8/13, as there's issues on East end; but said 'waters a little thicker was no further interview or ing this statement. 5/2/13 at 11:15 a.m., the ated they had not followed up the statement he made and hat it meant. e completed by the ADON ed, "Have any of your yout any verbal or physical ne else may have done to a | F 226 | | |

| | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | · | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 226 | resident bed while the bathroom. There we investigation of these A staff questionnair 3/7/13 asked, "Have physical abuse to a RN-B had responde for not doing proper face." There was not investigation of this residents, nor employer and the DON states completed by RN-A up on, and there we available regarding A staff questionnair 3/11/13 indicated, "INA-C; NA-C came laughed as she told fell; didn't find nurse current resident and 4/1/13, indicated shimpairment. During interview on DON and LSW-A staff puestionnair and 4/1/13 indicated shimpairment. | wee texting while sitting on a he resident was using the as no further interview or se statements. e completed by RN-B dated by you witnessed any verbal or ny resident on the East end?" by any resident on the | F2 | e Si N C w ra | 10. Fall was reported by former mployee and allegedly occurred moago. Interview/investigation complitaff training on transfer compliance lursing staff will/are conducting are/Transfer audits on 35 residents weeks and 25 residents for 4 weeks. Ails removed from bed as she needs ersons to assist with bed mobility on 2/18/12. Staff to utilize lift sheet, and 25 residents weeks. | for 4 Side 1-2 | |
| | was no neglect or m The facility provided (IDP) note (which the | is the facility had determined there tor mistreatment which occurred. vided an interdisciplinary progress ich the facility identified as their f the fall) for R10 dated 12/20/12, | | ai po ca tr | ad and the resident to reposition. Event to be on during transfers and resositioning. Staff directed to be more areful and move slower when dress tansferring, turning in bed, try not tour prise her to help prevent bruising. | re ing, | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l · ′ | PLE CONSTRUCTION | COMPLETED |
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| | | 245427 | B. WING | *** | 05/08/2013 |
| | ROVIDER OR SUPPLIER | W | S. | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY) | BE COMPLETION |
| F 226 | regarding the fall who was caring for the rithe following: "Resident slid out of Staff was unhooking resident leaned for and pulled herself for slip to the floor; staff groundResident clong abrasion to the Bruising may happed posterior side of leg floor and legs of the have bed bath" After review of the IDON on 5/2/13 at 1 the 12/20/12 progres being transferred we resident is suppose staff. DON stated to investigated and readministrator, which was the cause of NA-D; resident [unknown] because of NA-D; resident [unknown] | f shower chair at 6:50 p.m. g straps to lift sling when ward and grabbed the lift bar broward. Resident started to ff assisted resident to the cloes have a 2 cm (centimeter) at left side of her head en to her coccyx area and the lift Resident proceeded to DP, during interview with the 1:15 a.m., the DON verified less note indicated R10 was lift only one staff; although the lobe transferred with two this incident should have been ported to the SA and the | F 226 | R179. Resident was not burned. Do investigation another resident was to have gauze bandaging on both had and up her arms due to multiple ski from falls at home. She was admitt the gauze bandaging and the NA mithe residents. The report and investigation were completed. Resident discharg 27-12. NA denied turning off the cast Staff training about vulnerable adulates ident rights, and the Elder Justice occurred in March 2013.; May 8 and | noted ands n tears ed with xed up tigation ed 11- Il light. t abuse, |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | 245427 | B, WING | | | 05/0 | 08/2013 |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVII | EW | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| PREFIX (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X6) COMPLETION DATE |
| The DON indicated regarding the allegated light, however to investigation of the reported to the adm HR-J had issued and to NA-D. The Employed at the admitted 3/14/13 inclusions witnessed being fruiturned off the resident here went back into DON was unable to referred to and state resident neglect or incident had not be DON verified there investigation included interviews regarding have an MDS available. A staff questionnain 3/7/13 indicated, Nationand hit her on the box resident and their question included in the resident and their question and their question included in the resident and their question and their question and the resident and their question and the resident and their question and the resident | urnt themselves in the facility. I R179 had been talked to ations of NA-D turning off her he DON had no documented incident, and it had not been ninistrator. The DON stated in Employee Corrective Action oyee Corrective Action form ded, "You have been ustrated with a resident. You ent light and walked out and o room with an attitude." The oclarify what "an attitude" red they'd felt there was no mistreatment occurring so this en reported to the SA. The was not a thorough ing employee and/or resident g the allegation. R179 did not able to identify cognition. The completed by NA-E on A-HH and NA-II "changed R5 oum." R5 was a current guarterly MDS dated 1/24/13, ent had severe cognitive The report to the state agency are of the allegation. The report submitted on 3/13/13, fing: "HR-J completed staff and The facility indicated as part of they spoke with R5 regarding | F | 226 | again by the DON and ADON June 3, and June6 by the NHA. Call light aud the NHA will occur 15 times per week weeks and pager/cell phone audits to occur 10 times per week for 4 weeks will be reported to QA committee for further direction. R5. Interviewed. Resident made var scattered comments which had not do with the alleged incident. Unable determine if the "hit to the bum" of Social services to interview and ask "hit to the bum". Social services to interview 5 residents per week for 8 Data to be reported to QA for further direction. | rious ning to e to courred. about a weeks. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW | | 901 SOL | DDRESS, CITY, STATE, ZIP CODE JTHEAST WILLMAR AVENUE AR, MN 56201 | | |
| (X4) ID PREFIX 'TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | the incident but she about staff mistreat which did not make "DON, ADON met in nursing staff on 3/8 on appropriate resistate agency reque from the facility reg state agency reque interviewed as part other residents voic their care? Was ot staff indicated they mistreatment by other on 3/25/13, "35 curinterviewed, some specific or substant from residents that mistreated by staff. interviewed, mostly past employees. Staff were neglectfuresidents but this witnessed, just that allegations received were filed with [state the facility interviewed as R5 about the abeing mean' or 'charthe resident was a care in general at the submitted a report not complete an invinterviewing other stallegations. In addisubmitted to the SA | e did not have any complaints iment and made remarks seense. The facility indicated with primary East end evening /13- staff were given direction dent care." On 3/25/13 the sted additional information arding the report on R5. The sted, "Were other residents of your investigation? Did see any concerns regarding her staff interviewed? Did had witnessed any ner staff?" The ADON replied rent residents were which do have dementia. No tiated reports were received they are/ were being 30 staff members were current employees and some ome staff alleged that other all and mistreated some as not reported to have been at they had heard about it. All dithrough these interviews | | 226 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION (XS | | COMPLETED | |
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| | | 245427 | B. WING | | 05/ | 08/2013 | |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 226 | observed which the facility to complete. A staff questionnair 3/7/13 indicated, The Resident grabbed harmstaff joked are equipment witnesse [residents] alarms a anyone else's call linurse on staff" Reavailable to identify The facility submitte the allegation of R1 NA-F. The facility into the SA indicated, current and former named as people of period of employme of time (May 2012), (NA-K) could not renames but stated shaw them again. Winvestigation and an notes to determine out as abusive perporcess it was idental a resident may have named resident die was one incident real bruise to his hand wheelchair causing reports of injury/ brut Although the facility | re completed by NA-E on ney "Heard [NA-F] hit R180; her and she punched his bund about catheter and not answer theirs or ghtsReported abuse to 180 did not have an MDS cognition. The dan OHFC report regarding 80 being hit in the arm by nvestigative report submitted "After our initial interview with staff, many names were interest. Due to short time ent, together with the passage one of the complainants call the alleged perpetrators he would know them if she would know them if she the still sorting through our whether any individuals stand the trators. In the investigative tified that an employee heard the been hit by a NA. The din March of 2012. There port of named resident having is during this time period, it not were bumped while in bruise to appear. No other | F2 | R180. Investigation/report con Resident died 3-19-13. East sid provided with training on Vulne Act, resident rights and care ex by DON and ADON. In addition above, all staff completed Vuln Abuse Act, Resident Rights and Justice Act training in the Healt Academy in March 2013. Vulne abuse act and resident right traoccurred May 8 and 9. Nursing have training June3, 4, 5 and al on June 6 by the NHA on reside and vulnerable adult abuse. So staff will interview 5 residents weeks. Data will be reported to committee for further direction | le staff erable Adult pectations to the erable Adult Elder h Care erable adult aining staff will I other staff ent rights, ocial services weekly for 8 o the QA | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | E SURVEY PLETED |
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| | | 245427 | B. WING _ | | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODI 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 226 | employee was inifacility did not con interviews regarding 180 being hit on the facility stated people of interest submitted nor was facility could provide A staff questionna 3/8/13, indicated, R57; 'here's your approach to resid investigation of the person identified R57. During interview of DON and LSW-A made but there has completed, also the reported to the stadirected by the farresident and their indicated the resident and their indicated the resident and quit turning of from of R181 to ghad submitted a regarding this acceptable. | d perpetrator, although the tially identified as NA-F. The implete any further staff ing the alleged accusation of the arm. In addition, although "many names were named as," there were no names is there any investigation the ide regarding this statement. Aire completed by NA-JJ dated "snippy comments made to drink and I got to go; staff ient." There was no further his statement nor was the staff who made these remarks to the verified these allegations were ad been no investigation hese allegations were not at agency or administrator as cility policy. R57 was a current quarterly MDS dated 3/14/13, dent had moderate cognitive the only person to take care of a lightsstaff would talk dirty in the thim to talk dirty." The facility eport to the SA's OHFC cusation on 3/13/13, regarding or the facility was aware of the | F 22 | R57Investigation and report of Resident calls out "owie" during matter how gentle the care given the interview, R57 responses to do with the discussion, for says, "get those darkies out of Tylenol QID initiated along with and pain logs. R39. Report/investigation con Resident interviewed with no Interviewed other residents a with no complaints. NA-R residents. | ng cares, no ver is. During have nothing example, f my room". th behavior mpleted. complaints. bout NA-R | |
| | 3/11/13 indicated, "[NA-R] verbally inappropriate to R39; she's not the only person to take care of and quit turning on lightsstaff would talk dirty in from of R181 to get him to talk dirty." The facility had submitted a report to the SA's OHFC regarding this accusation on 3/13/13, regarding R181, 2 days after the facility was aware of the incident. The Investigative report submitted to OHFC indicated the following: | | With the control of t | Interviewed other residents a | bout NA-R | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | ELE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | | 05/6 | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | :W | ST | - | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | abuse have surface substantiated any retheir abilities affected much of what we didirection of a dysfur rather than any subsissues Human restaff interview with linterview, NA-G stafront of him [R181] supposed allegation sometime before 7/these supposed allegation staff were given directore" Although the facility abuse to the SA regnot completed, or sinvestigation including members, nor was been interviewed to staff who had been did not have an MD During interview on DON and LSW-A stup or investigation r NA-R being verbally was a current resided atted 4/4/13 indicated the DON verified shows a regarding the | urse of our internal aber of occurrences of alleged ad It has not been esident was actually injured, ed, or lifestyle altered. Indeed, scovered points in the actional employment culture stantive resident abuse sources (HR)-J completed NA-G on 3/11/13 During the ted 'staff would talk dirty in to get him to talk dirty. This a would have occurred 4/12 when R181 died. Due to egation, DON and ADON met ang nursing staff on 3/8/13-ection on appropriate resident submitted the alleged verbal parding R181, the facility had ubmitted, a thorough in terviews done with staff it clear whether NA-G had provide names regarding talking dirty to R181. R181 | F 226 | R181. Report/investigation completed Deceased 7-4-12. DON and ADON rewith evening staff on unit. They add Vulnerable adult abuse act, residentiand care expectation. All staff com Health Care Academy programs on Vulnerable adult abuse, residents riand Elder Justice Act in March 2013 Training in vulnerable adult abuse a resident rights occurred May 8 and Nursing staff will be re-educated on vulnerable adult abuse, resident rigicare expectations by the DON and A on June 3, 4, 5 and all other staff by NHA on June 6. | net dressed t rights pleted ghts ct and 9. hts and | |

| AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA (X1) PROVIDERSUPPLIER | | 1 ' ' | | E CONSTRUCTION | COMPLETED | | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | ROVIDER OR SUPPLIER DANHPLEASANTVIE | · | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 226 | to the administrator policy. A staff questionnair nurse (RN)-B dated resident "said a coucomplain about R10 daughter said she'd they have 13 reside anymore." The queever gone to the nurabuse. CM-B had a regarding the compshe was aware if the she received a resp department she res responded with her reads her emails!" 4/1/13 indicated she impairment. During interview on stated she rememb complaint but believe another resident who to the resident who to the resident of the administration with facility policy. A staff questionnair 3/8/13, indicated "D communication to restaffed; short lipped and the staffed; short lipped and the staffed a | or SA as indicated by facility e completed by registered 3/8/13, indicated another ple of (unknown) NA's always having to peeR10 overheard NA's complain ints and they just can't do it estionnaire asked if CM-B had rsing department to report inswered, "Yes; emailed DON laint above." When asked if e report was investigated or if onse from the nursing ponded, "Never answered or follow up; do you think she R10's quarterly MDS dated had severe cognitive 5/2/13 at 11:00 a.m. DON ers "hearing" about this red the "talk" was coming from to roomed next to R10; so the mown) was complaining about complaining, not the staff. | F2 | 226 | | | |

| | OF CORRECTION | DENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | w | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | bloody nose; picked This is all the question resident named what LPN-G was reported by the LPN-G was reported the provided the provided by the | up tissue don't have time." onnaire indicated. There was nor was there any follow up of ferring to. 5/2/13 at 11:15 a.m., the erified there had been no ation regarding the v LPN-G, and there had been w with LPN-G. In addition, egation had not been reported or SA as directed by facility e completed by NA-F dated unknown NA, "Would argue cream at each other heard g a resident while texting and "NA-F indicated she had | F2 | 226 | | | |
| | 3/11/13, indicated sl "doing the bare mini | me had witnessed neglect, mum not positioning/call lights not in reach; don't | | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | IPLE CONSTRUCTION 4G | | COMPLETED | | |
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| | | 245427 | B. WING_ | | 05/ | 05/08/2013 | |
| | PROVIDER OR SUPPLIER DANH PLEASANTVI | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE | |
| F 226 | put on toilet, just mon toilet; turned off don't do peri care; while feeding reside thical standards at o see what's happ several staff name questionnaire, ther up regarding these any follow up staff the staff identified. During interview or DON and LSW-As investigation, nor a regarding NA-KK's neglect. The DON not spoken to NA-the administrator hreport to the SA ha An undated staff quelle, indicated the N staff mistreatment bent out of shape a RN supervisor); ne DON" Witnesses screaming at him belate; R59 also talked throws people into getting ready" R51/4/13, indicated he no longer resides in During interview or DON stated she be referring to a situation situation of the staff mistreatment between the staff mistreatment bent out of shape a RN supervisor); ne DON" Witnesses screaming at him belate; R59 also talked throws people into getting ready" R51/4/13, indicated he no longer resides in During interview or DON stated she be referring to a situation of the staff was a s | eant to change rather then put call light without doing cares; hide in resident's room, texting entsI'm quitting because my re very high and I can't stand ening" Although there are swritten on the side of the e was no investigation or follow accusations, nor was there interviews conducted regarding in 5/2/13 at 11:15 a.m., the stated there had been no dditional interviews conducted accusations of resident and LSW-A verified they had KK regarding the allegations, ad not been notified, and no d been made. Justionnaire completed by NA-A had gone to the DON about to residents but "[DON] got and told to go to nurse (LPN or ver comfortable going back to d abuse; "R59NA-B because resident keeping hered to nurse; R59 scaredNA-B bed and yells at them while 9's quarterly MDS dated as was cognitively intact. R59 | F 22 | R59. Report/investigation comple Removed NA-B from schedule whi investigation was being conducted Corrective action with NA-B. May before staff began work they receitraining on the revised Vulnerable Abuse act, counseling on teamwor positive staff interaction, taking the residents, empathy and considering residents cognitive ability when procare. Inservices by DON and ADOI 4, 5 and the NHA on June 6 on vulne adult abuse and resident rights. So services will interview 5 residents about resident rights, the data will | le . 3 and 4 ved Adult k, ne with g each oviding I June 3, ne able ocial weekly | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | | | 05/0 | 08/2013 |
| | PROVIDER OR SUPPLIER | | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE IN SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | stated she had no for there been a report stated NA-B had tood this" to R59. The DOR59 and felt R59 "were any concerns was unable to provinvestigation of this allegation should had immediately, then it verified the administ accusation. During interview on stated he was not a of staff mistreatment the staff and/ or res 2013. The facility provided allegations of reside been submitted to the indicated the following. R75 had allegations MDS dated 1/1/13, intact. The facility submitted for R75 dated 11/8/including, "Staff republister on his inner the staff applied warm provided and the staff applied warm provided the staff applied the staff applied the staff applied warm provided the staff applied the staff applied the staff a | ormal investigation, nor had made to the SA, but the DON d her "she would never do DN stated she had spoken to rould have told me" if there of abuse. However, the DON de any documentation of an incident. LSW-A verified this ave been reported to the SA investigated. The DON trator was not aware of this set and abuse which came from ident interviews from March diseveral other submitted ent mistreatment which had ne state agency. The reports | F2 | 226 FI C V | or further direction/action needed. R75. Report/Investigation completed raining on facility policy regarding works by DON and ADON on June 3, 5th. Nursing staff conducted/conductore/transfer audits for 35 residents week for 4 weeks and then 25 reside per week for 4 weeks. Data will be eported to QA for further direction. | varm 4, and ting per | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | LE CONSTRUCTION | COMPLETED | | |
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| | | 245427 | B. WING | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | W | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHEAST WILLMAR AVENUE NILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | SA on 11/15/12 (7 of indicated, "On 11/7/ redness and a blister left inner thigh. Blist caused by a warm president's left thigh pain control. Care proceeded the series of the blister. In talling resident does requested that resident does requested that resident does requested that resident does requested that resident and the source. As stated publister on his left inner affected his abilities perpetrator has not been instructed on the packs to attempt to incident." The facility also provinced in the DON dated indicated R75 "Famon his left thigh this packs the resident has all though the facility also provinced the packs the resident has all though the facility had not sent investigation. An all which appears to have and the DON dated indicated R75 "Famon his left thigh this packs the resident has all though the facility also provinced the packs the resident has all though the facility had not sent investigation. An all which appears to have also the packs the resident had the packs the resident has all though the facility also provinced the packs the resident had the packs | days after the incident) 13 resident was noted to have er within the red area on his ter was thought to have been back that was applied to per his request to help with blan interventions were being neident occurred. Internal ed that resident and his e warm pack was the cause king with staff, they report the est warm packs. Staff also not has requested that staff esk hotter. This information nursing assistants that work ey are considered a credible orior, the resident sustained a ner thigh which has not for lifestyle. An alleged been identified. All staff have facility policy regarding warm prevent recurrence of the vided the Resident Incident/dated 11/7/13, which the to the SA as part of their stached note from the nurse, are been addressed to A-L 11/7/12 at 9:32 p.m., ally noted a 3 cm long blister evening that came from warm has been requesting recently." | F 226 | | | |
| | report was made 11 | R75's blister to the SA, the I/8/12 (the next day), and the lit complete results of the | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | COMPLETED | |
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| | | 245427 | B. WING _ | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER | EW | | TREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVENU WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X6) COMPLETION DATE | |
| F 226 | investigation includinterviewed, wheth warm pack in the president interview haven and who place identification of how using the warm pack of the submitted to the Salso verified she was had been any staff use of warm packs stated R75 was no cognitive problems. R117, a current reservated to alleged in MDS dated 1/17/13 intact. The facility submitt regarding R117 datransferred from the fell-he was being to transfer him wheelchair when she was transferring have a second perplan interventions of the incident occurred during this fall NA | ling names of staff who were er the resident had used a revious days, whether a nad been completed regarding sed the warm packs, or w staff was warming up and cks. 15/1/13 at 10:15 a.m., the rerified the investigation results A were not complete. The DON as not aware of whether there training regarding the proper of following this incident. SW-A longer in the facility but had no | F 22 | R117. Report/Investigation terminated. Training on the and following the plan and t Nursing staff conducting or a transfer/care audits 35 residents weeks and then 25 residents Data to be reported to the C meeting for further action. | plan of care ransfers. are conducting dents for 4 s for 4 weeks. | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | IDENTIFICATION NUMBER: | 1 ' ' | | LE CONSTRUCTION | COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | • | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO | | BE | (X5) COMPLETION DATE |
| F 226 | as signed a correction During interview on DON and LSW-A sit the above incident of the SA. However, the SA. However, the SA. However, the SA. However, the SA indicating, herself he is a two period of the Holman of the Holman of the SA in the SA i | 5/1/13 at 10:15 a.m., the tated they were not aware of which had been submitted to he facility provided an re Action Notice for NA-I dated "Transferred resident by person assist with transfers. In his bathroom." The rm was completed by HR-A. A were unable to identify eccived any additional ied in the investigative report a 12/17/12, which indicated re-educated to the resident's ON stated that if NA-I had education should have been which would have been and and not by HR-A. Although the alleged neglect of health e were discrepancies in the regarding the employee's | F2 | 226 | | | |
| | neglect. R57's quar indicated she had mimpairment. The facility submitted dated 10/11/12 indicated for the staff moved her call was in bed. She was staff told her if she is she'd have to do it wasn't getting up. | ent, made allegations of terly MDS dated 3/14/13 moderate cognitive ed an incident report to the SA cating R57 "Reported that I light out of reach while she as told to stop yelling and then needed to use the bathroom where she was because she She said she felt closed in with and no way to get up and out | | | R57. Report and investigation compl Nursing staff training on May 8 and 9 included call light placement. That traiso included appropriate responses residents. Nursing training on June 3 and 5 included responding to call ligh NHA administrator will audit 15 call ligh each week for 4 weeks. Resident is not reliable during interviews. Her respondable during interviews interspers with the topic of the conversation. Downlib be reported to QA for further act | raining to 3, 4, ats. ights not anses sed | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW | | | SS, CITY, STATE, ZIP CODE EAST WILLMAR AVENUE MN 56201 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | (EA | PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SEREFERENCED TO THE APPROPREFICIENCY) | FION SHOULD BE THE APPROPRIATE | |
| F 226 | submitted to the SAR57 had to wait aboreople to return to a reports that R57 did to wait for them Twriter was asked by room. He told write care she had receivher The alleged p (un-named) Where writer R57 had repthis NA This AP (a scheduled to work to enter her room whold 10/1612, the SA had from the facility ask (alleged perpetrator residents interviewed concerns regarding response identified included "No othe Staff working with Noreported R57's call who informed the reto reposition her The believed R57 who informed the reto reposition her The believed R57 who informed the reto reposition her The believed R57 who informed the reto reposition her The believed R57 who interested | ative report dated 10/16/12, Indicated"Staff believes but 6 minutes for two staff assist with her request. Staff I become upset when she had he following day, 10/11/12, / R57's son to come to her or she was very upset about yed. This writer spoke with | F2 | 26 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION 3 | (X3) DATE SURVE COMPLETED | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING _ | <u>,</u> | 05/08/201 | 13 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | :W | S | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE COMPL | 5) ETION TE |
| F 226 | was not "complete" reported to be intenthere any record of There was also no in DON stated NA-MM facility and was not she no longer worke facility reported the thorough investigating they ensure NA-MM though R57 was upon During interview on stated back in Janu "accusations" of resident mistreatment and girls club" wire reported, because of said he'd felt the accument made by NA-LL in Jaceived allegations NA-K in March 2013 NA-K identified were identified by NA-LL, would be best to locallegations. The facility failed to origin were thorough to the State Agency | as none of the staff who were viewed were named, nor was which staff was interviewed. Interview with NA-MM. The I was still working at the being monitored to ensure ed with R57. Although the allegation to the SA, a on was not completed and did I did not work with R57, even set by NA-MM actions. 5/2/13 at 11:15 a.m., A-E ary 2013, NA-LL had made ident mistreatment by staff. was done at that time, or of the "staff dynamics." A-E cusations were all part of the th staff accusing other staff of ent to get them in trouble. mentation of these allegations anuary. Then the facility of abuse and neglect from 3. Many of the allegations that as "the same" as the concerns so at that time A-E decided it | F 226 | Incident reports were completed for resident with bruising. Incident repreviewed at the daily Falls meeting. Training on May 8 and 9 on the vuluadult abuse act included bruises of unknown origin. Training by the DO ADON June 3, 4, 5 and by the NHA other staff on June 6 th will include Vulnerable adult abuse act and bill | nerable ON and for all | |

PRINTED: 05/24/2013 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 245427 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) rights and Elder Justice Act training via F 226 Continued From page 93 F 226 Health Care Academy. Nursing staff Review of the Bethesda Homes Resident will/have conducted audits for cares/ Incident/Injury Report Form Evaluations, from transfers of 35 residents each week for August 2012 thru May 2013 were reviewed and four weeks and 25 residents each week for the following was noted: four weeks will occur. Results will be R115's quarterly MDS dated 3/28/13 indicated reported to the QA committee who will severe cognitive impairment and required determine continued auditing needs. extensive assistance from staff with most activities of daily living (ADLs) R115 incident report noted bruises on 12/10/12, measuring 8 centimeters (cm) X 6 cm on the top left hand, 4 cm X 2 cm between the third and fourth finger of the left hand, 4 cm X 4 cm on right arm and a 6 cm X 4 cm bruise on the left buttock. The incident report indicated the staff were unsure when the bruises occurred, did not determine the source of injury, there were no observation of cares to determine if the bruises could have been a result of care received and no staff were interviewed. Although the administrator and DON were notified on 12/10/12, it was not reported immediately to the state agency (SA) as directed by the facility's policy. The facility investigation indicated resident "has been resistive and combative with cares", "bumps into things when up in Merry Walker", and bruise on buttock was explained "? from sitting down hard or bumping his buttock". There was no further investigation of the incident. R115 incident report noted bruises on 2/20/13, measuring 2 cm X 2 cm on left forearm, 5 cm X R115. Walks in Merry Walker. Frequently 2.5 cm on right outer elbow and 2 cm X 2 cm on bumps into walls, chairs anything,

the back of the right elbow. The incident report

indicated the staff were unsure when the bruise

injury, no observation of cares were completed to

occurred, did not determine the source of the

Receives aspirin therapy. Sleeve protection

in place. Audits of sleeve protection use

will occur by DON three times a week for

four weeks. Results will be reported to

| AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|---|----------------------------|
| | | 245427 | B. WING | | 05/08/2013 | |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | w | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY I | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | determine if bruises care received nor w interviewed about the administrator and D it was not reported in directed by the facili investigation indicate run into tables, cour walking in Merry Wainvestigation of the investigation in the investigation in the investigation indicate hour notes or behave bruising or a possible staff interviews or furnicident was completed in the incident report in the inc | could have been a result of ere the resident or any staff re injury. Although the ON were notified on 2/20/13, mmediately to the SA as ty's policy. The facility ed the resident is known to ster tips and chairs when up alker. There was no further incident. Sidated 2/21/13 indicated pairment and required erom staff with most ADLs. Inoted a bruises on 4/28/13 indicated a bruises on 4/28/13 indicated are from staff with most ADLs. Inoted a bruises on 4/28/13 indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA as ty's policy. The facility indicated R19 indicately to the SA ind | | R19.Wheel chair armrest padding ap May 29, 2013. Resident moves about bed a great deal. Side rail assessment completed 5/30/2013, side rails rem same date. 5-30-13 sleeve type arm protection in place. Staff training on vulnerable adult abuse, resident right Elder Justice Act occurred on Health Academy in March 2013. Vulnerable abuse and resident right training occur on May 8 and 9. Nursing staff traini June 3, 4, 5, by DON /ADON and by the NHA on June 6, 2013, for all other struin and the struin conduct abuse and resident DON will conduct abuse and resident DON will conduct abuse/neglect interaudits three times per week with nurstaff. Audits of wheel chair arm padding occur three times a week for four weeks by the DON. Audit results will reported to the QA committee for fursicion. | plied at in at oved ts, and Care adult aurred aff on rights. rview rsing ding r | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | f . | | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | | | 901 SC | ADDRESS, CITY, STATE, ZIP CODE DUTHEAST WILLMAR AVENUE MAR, MN 56201 | | |
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| F 226 | Although the admin on 3/13/13, it was n SA as directed by the investigation indicat with leaning towards leaning against the further investigation | t or staff interviewed, istrator and DON were notified of reported immediately to the refacility's policy. The facility ed the bruise was "consistent is the left in her wheelchair and arm rest". There was no | F2 | 226 | | | |
| | 3/1/13 measuring 3 cm on right forearm cm X 0.5 cm on the measuring 1.5 cm x further up the same bruise on top of left indicated the staff woccurred, no staff in The form identified were notified on 3/2 of unknown origin wwas not reported im the bruise on the top explained to be from report indicated resi of bumping her arm and grab bars in the further investigation | cm X 2 cm and 2.5 cm X 3, two bruises measuring 0.5 left forearm, two more (2 cm and 1.5 cm X 1.5 cm left arm, 2.5 cm X 4 cm hand. The incident report ere unsure when the bruises terviews were completed, the administrator and DON /13, one day after the bruise as discovered, the incident mediately to the SA and while of the resident's hand was a blood draw 2/26/13, the dent "is active and is capable is on her wheelchair, siderails bathroom". There was no of the incident completed. | • | | | | |
| | measuring 2.1 cm X The incident report i when the bruise occ marked as not interv administrator and D it was not reported is | 7 cm on her lower back. ndicated staff were unsure urred, and the resident was viewable. Although the ON were notified on 2/17/13, mmediately to the SA as ty's policy. The facility | | | | | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | - | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVI | EW | | 901 | ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | · · · · · · · · · · · · · · · · · · · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | "quickly" tries to tra hitting the arm rest was no further inve completed. | age 96 ated the resident sometimes ansfer into the wheelchair, with her hips or back. There estigation of the incident | F2 | 26 | | | |
| | measuring 3.5 cm Although the admir on 1/14/13, it was r SA as directed by t investigation indica in bed, resident roll bar of the side rail" interviews were con | X 2.0 cm on her right breast. histrator and DON were notified not reported immediately to the he facility's policy. The facility ated "when staff laid her down led and hit her chest on middle". No staff or resident mpleted, or further bruising even though the | | | | | |
| | measuring 2.5 cm cm X 2.0 cm and 5 side of back and at report indicated state bruise occurred, not conducted to deter been a result of catadministrator and I was not reported in directed by the faci investigation indicated with resident hitting not sitting up straigher side on the arm were completed, or completed to determine the side of th | t noted bruises on 1/4/13 X 1.5 cm on right forearm, 4.0 i.0 cm X 3.0 cm bruises on left odomen area. The incident aff were unsure when the observation of cares were mine if the bruise could have re received. Although the DON were notified on 1/4/13, it nmediately to the SA as lity's policy. The facility sted the bruises are "consistent garms on bedside table and the tin the wheelchair and hitting in rest". No staff interviews a further investigation was mine possible cause. | | | | | |
| | | t noted a bruise on 11/18/12 6.5 cm on left upper thigh. The | | | | | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVI | EW | | ADDRESS, CITY, STATE, ZIP CODE COUTHEAST WILLMAR AVENUE MAR, MN 56201 | • | | |
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| F 226 | the bruise occurred "thought it is possil when she was tran R19 was not able t indicates "she doe with her, does not scratching herself" conducted to deter been a result of ca administrator and I it was not reported directed by the fac- investigation of the R19 incident report 11/12/12 measurin shoulder, 2 cm X 1 wrist and 5.5 cm X The incident report when the bruise occares were conduct could have been a staff interviews were administrator and I it was not reported directed by the fac- report indicated the consistent with res table and side rail of staff did not determ injury. No further in completed. | cated staff were unsure when d. Staff was interviewed ble resident bumped her thigh isferring", and that although the to be interviewed, the report is not recall anyone being rough recall bumping, pinching, and observation of cares were mine if the bruise could have re received. Although the DON were notified on 11/18/12, immediately to the SA as illity's policy. No further incident was completed. It noted multiple bruises on a g 2 cm X 0.5 cm on left cm on left hand below her a 2 cm on left arm above wrist. It indicated staff were unsure courred, no observation of sted to determine if the bruise result of care received and no recompleted. Although the DON were notified on 11/12/12, immediately to the SA as illity's policy. The facility incident the bruises on her wrist were ident hitting arm on bedside on bed and further indicated nine the source of the shoulder avestigation of the incident was | F2 | 226 | | | |
| | moderate cognitive | MDS dated 10/15/12 indicated impairment and required ce from staff with most ADLs. | | ı | 77. Deceased, hospitalize 11-28-1 d there. | l2 and | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 226 | on 11/26/12, measing X 1 cm bruise of and 2.5 cm X 2 cm to back of left thigh conducted to determine the area administrator and Lit was not reported directed by the faci investigation indicated unsure when the bruise on left thigh wheelchair and the transfers from staff further investigation completed. R8's significant chaindicated severe correquired extensive most ADLs. R8 incident report reported administrator and Lit was not reported directed by the faci report indicated that when the bruises of from "hitting her sic bruise was from "hit wheelchair". No staff was not reported that wheelchair". | rt noted a scratch and bruises uring 12 cm (scratch) and 3 on left buttock, 1 cm X 1 cm to right buttock, a light bruise. No observation of cares were mine if the bruise could have the received. Although the DON were notified on 11/26/12, immediately to the SA as lity's policy. The facility the that although staff was uises/scratch occurred, the was from her cushion in her others were consistent from and the incident was linge MDS dated 1/25/13 agnitive impairment and assistance from staff with the one of the incident was and on right shin. Although the DON were notified on 1/11/12, immediately to the SA as lity's policy. The facility incident that although staff was unsure courred, the arm bruises were le rails while in bed" and shin | F 2 | R8. Side rail assessment comp 13. Side rail use appropriate. using them. | | | |

PRINTED: 05/24/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 226 Continued From page 99 F 226 R86's quarterly MDS dated 2/28/13 indicated R86. Resistive to cares routinely, bruising severe cognitive impairment and required believed to occur during cares. Sleeve extensive assistance from staff with most ADLs. protection applied. Nursing staff are conducting/conducted Care/transfer audits

R86 incident report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident. Although the administrator and DON were notified on 11/20/12, it was not reported immediately to the SA as directed by the facility's policy. The facility incident report indicated that although staff was unsure when the bruises occurred, the resident was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No staff or resident interviews or further investigation was completed.

R86 incident report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. Although the administrator and DON were notified on 4/16/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the staff were unsure when the bruises occurred, but noted it was from "being combative with HS cares". No staff or resident interviews were completed, or further investigation of the incident was conducted.

R109's quarterly MDS dated 3/14/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs.

R109 incident report noted a bruise on 10/30/12, measuring 12 cm X 3 cm on her back. Although

on 35 residents for 4 weeks, and for 25 residents for 4 weeks. Data reported to QA committee for further action needed.

R109. Forcefully seats self in chairs, on

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| | | 245427 | B. WING_ | | 05 | /08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | W | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPRINTED DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 226 | the administrator ar 10/30/12, it was not SA as directed by the report indicated the bruises occurred, beinjury to be when ar sat down hard and I toilet. No additional investigation of the ST to a compart of the severe cognitive improvements as a compart of the severe cognitive improvements are severed as sistence. The severe cognitive improvements are severed as a compart of the severe cognitive improvements are severed as a compart of the severed in the severed indicated the staff was not reported indicated the staff was not reported indicated the staff was not reported indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported. And did not indicated the staff was not reported in the staff was not reported. And did not indicated the staff was not reported in the staff was not reported | ge 100 Ind DON were notified on reported immediately to the ne facility's policy. The incident staff were unsure when the ut "assumed" the source of a alde reported the resident nit her back on the top of staff interviews or further incident was completed. S dated 12/7/12 indicated pairment and required e from staff with most ADLs. Inoted bruises on 11/23/12, 2.5 cm and 3.5 cm X 4.0 cm X 2.3 cm on left wrist and 3.4 at hand. Although the ON were notified on 11/23/12, mmediately to the SA as ity's policy. The incident report were unsure when the bruises of determine the source of sident was combative prior to onal staff interviews or further incident was completed. | F.2: | R15. Resident had history of pun and hitting staff. He was resistive measuring bruising. He died 1-16 | to | |
| | | S dated 1/17/13 indicated pairment and was totally with all ADLs. | | R51. Deceased 3-22-13. | | |
| | on 12/28/12, measu | noted a skin tear and bruise Iring 6 cm X 2.9 cm skin tear a 7.1 cm X 5.4 cm bruise | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | · | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW . | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
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| F 226 | 226 Continued From page 101 surrounding the area. Although the administrator and DON were notified on 12/28/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report determined the source of injury was from staff boosting resident up in the chair and sliding the lift sheet up. No further staff interviews, observations of care or further investigation of the incident was completed. R68's quarterly MDS dated 2/7/13 indicated severe cognitive impairment and required extensive assistance from staff with ADLs. | | | | R68. Resident is resistive to cares. T bruising incident occurred while resi shower. Showers will be changed to | sting a | |
| | yellow in color on the observation of care determine if the bru of care received. A DON were notified cimmediately to the Spolicy. The incident was consistent with during a shower. N | noted a bruise on 4/22/13, e right frontal mid thigh. No s were conducted to ise could have been a result though the administrator and on 4/22/13, it was not reported SA as directed by the facility's report indicated the bruise "resistiveness with cares" o staff or resident interviews further investigation was | mornings and re-evaluated. It are conducting/conducted Ca audits on 35 residents for 4 w | | are conducting/conducted Care/trar audits on 35 residents for 4 weeks a residents for 4 weeks. Data reporte | nsfer nd 25 | |
| | extensive assistance R98 incident report measuring 1.5 cm 2 | S dated 2/21/13 indicated pairment and required e from staff with ADLs. noted a bruise on 11/28/12, K 1.0 cm on right inner thigh. ares were conducted to | | | R98. Bruising believed to be caused Merry Walker strap. Now, only occasionally uses Merry Walker. | by the | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | EW | | STREET ADDRESS, CITY, STATE, ZIP C 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201 | | | |
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| F 226 | determine if the bru of care received. Al DON were notified reported immediate facility's policy. The staff were unsure we presumed the bruisincontinent pad is a further investigation. R128's who was a MDS dated 2/14/13 intact and required staff with most ADL. R128 incident reported measuring 1.6 cm // buttock crease. Alth DON were notified immediately to the policy. The incident time of injury was usefrom bumping into a transfer with a PA with staff, or further. R128 incident report 10/30/12, measuring X 1.6 cm to lower results in the staff was unaware and determine the staff was unaware and determine the staff incident report determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff was unaware and determine the staff incident report determine the staff was unaware and det | uise could have been a result though the administrator and on 11/28/13, it was not ely to the SA as directed by the incident report indicated the when the bruises occurred but se was consistent where her at times. No staff interviews or a was completed. current resident, quarterly indicated he was cognitively extensive assistance from | F2 | R128. Side rail assessment is appropriate and he continuenthem. Ambulates with a whoumps into objects routinel type arm protection on. Nuprotection audit three time weeks. Data reported to Oxfurther action. | nues to use heel chair, and ly. Has sleeve ursing do Sleeve s a week for 4 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1''' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | investigation noted and other objects fr | ge 103 ity's policy. The facility "bumps his arms on the table equently". No interviews with stigation was completed. | F2 | 226 | | | |
| | R10's quarterly MDS dated 4/1/13 indicated severe cognitive impairment and was totally dependent on staff with most ADLs. R10 incident report noted six bruises on both arms on 11/29/12, measuring 1.0 cm X 2.5 cm | | | R10. Re-arranged room. Side rails removed 12/18/2012. Recliner removed from room. Tried sleeve arm protected in the work due to arm swelling. Per wall by bed with a fall mat. Nursing | tion, added staff | | |
| | and 2.0 cm X 2.0 cr X 2.5 cm bruise by below left elbow, 1.5 and 3.0 cm X 1.0 cr Although the admin on 11/29/12, it was the SA as directed by facility investigation history of bruising to bumping them on the | n on upper right arm, 1.0 cm left elbow, 2.0 cm X 3.0 cm 5 cm X 2.0 cm on left forearm n bruise on lower left forearm. istrator and DON were notified not reported immediately to by the facility's policy. The indicated resident "has a b her arms and hands from ne bedside table, side rails, g transfers". No staff | | 1 | conducted/conducting Care/transfer on 35 residents for 4 weeks and 25 residents for 4 weeks. Data to be re to QA committee for further directio | ported | |
| | measuring 4 cm on cm by right thumb, top of left hand. No conducted to determ been a result of care the administrator ar 1/14/13, one day afforigin was discovered. | noted bruises on 1/13/13, top of right hand, 2 cm X 3 2 cm circle from left thumb to observation of cares were nine if the bruise could have e received. The form identified ad DON were notified on ter the bruise of unknown ed by a family member, the ported immediately to the SA, | | paraphone, and printing a | | | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|--|---|-------------------------------|----------------------------|
| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVII | EW | | 91 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | and facility investig were "consistent w room or where bed | age 104 ation indicated the bruises ith where table is in dining side table is", there were no urther investigation completed. | F2 | 226 | | | |
| | severe cognitive im | dated 1/17/13 indicated pairment and required ce from staff with most ADLs. | | | R4. Deceased 2-12-13. Was combat with cares as well as resistive. Hit w his hand. | | |
| | measuring 3 cm X right hand and a 2.4 right hand and wrist and DON were noti reported immediate facility's policy. The indicated the reside shower hitting his hithere was no staff in | noted bruises on 8/3/12, 1.5 cm and 1.5 cm X 2 cm on 5 cm X 1.5 cm bruise on the t. Although the administrator fied on 8/3/12, it was not bely to the SA as directed by the facility incident report ent was combative during his ands against a wall, however nterviews or further eted about the incident. | | TOPPY TO THE TOTAL THE TOTAL TO AL TO THE TO | - | | |
| | severe cognitive im | S dated 2/14/13 indicated pairment and required to from staff with all ADLs. | | | R37. Resists cares and showers. Tric sleeve type arm protection; will not them on. | | |
| | measuring 1 cm X a 0.5 cm X 0.5 cm of report indicated that on 7/30/12 during h respond when ques | noted bruises on 8/3/12 1 cm on upper right wrist and on left inner wrist. The incident t she was resistive with cares er shower. R8 was unable to blioned. Although the DON were notified on 8/3/12, it | | | | | |

PRINTED: 05/24/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE BETHESDA NH PLEASANTVIEW WILLMAR, MN 56201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 Continued From page 105 F 226 was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated resident was resistive with cares on 7/30/12 during her shower. There were no staff was interviewed or further investigation of the incident. R120. Receives aspirin daily. Was R120's quarterly MDS dated 3/21/13 indicated ambulating at that time with a walker. severe cognitive impairment and required when she sat the walker was in front of her extensive assistance from staff with most ADLs. and she may have hit her chest on it. Deceased 5-16-13. R120 incident report noted bruises on 8/19/12, measuring 3.5 cm X 5.0 cm on chest and a 9 cm X 13 cm on her right hand. The incident report indicated the staff was unsure when the bruises occurred or the source of the injury. Although the DON was notified on 8/19/12, it was not reported immediately to the administrator or to the SA as directed by the facility's policy. The facility investigation indicated "resident has been wandering the halls and throughout the unit this

shift". There were no staff interviews or further

R67's who was a current resident, quarterly MDS dated 1/24/13 indicated moderate cognitive impairment and required extensive assistance

R67 incident report noted a bruise on 1/8/13, measuring 8.8 cm X 3.3 cm on left side of abdomen. Although the administrator and DON were notified on 1/8/13, it was not reported

investigation completed.

from staff with most ADLs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/24/2013 **FORMAPPROVED** 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 245427 B. WING _ 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BETHESDA NH PLEASANTVIEW** 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 226 Continued From page 106 F 226 immediately to the SA as directed by the facility's policy. The facility investigation indicated resident skin was pinched in PAL belt. There were no staff interviews or further investigation completed about the bruising. R67 incident report noted multiple bruises on 8/2/12, measuring 0.9 cm X 1.1 cm on left forearm, 0.5 cm X 0.8 cm on top of right hand, 1.0 cm X 0.8 cm on right elbow, 0.9 cm X 0.9 cm on right deltoid, 0.6 cm X 1.0 cm on left buttocks. Although the administrator and DON were notified on 8/2/12, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated the resident bumps her arms all the time. There were no staff was interviewed nor further investigation of the incident as directed by the facility's policy. During interview on 5/1/13 at 11:15 a.m., the DON and SW-A stated all the above reports and investigations of bruising were complete and there was no further investigation conducted. The SW-A stated the "nurses" bring all bruising

INDIVIDUALITY

F 241

SS=D

investigations to a Monday staffing meeting, and the staff review the bruising reports. However, the DON and SW-A could not remember having reviewed the above bruises of unknown origin. Following review of the investigations, they verified the investigations were not complete, and that these bruising of unknown origin should have

been reported to the administrator and SA

The facility must promote care for residents in a

manner and in an environment that maintains or

483.15(a) DIGNITY AND RESPECT OF

according to facility policy.

F 241 BPV promotes care for residents in a

manner and in an environment that maintains or enhances each resident's

or her individuality. The case manager

dignity and respect in full recognition of his

| | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDIN | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|--|----------------------------|
| | | 245427 | B. WING _ | | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTVII | EW | S | TREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | <u></u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 241 | This REQUIREMENT by: Based on interview the facility failed to (R43) in a dignified regards to the reside Findings include: R43 reported she is alone at least once this. She reported if feel sad to be left the The resident was as with diagnoses of or unspecific arthropal congenital anomalismitral insufficiency and A quarterly minimum completed on 2/1/13 intact. The MDS into aid and glasses, had to communicate her She had no specific of delirium. She need from one staff for all primary means of the wheelchair or walke on one staff for all her A phone interview were stagged to the staff for all her and the staf | ident's dignity and respect in is or her individuality. NT is not met as evidenced and documentation review, provide care for 1 of 1 resident and respectful manner with ent's personal preference. I being left in the dining room, per week and she did not like it is lonely and it makes her ere by herself. I dmitted to the facility on 9/12 steoarthritis (chronic arthritis, thies (disease of the joints), as of the heart with congenital and adult failure to thrive. In data set (MDS) was anoted R43 was cognitively dicated she wore a hearing diclear speech and was able in needs without any problems. Behaviors or any symptoms ended extensive assistance ansportation was the responsive totally dependent in the responsive totally dependent. | F 24 | responsible for a plan to assure tha not left in the dining room alone. To clinical manager and evening super will audit the dining room 5 times p for 4 weeks to assure the plan is be followed. Results will be reported to QA committee. DON and ADON will conduct training on dignity June 3, and the NHA will be responsible for training on June 6th. Case manager responsible to assure R43 is not left in the dining room. Social services interview R43 weekly for four week her dining experience. Results will a discussed with case manager weekly changes made as needed. Data rep to QA committee for further action NHA is responsible for compliance weekledent rights. | he visor er week ing to the l 4, 5, is alone will s about be y and orted . The | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-----------|-------------------------------|--|
| | | 245427 | B. WING_ | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | EW . | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X6) COMPLETION DATE | |
| F 241 | on a Sunday night, previous. She foun room, by herself an indicated R43 told hand that she could her room. FM-AA in in the dining room at the dietary aid did n FM-AA indicated shassistants who were they admitted to her dining room. R43 was interviewe reported she had be room by staff severe occurs on a regular She stated she felt happened and was she felt when this had interview with nu NA-EE at 11:20 a.m Both NA's reported not like to be the last as the resident had An interview with received the last as the resident had RN-A reported she request, nor was shincident. RN-A indicated room in the room with received the last as the resident had RN-A reported she request, nor was shincident. RN-A indicated room indicated received request. RN-A indicated room indicated room in the room request. RN-A indicated room room room room room room room roo | to see R43 at about 6:45 p.m. approximately 5 or 6 months d R43, sitting in the dining d she was crying. FM-AA ler, she had been left all alone not get any help to get back to indicated that a dietary aid was at the time but R43 reported of pay attention to her. e talked to some nursing a working that evening and they had forgotten R43 in the don 5/7/13 at 11:00 a.m. and sen left alone in the dining al times. She indicated this basis about once a week. onely and sad when this unsure why but told staff how appened. It is not staff to they were aware that R43 did at resident in the dining room talked to them about this. If it is gistered nurse care manager the don 5/7/13 at 11:34 am. It is a was not aware of R43's e aware of the reported cated she should have been | F 24 | 41 | | | |
| F 242 SS=D | plan for ensuring R4 dining room should She indicated it was | e nursing assistants and a 43 was not left alone in the be part of her plan of care. currently not in her care plan. TERMINATION - RIGHT TO | F 24 | Please see top of page 110 for th correction. Thank you. | e plan of | | |

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hours."

to lay in bed."

was observed laying in his bed sleeping.

R122's current plan of care dated April 2013

R122's current nursing assistant care sheets dated 5/1/13 instructed staff resident "allowed to

offered option of change of position every 2

identified R122 "sleeps in recliner often, refuses

be in recliner as much as he wants; patient to be

R122's current physician orders dated May 2013

abuse and resident rights. Nursing staff were trained on June 3, 4, 5 all other staff

on June 6 by the NHA about vulnerable

are trained on the bill of rights in new employee general orientation and

adult abuse and resident rights. All staff

annually. Quarterly nursing department

meetings will have a standing agenda item

of resident rights. The NHA is responsible

for compliance with resident rights policies and procedures. Staff will continue to

collect data on resident choices and

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R122 tells them not to.

times" R122 can sleep in the recliner if he chooses; they had even obtained a physician order to allow the resident to sleep in the recliner, but staff still lays him in bed at night even when

Although R122, a family member, and a physician

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------|--|---|-------------------------------|--|
| | | 245427 | B. WING | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTV | | | STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVENU WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 242 | order made staff a sleep in the recline failed to allow R12 wished to sleep. | age 111 ware of the residents wishes to er in the evening; the facility 2 a choice regarding where he CARE/SERVICES FOR | F 2 | 09 | | | |
| SS=D | Each resident mus provide the necess or maintain the hig mental, and psych | | | BPV provides the necessary services to attain and mainta practicable physical, mental social well-being, in accorda comprehensive assessment care for each resident. R122 the NP on May 10, 2013, medecreased from 50 mg to 25 orders to monitor vital signs | ain the highest and psycho- nce with the and the plan of was seen by etoprolol orders mg with | | |
| | by: Based on interview facility failed to ensighe changes in a reside fainting spells during | NT is not met as evidenced w, and document review the sure a physician was notified of ents condition which included ng transfers and abnormal vital idents (R122) who had a n. | | NP. Subsequently, the dose to 12.5 mg on May 13, 2013 2013, the resident's physicia made no further changes. T no further episodes of lighth The policy and procedure for families and physicians has a land revised. The policy and vital sign outlier's has been in | . May 15, in saw him and here have been leadedness. Ir notifying been reviewed procedure for eviewed and | | |
| | R122 since 12/07/2 episodes of passin mechanical (PAL) the normal parame pressure ulcer on 3 never notified of th condition. R122 had diagnosi heart disease. R12 | 2012, had experienced several g out while using the standing lift, had vital signs outside of eters, and developed a 8/29/13. R122 physician was ese changes in R122 s including hypertension and 22's quarterly minimum data 1/1/13 identified the resident had | | revised. Staff training will o and 5th about vital sign mon expectations of reporting to manager, notifying physiciar extenders, families about ch condition. The 24 hour repo MD notification and family nadded to it. Consulting phangiven access to care tracker monitor vital signs as needed manager to review all reside | ccur June 3, 4, hitoring and the clinical hs/physician anges in ort tool has had notification macist will be in order to d. Case | | |

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---------|---|------------|----------------------------|
| | | 245427 | B. WING | B. WING | | 05/08/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 90 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 | extensive assistance living, was totally detransfers, and did no pressure ulcers. During interview on member (FM)-G stated stated that to speed by the lift and he "look FM-G stated she has or nurses why R122 the lift. During observation was being transferred with nursing assista R122 was raised upwere shaking while his toes were just to standing lift. His feed any weight while in NA-N verified R122 were just touching to NA's stated R122 has when lifting him, wh "lose his breathe." During interview on stated he believed it standing lift because and he is just "hang he passes out it hap is only one staff transfers." | impairment, needed be with all activities of daily sependent on staff for all sot have any skin concerns or a 5/1/13 at 12:30 p.m. family ated she was aware R122 had at before and thought it could use only one person is ident in the lift, and the and more time being "heid" up uses his breath and faints." and not spoken to the physician 2 was passing out while using on 5/8/13 at 11:07 a.m. R122 and by the PAL mechanical lift ant (NA)-M and NA-N. When a during the transfer, his arms holding onto the handles, and buching the platform of the et were swaying, not applying the mechanical lift. NA-M and the was not 'standing', his feet the platform of the lift. Both has "passed out" on the lift nich NA-N stated R122 would | F | 309 | | | |

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|-----|--|------------|----------------------------|
| 245427 | | 245427 | B, WING | | | 05/08/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 901 | ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY I | MUST BE PRECEDED BY FULL | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | F | 309 | | | |

| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | | | COMPLETED | |
|--|--|--|-------------|--|--|------------------|--|
| 245427 | | B. WING | | | 05/08/2013 | | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST WILLMAR AVENUE MAR, 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 CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY) | | LD BE COMPLETION | |
| F 309 | responded after one had taken were chapressure 113/59. During interview on registered nurse clir the physician or nurbeen aware of R122 lift. She stated she make her aware of the lift and she was RN-A verified there ensure R122 was salift since admission was unable to locate pressures done on and verified it was 'f should be getting or checked monthly. Expassing out on the spressures should havital signs should have sident passed out unable to provide vit the resident had passed in the normal range Clinic identifies a "not 120/80" and your "hor form 60-100 beats promise to consult your passed in the pressure of dizzing are to consult your passed in the pressure of the normal range Clinic identifies a "not 120/80" and your "hor form 60-100 beats promise to consult your passed in the pressure of the normal range Clinic identifies a "not 120/80" and your "hor form 60-100 beats promise to consult your passed in the pressure of the normal range Clinic identifies a "not 120/80" and your "hor form 60-100 beats promise to consult your passed in the pressure of the pre | e minute." Vital signs staff rted as pulse 43 and blood 5/8/13 at 10:30 a.m. nical manager (RN)-A stated se practitioner (NP) had not 2 passing out on the standing had called the NP today to R122 passing out spells on going to see R122 'tomorrow.' had been no assessment to afe to use the standing PAL in 2011. In addition, RN-A any orthostatic blood R122 since admission in 2011 acility policy' every resident thostatic blood pressures RN-A stated with R122 standing lift, orthostatic blood ave been checked as well as a light readings from when seed out on the standing lift. Ious vital signs that were out for individuals. The Mayo formal blood pressure is eart rate (pulse) can range for minute. If your pulse is a rhigher than this and have less or lightheadedness you onlysician." In review of R122's ders, dated 4/2013, identified | F | 309 | | | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | | |
|--|--|---|-------------------|-----|---|------------|----------------------------|
| 245427 | | 245427 | B. WING | | | 05/08/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY I | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | Metoprolol tartrate 8 hypertension (high It Lisinopril/ HCTZ 10/ hypertension. Lasix 40 mg twice a Zaroxylin 2.5 mg da Upon review of R12 Tracker under "Resthe following: 2/26/13- Blood presthe following: 2/26/13- Blood presthe following: 2/26/13- Blood presthe ywere accurate improved. 3/5/13- P-49. There reading. 3/12/13- B/P-55/96. of this reading. 3/15/13- B/P- 53/99 recheck of this reading. 3/19/13- B/P- 97/55 recheck of this reading. 4/12/13- P-45. The reading. 4/12/13- P43. There reading. 4/16/13- B/P- 100/5 recheck of this reading. 4/16/13- B/P- 92/54 recheck of this reading. 4/30/13- B/P- 92/54 recheck of this reading. During interview on assistant (NA)-O stathe vital signs and if | 50 mg twice a day for blood pressure). 12.5 mg everyday for day for edema (swelling). 19 sily for edema. 2's vital signs charted in Care ident Vitals Chart" indicated sure (B/P) 95/57 pulse (P) 45. Were not rechecked to ensure or if the B/P and pulse was no recheck of this P-41. There was no recheck P-44. There was no ing. P-46. There was no ing. re was no recheck of this was no recheck of this re was no recheck of this 7. P-45. There was no ing. 8. P-46. There was no ing. 9. P-49. There was no ing. | . F: | 309 | | | |

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/24/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** 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 245427 B, WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 116 F 309 charge. NA-O was unaware of R122 having out of range vital signs. During interview on 5/7/13 at 1:05 p.m. licensed practical nurse (LPN)-A stated if a blood pressure or pulse is "out of range" the NA's should be reporting the vital signs to the nurse so it can be closely monitored, and are to be reported to the physician. LPN-A stated the nurses do not check the vital signs the NA's do on the residents, but it is the it is responsibility of the NAs to report to the nurse if there are vital signs is an out of range. LPN-A acknowledged that R122's current medications can effect blood pressure and pulse, but was unaware of R122's past abnormal vital signs. During interview on 5/7/13 at 1:15 p.m. RN-A reviewed the vital signs charted for R122 and stated the vital signs should have been rechecked, reported to the nurse, and to the physician. RN-A verified the abnormal vital signs were not followed up on or reported to the physician. RN-A stated when the physician or NP visits the resident, the vital sign review is done off the most recent vital signs obtained, they don't always see all the vital signs that were done for the last month. During Interview on 5/7/13 at 3:20 p.m. facility pharmacist (P)-I stated she was not aware of R122's out of range vital sign readings. She

stated she does not have access to care tracker where the vital signs are charted. P-I stated she reviews the last physician note regarding vital signs and they have all been within normal range. P-I stated she would expect the facility would

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|-----|--|--|----------------------------|
| | | 245427 | B. WING | i | · · · · · · · · · · · · · · · · · · · | 05/08/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | <u>. </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | notify her if there w vital sign readings. medications R122 effect the blood pre should be monitore | vere concerns with abnormal P-I also stated the is currently on would greatly essure and pulse and these ed closely. | F3 | 309 | | | |
| F 314 SS=D | The facility policy, entitled: Vital Sign Policy and Procedure (dated 1/07) instructed, "Vital signs will be monitored weekly and as needed. Licensed Practical Nurses or trained nursing assistants are responsible for obtaining vital signs. All vital sign results will be reported to the nurse." 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES | | Fŧ | | BPV, based on a comprehensive assessment of a resident, ensures the | | 7/08/2013 |
| | resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received to promote | Based on the comprehensive assessment of a esident, the facility must ensure that a resident who enters the facility without pressure sores loes not develop pressure sores unless the adividual's clinical condition demonstrates that hey were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | | | resident who enters the facility with pressure sores does not develop pre sores unless the individual's clinical condition demonstrates that they we unavoidable; and a resident having pressure sores receives the necessar treatment and services to promote horevent infection and prevent new sofrom developing. Resources were contacted to assist in the developme | ere Y nealing, ores | |
| | by: Based on observateview, the facility fand assess pressul | NT is not met as evidenced tion, interview, and document failed to adequately monitor re ulcers for 1 of 2 residents ble who had a pressure ulcer. | | | wound system to include product lin selection and when to utilize each pr monitoring of pressure ulcers which include location, staging, size, exudaingly, description of wound bed and vedges. Weekly wound rounds will oct | e roduct; would tes, wound ccur. 013 for | |
| | | imum data set (MDS) dated e resident was moderately | | ļ | nurses on the wound protocol. R12 pressure ulcer documentation and IP completed on May 3, 2013; family ar | N was | j l |

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE BETHESDA NH PLEASANTVIEW 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 (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY May 3, 2013; family and MD notified as of F 314 Continued From page 118 F 314 May 3, 2013. Follow up with the CNP on cognitively impaired, was an extensive assist with 5/5/13 for further treatment advisement. all activities of daily living (ADL's), and had no Response from MD regarding treatment on pressure ulcers. 5/7/13. Single use measuring tools are on the treatment carts. DON will audit During observation on on 5/2/13 at 9:20 a.m. with charting weekly on each resident who has a registered nurse clinical manager (RN)-A R122 had a pressure areas on the buttocks. RN-A pressure sore and assure wound/skin pointed out two small open areas on R122's left rounds are completed weekly for 8 weeks. and right buttocks and stated she thought they Audit results will be reported to the QA appeared "better," although she was unable to committee monthly. DON is responsible verify the last time she had seen R122's pressure for implementation of on-going wound ulcers. RN-A stated she had nothing to currently program. measure the pressure ulcers with, but both the areas (one on the left buttocks and one on the right buttocks) appeared to be stage one pressure ulcers, and she would return "later in the day to measure them" and then document the measurements in the interdisciplinary progress notes (IPN). Upon review of R122's IPN identified the following notations: 3/29/13- "Coccyx is red. Applied as needed calmoseptine. Notified RN. 3/31/13- "Resident has red open area on his bottom. Calmoseptine cream applied. Will continue to monitor." 3/31/13- "Resident was repositioned every 2 hours and Calmoseptine was applied to his open area on his bottom..." 4/1/13- "Resident has two open areas on bottom." One on right upper buttocks and one on left upper buttocks. Stage one with no drainage. Staff have

been applying Calmoseptine to area daily with cares, however, they have not minimized. Assisted staff with cleansing buttocks area. Applied skin barrier prep. Let dry. Applied PRINTED: 05/24/2013

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID | | (X1) PROVIDER/SUPPLIER/CL!A IDENTIFICATION NUMBER: | 1'' | TIPLE CONST | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | /08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | | STREET ADDRESS, CITY, STATE, ZIP COL 901 SOUTHEAST WILLMAR AVENUI WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 314 | Calmoseptine over Mepilex dressings, 4/11/13- "Per RN re wound/ sore open to Will continue to more 5/1/13- "Resident or areas on bottom. Or close to butt crease drainage. It appears previously recorded healed and is a stage present close to but. The facility did not comonitoring of R122' location, staging, six of wound bed and word wound bed and word stage one to the rigic cm x 3 cm with a stage one/stabottom near his but followed out wound stage one to the rigic cm x 3 cm with a stage one to the rigic cm x 3 cm with a stage one to the rigic cm x 3 cm with a stage one to the rigic cm x 3 cm with a stage one to the rigic cm x 3 cm with a stage one to the rigic cm x 3 center which measures 3 cm x 3 center which measures 3 cm x 3 center which measures 4 cm x 3 center which measures 5/2/13 interview on stated staff were awat the end of April, to physician or nurse process. | both open areas. Applied one to each open area." equest leave residents bottom or air dry. Please apply calmonitor." ontinues to have two open one area on right buttocks is stage two with notes smaller in area than i Left area of buttocks is ge 1 with a pinpoint stage two at crease, no drainage." | F | 314 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDED SUPPLIES (X1) PR

| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 245427 | B. WING_ | | 05/08/2013 |
| BETHES | PROVIDER OR SUPPLIER DANH PLEASANTVIE | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | 00/00/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 314 | their wound protocol facility identified R12 A verified they shoul about the pressure use the treatment was change the treatment consistent (weekly) ruicer characteristics staging, size, exudate bed and wound edge. The facility policy title Policy and Procedure. "The physician or numotified of all new wo significant change in | (about one month after the 22 had pressure ulcers). RN-d have notified the physician electron to determine effective or if they wanted to at. RN-A verified there was no monitoring of the pressure that identified location, e, pain, description of wound es. ad Pressure Ulcer Treatment ed dated 2/23/04 instructed, ree practitioner will be unds, when there is a a wound, and when a wound | F 31 | 4 | |
| F 323 SS=D | appropriately." 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ension environment remains as is possible; and eadequate supervision prevent accidents. This REQUIREMENT by: Based on observation review the facility failed assess falls for 1 of 5 | is not met as evidenced in, interview, and document d to comprehensively residents (R78) who were to ensure safe transfers for | | BPV assures that the resident environmental assures that the resident hazards a possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The fall policy and procedure was reviewed a revised. Falls incident report form wareviewed and revised. Falls incident reports are to be completed for an observed fall or unobserved fall. All fare reviewed by the daily (Monday the Friday) falls committee for completer the report, analysis and for any other recommendations to the plan of care Safety Risk Data Assessment is completed on admission and quarterly. Each fall flogged' onto the form. The ADON is | Ils Ind as falls arough ness of |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION NG | (X3) DATE SU COMPLET | |
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| | | 245427 | B. WING_ | | 05/08/2 | 2013 |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | :W | : | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE CO | (X5) IMPLETION DATE |
| F 323 | Findings include: R78's annual minim 2/1/13 identified R7 impairment, needed transfers, and was uplan of care dated A at risk for falls. The light available at all reach, bed in low powheelchair, and pre R78 was observed in her wheelchair in sling underneath he alarms, (an alarm the moved), clipped to the sweatshirt. Review of R78's inte (IPN) revealed the found on floor with the did receive a skin te 1 cm x 1 cm, skin wheelch found on minimum as able to mobruising at this time late hour and doctor 4/18/13 at 12:46 a.m. crying with left hip p | sferring to prevent potential aum data set (MDS) dated 8 had severe cognitive I extensive assistance with all unable to walk. R78's current april 2013 identified R78 was interventions included call times, have objects within osition, tabs alarm in ssure alarm in bed. on 5/1/13 at 11:50 a.m. sitting the dining room with a hoyer or with a personal (tabs) nat would notify staff if R78 the upper part of the back of erdisciplinary progress notes collowing: "Resident fell this evening tesident attempted to self chair to bed. Resident was back to the ground. Resident ear to the left elbow measuring tas still intact and retracted tion Resident with left hip ove leg up and down, no Family not notified do to the | F 32 | responsible for maintaining a sprewith information about each fall a experiences. The spread sheet is use the falls committee to assist with a Nursing staff training on June 3, 4, for all other staff on June 6 by the include the falls incident report chancessity to follow resident care poste use of the falls spread sheet. It committee meeting will occur daily (Monday through Friday) to review incident reports from the time of the previous meeting. DON is response assure that the falls incident report complete, and the Safety Risk Dath Assessment is updated with each for Transfer methods are determined case managers with assistance from physical therapy as needed. Two putransfers or various mechanical decused for resident/staff safety. This re-iterated in the staff training. Not staff are/have conducted auditing care/transfers 35 times per week for Results will be reported to the QA committee who will determine the auditing plan. | resident ised at inalysis. 5 and NHA to anges, ans and falls / / all is are a inal. by the moreon vices are s will be ursing of or 4 4 weeks. | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | was making her do hurts so much.' Phroom and received send over via ambupain from recent fat 4/18/13 at 2:52 a.m resident fractured hist. Cloud hospital." The facility provide regarding R78's fall investigation of the indicated the currer been in place to prereach, call light on, side rails, tab alarm hi/ lo bed, bed by windicated the resident had her cawhich were immedi "assessed for injury medication." The faby the director of nu (A)-E, and the licen who was working with out include if the interviews with staff interventions should R78 risk of falling. Review of the Safed dated 4/21/13, indicincluded tab alarm against wall, pressibathroom, and hi/ leinterventions and/o | that. Crying 'what can I do it one call placed to emergency an order from triage nurse to plance for evaluation of left hip il." "Emergency room stating ner left hip and is on her way to | F | 323 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DANH PLEASANTVIE | · W | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | : |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | stated she had "hea facility was short sta stated another staff been in R78's room resident she would but never came back stated there waiting never came back stand fell. During interview on stated she was wor NA-L stated she was wor NA-L stated she we check on R78's roo resident laying on the alarm was not soun unclip her own tabs up to her at the time always told [R78] not did it all the time." If interviewed her about happened. NA-L stated she did the in "thought" she had in with R78 on 4/17/13 however, she was a documentation of the interviews complete fall to determine if the same and the state of the same and the s | ks." 5/6/13 at 12:05 p.m. LPN-A ard" about R78's fall and the affed that evening. LPN-A member told her an aide had prior to the fall, and told the come back to put her to bed, ck. The resident had been to go to bed and "she (aide) o she just transferred herself" 5/6/13 at 2:45 p.m. NA-L king when R78 fell on 4/17/13. Int in the residents room to mmate and then saw the ne floor. NA-L stated the tabs ding because R78 was able to alarm and it was not hooked to of the fall. NA-L stated "I out to unclip her tabs alarm; she NA-L stated no one had ever out R78's fall and what had ated the night R78 fell they that evening, and she was | F3 | 323 | | | |

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| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | l ' ' | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING _ | | 05/ | /08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | ΕW | S | TREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 323 | manager (CM)-A st implemented any n place for R78 to preverified an investigated R78 fall on 4/17/13 interventions could R78 risk for falls. Cable to remove the spoken to any of the evening of 4/17/13. Review of the facility dated 1/2013 instruinterdisciplinary teatherapist, will review weekly falls commit investigation works LPN/TMA at the timinterventions will be try to prevent additinstructs staff to debeing followed during the reported to the stacility did not do a the residents currer and being followed. R122 was not transplan to prevent potential reported to the stacility did not do a the residents currer and being followed. R122 was not transplan to prevent potential reported to the stacility did not do a the residents currer and being followed. | ated the facility had not existed the facility had not ew interventions to be put into event further falls. CM-A ation was not completed after to determine if other be implemented to decrease M-A was not aware R78 was clip tab alarm and she had not e staff who were working the when R78 fell. It policy titled Falls Policy cted staff "The im, including the physical of falls on a weekly basis at the interest will be completed by the ne of each fall and appropriate implemented immediately to onal falls." The policy also termine if the plan of care was not falls, and if it is not it is to state agency. However, the investigation to determine if not plan of care was in place. If erred as directed by the care ential accidents and injury. Imum data set (MDS) dated 22 had moderate cognitive dextensive assistance with all | F 32 | 23 | | |
| | plan to prevent pote R122 quarterly min 3/1/13 identified R1 impairment, neede | imum data set (MDS) dated 22 had moderate cognitive d extensive assistance with all ing, and was totally dependent | | | | |

PRINTED: 05/24/2013 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 IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 323 Continued From page 125 F 323 R122's current plan of care dated April 2013 identified R122 was an extensive assist of two with a standing PAL lift for all transfers. During observation on 4/30/13 at 3:55 p.m. nursing assistant (NA)-A was observed coming out of R122's room alone with the standing PAL lift. NA-A stated he had just taken R122 to the bathroom using the standing lift. NA-A verified R122 was suppose to be an assist of two staff, however, the facility was short staffed and there was no other staff to assist with the transfer so he did it alone. NA-A stated he "usually" transfers R122 alone with the standing PAL lift as there is no other staff available to assist. During interview on 5/1/13 at 12:30 p.m. family member (FM)-G stated she is at the facility on a daily basis in the afternoon. She was aware R122 had fainting spells in the past using the standing lift and believed it happened more often when there was "only one staff doing the transfer" with the standing lift. FM-G verified she had observed "many times" when only one staff transfers R122 using the standing lift. During observation on 5/8/13 at 11:07 a.m. R122 was being transferred by the PAL mechanical lift with nursing assistant (NA)-M and NA-N. When

R122 was raised up during the transfer, his arms were shaking while holding onto the handles, and his toes were just touching the platform of the standing lift. His feet were swaying, not applying any weight while in the mechanical lift. NA-M and NA-N verified R122 was not 'standing', his feet were just touching the platform of the lift.

During Interview on 5/8/13 at 10:30 a.m. clinical

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dated 3/21/13 indicated she was alert and orientated and needed assist of two with

transfers. R3's current plan of care dated 3/25/13 indicated that she is alert and orientated and

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | i . | LE CONSTRUCTION | | E SURVEY PLETED |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | w | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
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| F 323 F 353 SS=E | assist of two staff. During interview on stated that there has NA-FF has transfer R3 stated this happestaff and NA-FF had doesn't get better hed 483.30(a) SUFFICIE PER CARE PLANS The facility must have provide nursing and maintain the highest and psychosocial wedetermined by resid individual plans of control of the facility must pronumbers of each of personnel on a 24-h care to all residents care plans: Except when waived section, licensed nurpersonnel. Except when waived section, the facility murse to serve as a duty. | 5/3/13 at 2:00 p.m., R3 s been several times that red her with only assist of one. ens because they are short of s told her if the staffing e is going to quit. ENT 24-HR NURSING STAFF we sufficient nursing staff to related services to attain or a practicable physical, mental, ell-being of each resident, as ent assessments and | F 353 | BPV provides sufficient nursing staff provide nursing and related services attain or maintain the highest practi physical, mental and psychosocial wheing of each resident, as determine resident assessments and individual of care. To assist in providing sufficient staffing new technological efforts artied (May 29 and 30 placed on web recruit nurses and NA's (as well as an other open position on the campus), were placed May 30 and 31 to come early June. Contacts were made to i positions available in area church publications. Incentive programs to current staff to pick up shifts were implemented. Time limited recruitm bonus' were implemented. All effor be evaluated by the Recruitment and Retention committee for efficacy. Schedules will be posted with open so staff know what shifts are availab pick up. | to cable ell- ed by plans ent e being) to ny Ads out in nclude entice hent ts will d | 7-8-13 |
| | | on, interview and document | | | | |

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| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW . | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | <u>-</u> | |
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| F 353 | staffing to ensure reassistance with actives assistance with active assistance with a council minutes. The facility. In addition, 6 of 8 faces as a composition of the staff and the staff assistance and the staff assistance and the staff assistance as a composition of the staff assistance and the staff assistance are staff assistance and the staff assistance and the staff assistance are staff assistance as a composition of the staff assistance and the staff assistance are staff assistance as a composition of the staff as | ailed to provide adequate esidents received required vities of daily living during and review of the Resident nese concerns were voiced by R26, R133, R3, and R24) out to currently reside in the amily members (FM-G, FM-FM-H, and FM-AA) neerns about personal cares due to a lack of staff If (LPN-B, NA-V, TMA-B, NA-IA-A, NA-GG, NA-C, -E, NA-HH, NA-II, NA-U, B, NA-M), interviewed; re unable to care for residents afficient staff. Ported to state agency on of the memory care unit at cort staffed especially on 1/12/13 (H5427019) of facility durning the audible part of the nursing stations and not ight. In addition, it was dents who required two person g transferred by one staff, were validated during the 8/13. | F 353 | and what is expected for the current DON is responsible for maintaining adequate staffing. DON will attend resident council to explain BPV plan hiring staff. All staff will be trained a expected to answer call lights by the ADON on June 3, 4, 5 and by the NH on June 6 th . Nursing staff will be expected to we utilize pagers to assist in responding lights. Cell phones are not to be on person' of any staff (except administand the DON and ADON when they call). Cell phones on the person of employee must be approved by the in charge of the building. Job fair to for all open positions on June 19 at a facility. Audits of who responded to lights will occur 20 times each week weeks by the NHA. Pager and cell paudits will occur 10 times per week weeks by the DON. Data will be reported to QA committee for further direct | s for and DON/A/DON ar and to call trator, are on an person be held the call for 8 hone for 4 orted to | |
| | 3/14/13 indicated m | nimum data set (MDS) dated noderate cognitive impairment. red on 4/30/13 at 3:40 p.m. | | R122. Staff trained in safe patient handling. Emphasis on plan of care two person transfer or two persons | - 1 | |

PRINTED: 05/24/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 245427 B. WING. 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (D (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) mechanical lift, then two persons must be F 353 Continued From page 129 F 353 involved. Nursing auditing 35 and stated when he asks to go to the bathroom at care/transfers per week for 4 weeks, then night staff told him they don't have time to take 25 per week for 4 weeks. Call light audits him to the bathroom and tell him to "poop or pee" of 15 per week for 4 weeks by the NHA. All in his pad. R122 stated about a month ago he data will be reported to QA for further put his call light on for help but the staff kept action needed. coming in and turning it off without helping him. He stated he started to scream for help, but finally

R26 significant change minimum data set (MDS), completed on 1/4/13 indicated R26 was cognitively intact. R26 was interviewed initially on 4/29/13 at 3:45 p.m. R26 voiced concern regarding facility staffing and staffing turnover. She reported that staff change all the time and there had been four occasions when the new staff placed her call light out of her reach and she was unable to call for help. She reported being aware that she was not to ambulate by herself as she had a history of falls but feels due to staff shortage she had no option but to take herself to the bathroom.

just gave up because no one would help him

R26 was interviewed on a second occasion on 5/7/13 at 4:05 p.m. and again verified she was very concerned about shortage of nursing staff. She reports there are times when two staff are to help her and there is only one.

R133 quarterly MDS completed on 1/18/13 indicated she was cognitively intact. R133 was interviewed on 4/30/12 at 9:27 a.m. She reported that did not feel the facility had enough staff. Indicated that will have to wait a long time to get some help just to use the bathroom. She also indicated for two days (day shift) the week prior, only one nursing assistant worked on her wing of the facility. R133 stated she told staff had "called

R26. Call light audit 15 times each week for 4 weeks. Nursing training on June 3, 4, and 5 included appropriate call light response and placement. Data reported to QA for further direction.

| TATEMEN' ND PLAN (| OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | LE CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
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| | PROVIDER OR SUPPLIER DA NH PLEASANTV | IEW | • | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
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| | in" for the shifts a reported that the she could but at or were on and the "indicated that she staff to work alone adequate care to the nursing assistant was weating during the her." She also start a sweating during the her. "She also start a heart attack." R133 was interviewed and rest and the heart attack." R133 reported the facility was due to reported she was a with her whenever the bathroom. She times and when she take herself to the increases the chanincident of falling a had fallen prior to he she had episodes of staff did not resportenough. R133 indimanagement of the enough staff to care | and they were not replaced. She taff person tried to do the best the point, four resident call lights yellers were yelling." She felt it was impossible for the on her wing and provide the residents. She indicated the was red in the face and e shifts and "I felt really bad for ated, "I told her just to sit on few minutes before she had a wed again on 5/5/13 at 1:30 her concerns regarding. She stated "I pay good money y should have more staff." primary reason, she was at the problems with balance. She ware she was to have staff she gets up, walks or goes to be reports urinary urgency at e knows staff are short, will be athroom, which she knows ce of falling. She denied any at the facility but reported that the radmission. She also reports of being incontinent of urine as and to her call light quickly cated she felt very angry at the efacility for not ensuring the for the residents. | F | 353 | R133. No resident identified as 133. | | |
| | R3 complained of s transferred accordi of insufficient staffi | hort staffing and not being ng to her plan of care because ng. | | а | R3. Training on transfers occurred Ma and 9. Training on transfers occurred une 3, 4, and 5. Care/transfer audits | on | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | LE CONSTRUCTION | | E SURVEY PLETED |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | ≣W | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 353 | paraplegia. R3's and dated 3/21/13 indicated and need transfers. R3's currindicated that she was care plan also spectransferred with a massistance of two simulated there had be transferred her by happens because the FF has told her if the is going to quit." reported this to the know the staff are of transfer." | including spinal cord injury with nual minimum data set (MDS) ated she was alert and ded assist of two with rent plan of care dated 3/25/13 was alert and orientated. The iffied that R3 was to be nechanical lift (Hoyer) and taff. on 5/3/13 at 2:00 p.m., R3 en several times NA-FF had berself. R3 then stated "this ney are short of staff and NA-e staffing doesn't get better R3 did state she has not facility but then stated "they only using one staff to | F 353 | each week, then 25 residents each Two persons are to used whenever mechanical lift is the designated to Safe patient handling training occur all of the training dates as well. Can audits will occur 15 times each we weeks with the data reported to the committee for further direction. | r a ansfer. arred on all light ek for 4 | |
| | voiced she was very staffing of the facilitial like it was quite frequere expected to withemselves, which withe facility has a lot seem to keep enough staff leave as they contain the reported he had Nurses about his contained the facility was not contained assistants. R24 also past, when he attempathroom and there | y concerned about the short y. He reported that it seemed juent that nursing assistants ork a wing of the facility by was not possible. He reported of turnaround and just can't gh staff. He indicated some lon't get paid enough and go ported 5 out of 7 days; there ursing assistants on his wing. talked to the Director of procern about staffing and felt doing enough to retain nursing or reported he had fallen in the expression of the process of the proces | | R24. Resident is self transferring. care/transfer audits for 35 residen week for 4 weeks occurred, then 2 residents for 4 weeks. Call light au times each week for 4 weeks. Data reported at QA committee for furt direction. | ts each 5 dits 15 a to be | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | · | · | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER DANH PLEASANTV | EW | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
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| F 353 | for help." He also incontinence as the residents and coul wet himself. R24 is and angry. There were 6 of 8 that identified concluding performed dispuring interview or incontinuous and incontin | age 132 reported episodes of urinary e staff were busy with other d not help him in time and he ndicated this made him mad family members interviewed eerns about personal cares not ue to a lack of staffing. n 5/1/13 at 12:30 p.m. FM-G s often short staffed. FM-G | F | 353 | | | |
| | stated her family m two people transfe standing lift for saf | nember is supposed to have r him with the mechanical ety, but she had observed one staff transferring him with | | True from | | | |
| | p.m. with FM-BB. member was no lot the memory care utof 2012. FM-BB redissatisfied with the provided. She inditransferring residents belt. She also felt the business to maconcerned about the reported the nurse seemed to be short care to the resident family and other reurinary incontinent enough staff to recall light FM-BB staff. | was completed 5/2/13 at 3:41 FM-BB reported that her family nger at the facility but was on the init in October and November exported she was very exported she had observed staffints without the use of a transfer the facility was very much in ake money and were not overly ne care of the residents. She is on the memory care unit and could not provide quality the staff of the provide of the prov | | | | | |

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 IND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA NH PLEASANTVIEW 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 353 Continued From page 133 F 353 her own. FM-BB stated luckily she did not get hurt. FM-BB also reported she had noticed her family member had a lot of bruising and felt this was related to staff being so rushed due to shortage. FM-BB indicated, she was at the facility as much as she could as she felt she needed to be there to make sure her family was getting the care she needed. During interview on 5/3/13 at 8:30 a.m. FM-M stated the facility is very short staffed. She stated because of the short staffing, staff is inconsistent and the care provided to the residents is not adequate as they don't know the residents. During interview on 5/3/13 at 1:42 p.m. FM-CC wanted to voice concern regarding staffing. Indicated she will visit her family member in the afternoon to ensure she is at the facility over a meal as her mother needs to be fed and a lot of times there are not enough staff to feed the residents their meals. She voiced concerns regarding how long it took for call lights to be answered and reported that it took at least 20 minutes for the staff to respond. FM-CC reported that a lot of times, staff are working 16 hour shifts and voiced concern regarding this. She also said the facility does not seem to be able to keep good staff and the morale of the nursing staff is "terrible" and is worried on the impact of this with the care of her mother. During interview on 5/6/13 at 3:20 p.m. FM-H stated the facility is very short staffed. She stated one evening her family member did not get their 8:00 p.m. medications until 10:30 p.m. because there was not enough staff to give the residents

their medications. FM-H also stated when she comes to visit her family member, residents will PRINTED: 05/24/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | bathroom as they cand they can't wait and they can't wait affed, and they can't wait a | e to help them to the an't get help from staff to go | F | 353 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | PROVIDER OR SUPPLIER DANH PLEASANTVIE | <u> </u> | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | responsible to give unit, which makes it their medications at During an interview reported the last yeabad, people are gettinew hires and as so one quits." NA-V stidifference in staffing the day there are eigadministrative desk are only 7 aides on further stated she detime to complete all During interview on stated the facility is a basis." She stated at give medications when core staffing is LPN for each hallwa TMA-B stated the wastaffed for the NA's, of the resident cares. During interview on stated the NA's "are especially on the we does her best to do can't possibly "keep She stated she is oft and she has to trans person transfer by he staff available to ass | medications for the whole difficult to get the residents coording to their schedule. on 4/29/13 at 6:25 p.m., NA-V ar, "it (staffing)has gotten realting burnt out, we can't get on as we get them, another ated she does see a glevels between shifts, during ght aides, nurse managers, staff and on evenings there for the entire east wing. NA-V does not feel there is enough the cares for the residents. 4/29/13 at 6:44 p.m. TMA-B short staffed "on a normal at times she is the only TMA to two halls of residents, as supposed to be one TMA or y to pass medications. eekends are very short so it is very difficult to get all a done on the weekend. 4/29/13 at 7:00 p.m. NA-Q always short staffed; ekends." NA-Q stated she cares for the residents, but an eye on all the residents." ien by herself down a hallway fer residents who are a two erself because there are no | F | 353 | | | |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| STATEMENT OF DEFICIENCIES (X1) PR IND PLAN OF CORRECTION IDE | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER DA NH PLEASANTV | EW | 9 | REET ADDRESS, CITY, STATE, ZIP COI 01 SOUTHEAST WILLMAR AVENU VILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES 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) COMPLETION DATE | |
| F 353 | short staffed, espesitated the memory NA short on the we facility's core stafficulties core stafficulties as sistent (short of staff. She short a lot of the timprior, worked on a get the residents ubreakfast/lunch an requested. She incomproximately 14 rhelp other nursing reported a staff pewere not replaced. prior to this intervisin" and was not renursing assistants reported that week staff almost always that residents know see us working so working the wing. short, she has bee residents. NA-H a (personal stand lift aware the facility's She also reported person assists indefind any other staff up" if she gets cau | stated the facility is "always" cially on the weekends. He care unit is usually at least two ekends, according to the ng requirements. If on 4/30/13 at 11:30 a.m., NA)-H reported she felt very reported they (the staff) work me. Indicated that the week wing by herself and needed to p, dressed for the day, fed d respond to residents as they licated she was responsible for esidents and also expected to assistants if needed. She reson had "called in" and they She also reported the day ew, she was ill and had "called placed and so the other had to work short. NA-H tends were "really bad" as as worked short. She indicated when they are short as they hard and they also ask, who is She reported when working in told to "slow down" by the dmitted to using a PAL lift by herself when she was policy is to be used by 2 staff. Ithat she had transferred two ependently as she could not a Stated she will get "written ught doing this but stated "what | F 353 | | | | |
| | staffing concerns to | do?" NA-H has brought o management personal but be trying to hire staff but they | | | | | |

| STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTV | | | 901 S | ADDRESS, CITY, STATE, ZIP CODE OUTHEAST 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 353 | happens. During interview o stated the facility i "all" the NA's need regardless if the retwo person transfer the "girls" in the msmall and transfer assistance. NA-A accidents have habeing short staffed give specific detail transferred R122, two, on the standil was "no other staff to find other staff to find other staff the would transfer resthe PAL lift. NA-G policy's were to have sidents using this reported she did noption. She acknown reprimanded if the reported she felt the unexplained bruisi rushed. NA-GG reidentify any specifically interview of the particular to the particular than the partic | this for a long time and nothing in 4/30/13 at 5:40 p.m. NA-A is very short staffed. He stated it to transfer residents alone, esidents are supposed to be a er. He stated he worries about emory care unit as they are ring "these big men" without stated he believed falls and ppened as a direct result from it, however, he was unable to is. NA-A verified he had just who was an extensive assist of ing lift (PAL) by himself as there | F | 53 | | | | |

PRINTED: 05/24/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE BETHESDA NH PLEASANTVIEW WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 353 Continued From page 138 F 353 only way they ever have enough staff is if another NA is willing to pick up a shift. During interview on 5/2/13 at 9:10 a.m. LPN-A stated the facility is short staffed and it can be "frustrating" to try to get all of the resident cares done. LPN-A stated she was aware NA's had to transfer residents who were supposed to be a two person transfer by themselves. She stated if the NA's don't have another person to help them, and there is only one nurse passing medications, "there is no other choice" regarding transferring residents with only one staff when they are assessed to be a two person transfer for safety. During an interview on 5/5/13 at 12:45 p.m., with RN-D reported that a resident had fallen the night previous. She indicated this resident had fallen previously and acknowledged the facility's short staffing probably was a factor in the falls. She reported there are not enough staff to watch resident's and ensure the resident's safety. During an interview on 5/3/13 at 1:15 p.m., licensed practical nurse (LPN)-E stated staffing

had been a significant issue for the past year at the facility. She reports there are times the wings of the facility are staffed by only one nursing assistant, especially on weekends. Indicates that staff shortages occur when staff "call in" and are not replaced and at times, the schedule "is short" (not enough staff scheduled). Indicated each wing at the facility does have residents, who are 2 person assists and when only one staff member is working, it is almost impossible for safe transfers. LPN-E indicated she was aware at

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | 1-00-0 | 05/ | 08/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW | · | 90 | ET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 353 | lift with only one state policy. LPN-E was specific incident bu LPN-E also reported residents were falling than previously who facility. During an interview voiced concern regreported working stresidents do not ge given. She also ack person transfers by by herself, which stresidents do not ge given. She also ack person transfers by by herself, which stresidents do not ge given. She also ack person transfers by by herself, which stresidents a call light sounding to disengage the bear of selection of the selecti | being transferred with a PAL off, which is against facility unable to remember any at stated "knows it happens." It is seemed like more and having more bruising on there were more staff at the on 5/5/13 at 1:40 p.m. NA-HH arding facility staffing. She nort at times at the facility and at the care they should be nowledged transferring 2 herself and using the PAL lift are knows is wrong. | F | 353 | | | |

STATEMENT OF DEFICIENCIES

| STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 4 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | i | | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER | IEW | | 901 | ET ADDRESS, CITY, STATE, ZIP CODE I SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | <u>,I</u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) . | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | During an interview reported concerns on the Memory Care was "tired of work the Memory Care the weekend as two short and one of the person was not reported the staffing short administer all med treatments on both unit. She reported talked to many time staffing issue. She with the residents by getting the care the shortage, she called employed by the factore, to come to the out resident's brea have enough staff. During an interview registered nurse (Facility was understown when we care unit, residents bath and walked as just not enough staff reported at times stresident cares and get as much attention. | w on 5/5/13 at 1:55 p.m., LPN-F regarding staffing, especially re unit. LPN-F reported she ing so short." She indicated unit has three staff short during to of the shifts were scheduled he staff "called in" and this blaced. She indicated due to ge, she is responsible to ications and do all the wings of the Memory Care management staff have been es without any resolution of the indicated she loves working but does not feel they are eay deserve. Due to the staff and her daughter, who is not icility but does work in health the facility this morning and dish kfast, Stated "we just did not to do it all this morning." Yon 5/6/13 at 8:45 a.m. RN)-B reported she felt the was the shortest in staffing uently worked short. RN-B staff are short on the memory would not get their weekly a care planned. Stated there is ff to get it all done. RN-B also taff are very rushed with therefore, the residents do not on as they should get. She es complain about staffing and | F3 | 353 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | B. WING | | 05/08/2013 | |
| | PROVIDER OR SUPPLIER | EW | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAC | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | reported to her that forgetting to put in a or glasses. During interview on stated the facility is stated there "are m transfer a resident alone. NA-M stated get another person the cares need to be | a nursing assistants are resident's teeth, hearing aids a 5/8/13 at 11:05 a.m. NA-M "always short staffed." She any times" when she had to who is a two person transfer at there is not enough help to to assist with a transfer and the done. NA-M also stated | F | 353 | | | |
| | soon as possible." turn call lights off, a will come back to h verified at times thi | o turn resident call lights off "as She stated staff will go in and and then tell the resident they elp when they can. She s can be over 20 minutes urn to help the resident. | | | | | |
| | from March 2012 to In August, Septemb were raised regard and saying "I'll be ri The activity director meetings filled out a Form (RCRF) on 8/1 the issue and gave 30, 2012 council no been raised severa | eeting minutes were reviewed of April 2013. Deer and November concernsing staff turning call lights off ght back", but not returning. If (AD) who attended the a Resident Council Response (31/12 and 9/28/12 outlining it to the DON. The November oftes indicated the "issue has I times and nursing is aware" bill as the administrator will be | Transfer of the state of the st | Tradition and the state of the | | | |
| | stated the residents waiting a long time | on 5/3/13 at 8:32 a.m., AD s have brought up the issue of for help after they put their call s since August of 2012. She | | | | | |

| STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | LIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | TE SURVEY MPLETED |
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| | | 245427 | B. WING | | | 05/08/2013 | |
| | PROVIDER OR SUPPLIER DA NH PLEASANTV | | - | 901 | ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES 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 353 | stated when issued a RCRF and give is manager to address she completed a Recomplaints of long answered (no spectroom and turning of "will be right back." who attended Resiss "do not get right baneed to respond to gave a written commembers to the direct August and when resubmitted the constated the staffing is November 2012 arresponse from the facility's administrated documentation as the received from the asystem crashed an lost. During an interview (SC) on 5/8/13 at 2 the facility was shown as specifically one regulation and the facility was shown as sistents. She also times when the two posted with holes in She indicated she wholes but some of the fill them and then the She also reported the "called in," she would recomplete the she | age 142 s are brought up she will fill out to appropriate department as. AD states in August 2012 CRF stating "numerous waits to have call light bific times), staff coming into all light off, and telling resident She reported that residents dent Council reported the staff ck" and at times forget they the call light. AD reported she plaint from the resident council ector of nurses (DON) in to response was received; she neern again in September. AD ssue was again brought up in a she had not gotten any DON, she sent an email to the tor. AD was unable to provide to the feedback or message administrator as their email all email messages were with the schedule coordinator 30 p.m., she acknowledged the twenty two (22) positions istered nurse, three licensed and eighteen (18) nursing to reported there have been week schedule had been them (no staff coverage). Would attempt to fill in these the time, there were no staff to be wings would work short. That when a staff person and try to replace them with a could work an extra shift. She | F | 353 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | 05 | /08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | EW . | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE | |
| F 353 | agree to work the e would work short. Swere posted short of staff to cover an ope DON of this. During an interview 2:40 p.m., the DON enough staff to prove residents. She also wings do work short this occurs. She also informed when the with open shifts. During an interview 5/8/13 at 10:05 a.m. nursing department She indicated she working shifts with I schedule was being Based on interview, facility failed to ensunotified of changes included fainting special signs and deverger to F157 for action of the residual signs and dignified regards to the residual signs and development signs and dignified regards to the residual signs and dignified regards to the residual signs and development signs and | ge 143 of the time, no staff would extra shift and then the wing SC reported when schedules or she was unable to find a en shift, she did inform the with the DON on 5/7/13 at reported she felt there were vide a safe environment for acknowledged at times, the transition and she is informed of when or acknowledged being nursing schedule is posted with the Administrator on acknowledged the does have staffing issues. It was not aware staff were ess than core numbers or the grosted with open shifts. In and document review the are that a physicians were in a residents condition which the ells during transfers, abnormal allopment of a pressure ulcer (R122) who had a change in the depression of the physician intervention. In and documentation review, provide care for 1 of 1 resident and respectful manner with ent's personal preference. In a diditional information. | F3 | 353 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

| | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | | 05/ | 08/2013 |
| BETHES | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 F 371 SS=F | review the facility fa assess falls for 1 of at risk for falls, faile 2 of 2 residents (R1 assistance with tran accident hazards. information. 483.35(i) FOOD PR STORE/PREPARE | on, interview, and document illed to comprehensively 5 residents (R78) who were d to ensure safe transfers for 22, R3) who needed asferring to prevent potential Refer to F323 for additional | | | BPV stores, prepares, distributes and serves food under sanitary condition April 30, the dishwasher was inspect | ıs. On | 5-30-2013 |
| | The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions | | | | had blown a fuse. Fuse replaced Ap 2013, with appropriate temperature The policy and procedure for when talternative sanitizing has been revie and revised. Dishwasher temperature logged three times per day. The foo service director or designee will che temperature audits for temperature compliance a minimum of three tim | ril 30, es since. to use wed ures are d ck the | |
| | by: Based on observat review, the facility fa dishwashing tempe the potential spread of 118 residents wh | ion, interview and document alled to maintain safe ratures in a manner to prevent of food borne illness for 117 o currently resided in the food/fluids from the facility | | | weekly for 30 days and no less than weekly going forward. Staff were trong the new policies and procedures May 30, 2013. Food service director responsible to assure all dishes, uter and etc are sanitized. | once ained on is | |
| | Findings include: | | | | | | |
| | 1:35 p.m. with dieta observed utilizing th | r of the kitchen on 4/29/13 at ry aide (DA)-E, staff was re high temperature dish stered the final rinse at 178 | | | | | |

PRINTED: 05/24/2013 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 IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245427 B. WING_ 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** 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 (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 371 Continued From page 145 F 371 degrees Fahrenheit (F), Review of the April dishwashing temperature log recorded three times per day, indicated 12 low rinse temperatures ranging from 163-178 degrees F between April 2-26, 2013 with 43 time slots having no temperatures recorded, 88% of the rinse temperatures in a two day period (April 24-26, 2013) were consistently lower than 180 degrees F. No temperatures for either wash or rinse were recorded between April 27-29, 2013 at time of survey. During an interview on 4/29/13 at 1:35 p.m. with DA-A stated the rinse temperatures were low and Ecolab was called today to fix the dishwasher. DA-A stated they record the temperature that is on the dish machine, but "don't know why I didn't today". DA-A and DA-B offered no other

strips".

information when asked what they should do when the dish machine temperatures were low.

During an interview on 4/29/13 at 1:50 p.m., the dietary manager, (DM)-A stated she was made aware today of the final rinse temperatures not being hot enough and a call had been placed to Ecolab on Friday, April 26, 2013 by another manager about the temperatures. DM-A stated when the temperatures are low they use Eco-San in the final rinse. Staff will put 1/3 cup in the rinse compartment and check with a chemical strip the parts per million (ppm) after every three trays. DM-A verified there was no record that either temperatures or the chemical strip identifying the ppm had been taken since 4/27/13, stating "I don't know why they didn't record temperatures or

During an interview on 4/29/13 at 3:50 p.m., the

PRINTED: 05/24/2013 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 IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 371 Continued From page 146 F 371 Ecolab representative (ER) stated he did not receive a work order until today (4/29/13), ER connected his computer to the Ecolab system (detergent and rinse compartments) that was attached to the dish machine to access data that includes temperatures. ER stated in March the dish machine registered 100% of rinse temperatures at 180 degrees or higher and that April 24th is first time an issue came up. Data indicated that on April 24, 2013 only 24% of the temps met the 180 degree F rinse guideline, April 25-29%, April 26-27%, April 28-35% and as of 4 p.m. on April 29, only 22% of the rinse temperatures were at or above 180 degrees. ER stated if the machine temperatures are low he was told the facility uses 1/3 cup Eco-Sanitizer in the rinse compartment for every 3 travs and further stated that they then should be verifying the effectiveness by checking the ppm on chemical strips. During an interview on 4/29/13 at 4:50 p.m., DA-C stated "if the dish machine is beeping, they go to "the book" and do what it tells us to do, such as changing or filling the white detergent container". DA-C and DA-D both stated they were not sure what to do if the dish machine temperatures were low. DM-A stated she was surprised that they did not know what to do. During an interview on 4/29/13 at 4:55 p.m., DM-B stated "I called Ecolab on Friday, I should have followed up on it, but I did not". On Friday she

was aware the Ecolab unit was beeping, but did not go back to look at what the problem was. DM-B verified it is protocol to use the sanitizer at times when the dish machine temperatures are low, but did not tell staff to use the Eco-Sanitizer

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | 05/ | 08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVI | EW | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | LD BE | (X6) COMPLETION DATE | |
| F 371 F 441 SS=F | During an interview p.m., DM-A verified for using the Eco-S machine temps and dishwashing policy needed to be chant 483.65 INFECTIO | opted to use disposable upper meal. v on Interview on 5/1/13 at 1:28 d she does not have a policy an solution when dishe low nor does she have a by DM-A verified that the system ged. N CONTROL, PREVENT | F 3 | ⁸⁴¹ BPV has established and maintain | s an | 7-8-2013 | |
| | The facility must endection Control Plasafe, sanitary and to help prevent the of disease and infection Control Plasafe, sanitary and to help prevent the of disease and infection Control Plasafe (a) Infection Control Program under who (1) Investigates, coin the facility; (2) Decides what plasafe (2) Decides what plasafe (3) Maintains a reconstruct of the spread isolate the resident (2) The facility must communicable disfrom direct contact will the sanitary and the spread isolate the resident (2) The facility must communicable disfrom direct contact will the sanitary and the sani | stablish and maintain an rogram designed to provide a comfortable environment and development and transmission action. of Program stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of Infection etion Control Program resident needs isolation to infection, the facility must | | Infection Control Program designed provide a safe, sanitary and comformation and to help prevent development and transmission of and infection. The program invest controls, and prevents infections if facility; decides what procedures, isolation should be applied to an iresident; and maintains a record coincidents and corrective actions reinfections. Policies, procedures have reviewed and revised. A policy for culturing of prolonged eye infections assigned his/her own glucometer. terminally cleaned upon death or discharge. The handwashing policinursing staff has been reviewed a revised. Policy/procedure for eye and eye cultures were reviewed a revised. The DON will be responsimonitoring/auditing infections an assuring facility practices have beefollowed. Infection data/analysis | ortable the disease digates, n the such as ndividual of elated to ave been It will be by for nd infectons nd ble for d | Address proprietation of Market Constructions and the State of Market | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | | IDENTIFICATION MILLIABRE. | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245427 | B. WING | | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVI | EW | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 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 COMPLETION | |
| F 441 | hand washing is in professional practi (c) Linens Personnel must ha | irect resident contact for which dicated by accepted | F 441 | Reported to the QA committee. Tra on the above will occur June 3, 4 an Additional training will be scheduled | d 5 th . | |
| | by: Based on observareview the facility for control program incomplete analysis of resident which would assist outbreak. This affer R68, R177 & R137 eye" and could potent who currently reside the facility of the facility, who had ble insulin injections. Findings include: The facility infection include tracking, tree | tion, interview and document alled to ensure the infection cluded tracking, trending, and t and employee infections in determining a potential cted 4 of 15 residents (R109, on the B wing who had "pink entially affect 120 residents, is in the facility. Which is a clean sing of the clipment for 1 of 2 resident of glucose monitoring which is affect 31 residents at the bod glucose monitoring and in control program did not ending, and analysis of eyee infections, which affected | | R109. Infection resolved and has no recurred. R68. Infection resolved and has not recurred. R177. Resident died at the hospital 11/28/12. R137. Infection resolved and has no recurred. Residents hands are washed pre and meals on memory care. | on | |

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE BETHESDA NH PLEASANTVIEW WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 149 F 441 resided on the B wing of the facility. During an interview on 5/2/13 at 3:41 p.m. with a family member (FM)-BB. She reported there had been an outbreak of "Pink Eye" on the B wing of the Memory Care unit and her family member (R177) "got it". She voiced she was very upset about this as felt the facility did not address the spread of this infection. On 5/6/13 at 8:15 a.m. registered nurse care manager (RN-B) stated there was an outbreak of "Pink Eye" on the B wing of the Memory Care unit in from November to December 2012. She was unsure how these infections were tracked and did not know what the facility's reporting mechanism for infections, other than urinary tract infections. RN-B stated there were four residents (R109. R68, R177 & R137) who all resided on the B wing that were treated for conjunctivitis (pink eye) infection. Review of the facility Infection Control summary report for the last quarter of 2012 indicated in October, one eye infection was detected but the location was not identified. November, 2012 there was one eye infection, but no location identified. December 2012, two eye infections were identified but no location given. Review of R109, R68, R177 and R137 record identified the following: R109 was initially treated for conjunctivitis, starting on 10/21/12 as had pus from one eye and conjunctiva redness to the left eye. She received Ofloxacin 0.3% eye drop (used to treat bacterial infections of the eye) twice per day for five days. According to the nurses ' progress noted from 10/21/12 to 10/24/12, the residents left eye continued to be red and mattery. On 10/28/12. her family voiced concern about R109's eye still

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/24/2013

PRINTED: 05/24/2013 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 IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245427 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 441 Continued From page 150 F 441 being red and on 10/29/12 Ofloxacin 0.3% was restarted and administered four times per day for an additional five days. This medication was again ordered on 11/16/12, for an additional week due to continued redness and mattery discharge from the left eye. On 12/26/12, the resident's family again voiced concern regarding the continued redness of the eye. A nurses' progress note, written 12/26/12, noted "continues to have redness noted to her sclera and redness

completed throughout the multiple treatments of conjunctivitis. R68 was treated for conjunctivitis, using Polytrim eye drops (a medication used to treat bacterial infections such as conjunctivitis) in each eye three times per day for seven days. R68's physician was contacted on 11/9/12 about R68 having mattery discharged from both eyes with a reddened and irritated sclera. The physician notification, also reported another resident in the same area was recently treated for "pink eye." R177 was treated for conjunctivitis on 11/9/12, when a physician was faxed requesting R177 be treated as the resident had mattery discharge from both eye and her eyes were reddened with irritated sclera. The 11/9/12 fax noted that another resident in the same area had a recent episode of "pink eye." The physician ordered Ciprofloxacin 0.3% ophthalmic solution eye drops (a medication used to treat bacterial infections

such as conjunctivitis) to both eyes four times daily for five days. A nurse's progress note,

also to the area surrounding her eye. Resident continues to itch area throughout the day. She is not able to communicate if she is experiencing eye pain." The Ofloxacin 0.3% was restarted on 12/27/12 and the resident received her last dose on 1/1/2012. No cultures of the eye drainage was

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES/CLIA

| ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1'' | G | COMPLETED | | |
|--|--|--|---------------------|---|-----|----------------------------|
| | | 245427 | 8. WING_ | | 05/ | 08/2013 |
| BETHES | PROVIDER OR SUPPLIER DANHPLEASANTVIE | | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY I | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | (X5) COMPLETION DATE |
| F 441 | red and R177 continuals received on 11/Ciprofloxacin 0.3% of eyes for 7 days. R137 was treated for 12/10/12 but was not there was no indicated wing had worked with contamination from In addition, the report (NA)-FF was ill on 1: There was no indicated residents on the B willness was not ident report of infections. The facility's Infection policy, last revised of major element of the detection, investigation outbreaks of infection done. The Surveillance was to determination of the evaluation, analysis a Surveillance was to infections in personn The undated facility procedure directed a care team to encourate their eyes if conjuassist resident with fire Staffs were to wash is care and in between and after removing grant of the evaluation of t | cated R177's eyes were still ued to rub them. An order | F 44' | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIED/CLA

| ND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | | | | COMPLETED | |
|--|---|--|-------------------|-----|---|-----|----------------------------|--|
| | | 245427 | B. WING | | | 05/ | 08/2013 | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 90. | EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY I | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 441 | though there was a the B wing of the fac An interview with the (ADON), who was ic Infection Control procompleted on 5/6/13 she was aware of the wing and a staff meinfection but stated analysis or additional implemented even to An interview with the was completed on 5 reported that no additional was done as result of the use of gloves during the use of | to the eye infections even pattern of eye infections on cility. e assistant director of nurses dentified as coordinator of the ogram for the facility, was at 11:30 a.m. She stated to eye infections on the Bomber, who also had an eye there were no investigation, at interventions were though this was identified. The director of nurses (DON) 1/1/13 at 12:30 p.m. The DON 1/1/13 at 12:30 p.m. The DON 1/1/14 at 12:30 p.m. The DON 1/1/15 at 12:30 p.m. The DON 1/1/16 eye infections. The glucometer was not properly the eye infections at 1/1/16 eye infections. | F | 141 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
|---|---|--|--|--|--|-----|----------------------------|--|--|
| | | 245427 | B. WING | i | · | 05/ | 08/2013 | | |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| F 441 | the resident's abdorgloves, wash or sar this observation. After the insulin was Novolog flex pen ar medication cart. She squirts of Purell har rubbed her hands with e glucometer into glucometer with the in her own hands. If glucometer in this in She also stated "the staff) want us to us machine" but report hard on her hands. cart and went to the heard to say "Where returned to the medication cart glucometer of the end my medication cart glucometer of the sanitize or wash he | 47 units of Novolog 70/30 into men. LPN-D did not wear nitize her hands throughout s injected, LPN-D carried the nd the glucometer to the he proceeded to place two and sanitizer into her hands and vigorously. She then placed her hands and rubbed the residual Purell hand sanitizer LPN-D reported they clean the manner between residents. They (facility's administrative this other stuff to clean the orted she felt it is toxic and She then left the medication or nurses' station. She was re is that stuff'. She then dication cart with a container of which she identified as a solution that the facility wanted the glucometer. LPN-D stated of the day to wipe the top of and will then I wipe the | F | 441 | | | | | |
| | have worn gloves to blood glucose testin The above observa completed on 5/3/1 verified the policies | addition, she stated she should or inject the insulin and during ang. ation with the DON was a at 11:15 a.m. The DON regarding glucometer testing, g, and hand hygiene had not | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED

| | | 245427 | B. WING | | 05/ | /08/2013 |
|--------------------------|---|---|-------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | EW | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | · I | D BE | (X5) COMPLETION DATE |
| F 441 | indicated the hand sused to "clean hand the used to "clean hand the used to "clean hand the Assure Platinum dilution of 1 ml of he sodium hypochlorite used and in accordace control (CDC) guide recommended the Acleaned in this man a multi-resident sett. The facility policy Bl reviewed on 1/2013 resident's hands with dry thoroughly, which also directed staff to between each resides ponge to remove here. | for Purell hand sanitizer sanitizer solution was only is only." recommendation for cleaning a glucometer specified that a busehold bleach (5-6% e solution) in 9 ml of water be ance to center for disease ellines, the manufacture Assure Platinum meter be ner between resident tests in | F | 141 | | |

dry. This policy was not followed.
The facility policy Standard Precautions, revised 3/2/2012, directed staff to wash hands before and after resident care and that singe use gloves were to be worn for all contact with body secretions and excretions, which included blood. This policy was not followed.
The facility policy Procedure For Subcutaneous Injections, last reviewed June, 2012 directed staff

wet the surface. The surface must remain visibly wet for two minutes and then to let the meter air

The facility policy Procedure For Subcutaneous Injections, last reviewed June, 2012 directed staff to wash their hands and glove prior to prior to administering the medication and after the syringe has properly been disposed of, to remove

Facility ID: 00792

PRINTED: 05/24/2013 **FORMAPPROVED** OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 . | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-------------------|---|--|---|----------------------------|
| | | 245427 | B. WING | | | 05/ | 08/2013 |
| | PROVIDER OR SUPPLIER | EW | 1 | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 441 F 496 SS = D | policy was not folio 483.75(e)(5)-(7) N VERIFICATION, R Before allowing an aide, a facility must that the individual requirements unle employee in a train evaluation program individual can provisuccessfully compicompetency evaluation program has not yet been in Facilities must folk individual actually Before allowing an aide, a facility mus State registry estal (2)(A) or 1919(e)(2) believes will include a training and compice has been a consecutive month individual provided services for moned individual must concompetency evaluation competency evaluation program has not yet been in consecutive month individual provided a training and competency evaluation provided services for moned individual must concompetency evaluation. | sh their hands again. This awed. URSE AIDE REGISTRY ETRAINING Individual to serve as a nurse of receive registry verification as met competency evaluation as the individual is a full-time and competency an approved by the State; or the rethat he or she has recently deted a training and ation program or competency an approved by the State and action program or competency an approved by the State and action program or competency an approved by the State and action program or competency are provided in the registry. The work of the extra such an approved by the State and activity and the sections are competed on the individual. The section of the extra section of the section o | | | BPV assures NA's are on the NA reg before allowing them to serve as a raide. During the interview process, placed to the registry and a fax is re to verify that the individual has met competency evaluation requirement last verified date of employment 27-13. This information was receive May 9, 2013. Every six months the registry sends a list of employees or registry. BPV will compare that list the list of active and terminated NA there are discrepancies, they will be addressed at that time. The results comparison will be reported to the committee. The DON is responsible assure all NA's are on the registry. | nurse a call is ceived the ts. NA- was 4- ed on state n the with 's. If of the QA | 7/8/`2013 |

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|---|---------------------|---|------------|----------------------------|--|
| | | 245427 | B. WING | 460-440-440-4 | 05 | 05/08/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTV | | 90 | ET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201 | I - | | |
| (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 APPR DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 496 | Based on intervier facility failed to ensure was current for 1 or reviewed. Findings include: During an interview DON indicated NA assistant registry anames she needed. Upon further review documentation sufficiently assistant rindicated that NA-lexpired on 1/3/10. During an interview administrator (A)-Find NA-H's certificate off the schedule. A responsible to chewhen an employee review and "some! Review of the facil Policy/Procedure" | w and document review, the sure nursing assistant registry of 5 nursing assistants (NA-H) w on 5/7/13 at 10:05 a.m., the a-H was current on the nursing and there was a mix-up with the d to "straighten out." w on 5/9/13 at 1:20 p.m. of bmitted by the DON, the registry was contacted and H's registry certificate had w on 5/9/13 at 1:40 p.m., the stated she was not aware that had expired and she was taken A-F stated the DON was ck the NA registry every year e receives a performance | F 496 | | | | |

F5427022

PRINTED: 05/24/2013 **FORM APPROVED** 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 01 - MAIN BUILDING 01 245427 04/30/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE 2013 DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE MEDERT OF FUBLIC SAFETY STATE FIRE MARSHAL DIVISION CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. POC ok 6-10-13 AN ON-SITE REVISIT 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, Fire Marshal Division. At the time of this survey. Bethesda Pleasant View Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES TO:** HEALTH CARE FIRE INSPECTIONS 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

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.

(X6) DATE

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------|--|---|-------------------------------|----------------------------|
| | 1939 | 245427 | B, WING | B, WING | | 04/30/2013 | |
| | NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | 90 | EET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTHEAST WILLMAR AVENUE 11LLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 000 | Continued From pa By e-mail to: Barbara.lundberg@ and Marlan.Whitney@st | gstate.mn.us | K | 000 | .9 | | |
| | DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficit 2. The actual, or pr 3. The name and/or responsible for comprevent a reoccurred. The facility was insulidings: Bethesda Pleasant 1-story building with building was construction original building was determined to be or 1994, an addition with wing that was determined to be or 1994, an addition with grant the east of G Wing Type II (000) construction. In 1995 the facility is being the facility is being the construction of the facility is being the facility is the facility is being the facility is the facility is being the facility is the facility is being the facility is the facility is the facility in the facility is being the facility is the facility in the facility is the facility in the facility in the facility is the facility in the facili | what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. pected as 2 separate View Main Building is a an a partial basement. The ructed at 5 different times. The sucted in 1979 and was f Type V(111) construction. In was added to the west of Commined to be of Type II(000) an addition was added to that was determined to be of uction. | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------|-----|---|-------------------------------|----------------------------|
| | | 245427 | B. WING | | | 04/3 | 30/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | ew . | | 9(| EET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE /ILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 000 | detection in the corr automatic fire depa | e alarm system with smoke ridors that is monitored for riment notification. The facility 23 beds and had a census of | ΚO | 000 | | | |
| K 020 SS=D | NOT MET as evide NFPA 101 LIFE SA Stairways, elevator shafts, chutes, and between floors are having a fire resista | shafts, light and ventilation other vertical openings enclosed with construction ince rating of at least one ay be used in accordance with | ΚO | | The door latch to the soiled liner room was replaced on 5-9-13. It is securely. No other door latches replacement at this time. During maintenance rounds door latches. Environmental services director is responsible. | latches equire | 5-9-13 |
| | Based on observati maintain vertical op by NFPA 101 - 2000 This deficiency cou combustion to mign of the facility an neg staff and visitors in Findings include: | s not met as evidenced by: ons, the facility has failed to ening protection as required 0 edition, section 19.3.1.1. Id allow the products of ate readily between two levels patively affect all residents, the event of an emergency. | | | Kick plate was installed on May 9 to the outer door of the soiled line chute room. | - | |
| | 04/30/2013, it was of chute room located station is a walk-in open to the lower le | veen 9:30 AM to 12:30 PM on observed that the soiled linen adjacent to the west nurses style of chute room that is vel linen chute termination oted that the door to this | | | | | ia. |

| | TO TOTAL MEDICAL | a MEDICAID SERVICES | | | | NVID NO. | 0938-039 |
|--|---|--|--|-----|---|--|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
| | | 245427 | B. WING | | | 04/3 | 30/2013 |
| NAME OF PROVIDER OR SUPPLIER BETHESDA NH PLEASANTVIEW | | | | 91 | EET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| K 020 | and tightly fit in the greater than 1/4 of knob that also did r These deficient cor soiled linen chute r provide the require | frame and that it also had a an inch gap around the door not fit tightly into the door. Inditions that are affecting the doom's door do not allow it to d vertical opening protection level chute termination room | Κ(| 020 | | * | 1/1 (SY) |
| K 029 SS=F | Maintenance Staff NFPA 101 LIFE SA One hour fire rated rated doors) or an extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sh doors. Doors are s field-applied protec 48 inches from the permitted. 19.3.3 This STANDARD Based on observat provide proper prof areas located throu accordance with N (2000 edition) sect deficient practices | construction (with ¾ hour fire- approved automatic fire am in accordance with 8.4.1 tects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are | K | | The penetrations listed in number and 3 below were filled to restor integrity to the fire wall on May 2013. Item 4. A bid was received and accepted to install a damper. This scheduled for 6-13-13. All redampers will be in place as of the Item 5. Each end of the open duwill be fire damped per HVAC recommendations. A bid was reand accepted. The work is schefor 6-13-13. Environmental Services director responsible for compliance of K | e 9, ne work quired nat date. net vent eceived duled | 7-8-13 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|-----|---|-------------------------------|----------------------------|
| | | 245427 | B. WING | | | 04/30/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | ew . | | 9 | REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST 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) | | | ix | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 029 | 04/30/2013, observed deficient conditions areas throughout the sease throughout the sease with approved. 1. A penetration was plastic "PEX" tubing corridor wall of the resealed with approved. 2. Several penetrate pipes above the door of the kitchen's dry slower level that are intumescent calking. 3. There were 4 veraround the pipes that is located above storage room that a intumescent calking. 4. There is an oper equipped with a fire above the door of the lower level next to the sequipped with a fire acquipped with a fire equipped with a fire eq | reen 9:30 AM to 12:30 PM on ation revealed the following affecting several hazardous e facility, as found around a section of a that was located in the main boiler room that is not ed intumescent calking, tions were found around the process of the control of the corridor wall storage room located on the not sealed with approved at are leading to the kitchen e the lower level kitchen dry re not sealed with approved at are leading to the kitchen dry re not sealed with approved at a control of the corridor wall se the lower level kitchen dry re not sealed with approved and the storage room that is on the ne boiler room, and In duct vent that is not some sealed with approved the storage room that is on the ne boiler room, and | K | 029 | | | |
| | E | · | | | | | |

| | | A WEDIOAID SERVICES | | | ONID NO. | |
|--|--|---|---------------------|---|---|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF A. BUILDING | | E SURVEY PLETED | | |
| | | 245427 | B. WING | 04/3 | 04/30/2013 | |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | | REET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 | | 100 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 029 | Maintenance Staff | actices were verified by the | K 029 | . 8 | add an exit | 7-8-13 |
| SS=D | accordance with se | signs are displayed in ection 7.10 with continuous erved by the emergency lighting 1 | | sign to the horizontal exit do located 10 feet further up (fro lower level outside the class south exit) and to the right in corridor that does lead to the way. Work is scheduled to b 6-10-13. Environmental services | or which is om the room by the the egress e public se done on | |
| | Based on observat correctly position 1 signs that marks th accordance with Ni (2000 edition), Sec practice could nega- residents, staff and positioned exit sign prevented a means | is not met as evidenced by: ion, the facility has failed to of several operational exit ie means of egress path in FPA Life Safety Code 101 a. 7.10.5.2. This deficient atively affect 12 of 38 divisitors, if the lack of properly is could misdirect and s of egress from being utilized in an emergency situation. | | coordinator is responsible to compliance with K047. | | 92 |
| | 04/30/2013, it was located on the lower classroom by the swill direct Individual sealed off from the arrows equipped or utilized to direct the exit door which is left. | ween 9:30 AM to 12:30 PM on observed that the exit sign er level outside of the outh exit is located such that it is to exit into a courtyard that is public way. The directional in the exit signs should be a individuals to the horizontal ocated 10 feet further up and gress corridor that does lead to | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------|---|--|-------------------------------|----------------------------|
| | | 245427 | B. WING | B. WING | | 04/3 | 30/2013 |
| | ROVIDER OR SUPPLIER DA NH PLEASANTVIE | ew - | | 9(| EET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTHEAST 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) | | | PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY) | | BE | (X5) COMPLETION DATE |
| K 047 | Continued From pa | ge 6 | ΚC |)47 | · · · · · · · · · · · · · · · · · · · | | |
| K 056 SS=F | Maintenance Staff I NFPA 101 LiFE SA If there is an autom installed in accorda for the Installation of provide complete of building. The syste accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipp | atic sprinkler system, it is not with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the | ΚC | | Items were removed from the lovel west stairwell that were with inches of the sprinkler deflector. Maintenance staff, while on round monitor areas to assure no items at the 18 inch limit in the building. Environmental services director is responsible. A sprinkler bid was received and accepted. The work was complet June 4, 2013. | hin 18 ds will exceed | .7-8-13 |
| | Based on observati system is not install accordance with NF Installation of Sprint to maintain the sprinwith NFPA 13 (99) activation of the fire affect the residents, facility. Findings include: On facility tour betw | s not met as evidenced by: ons, the automatic sprinkler ed and maintained in FPA 13 the Standard for the kler Systems (99). The failure nkler system in compliance could allow a delayed sprinkler system and could visitors and staff of the | | | e 0 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | (X3) DAT | E SURVEY IPLETED | |
|--------------------------|---|--|---|-----|--|---------------------|----------------------------|
| | | 245427 | B. WING | _ | | 04/30/2013 | |
| | PROVIDER OR SUPPLIER DA NH PLEASANTVII | EW | D. SIP. | 90 | EET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTHEAST WILLMAR AVENUE IILLMAR, MN 56201 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| K 056 | deficient conditions sprinkler system: 1. The fire sprinkle level west end stair | ige 7 were found affecting the fire ir head located in the lower well has storage that is ches of the sprinkler deflector, | K | 056 | | | 1 |
| | sprinkler system printed spaces located duct work located in the lower level next | | | | | 72 | 2 |
| | These deficient pra Maintenance Staff | ctices were verified by the Member (LR). | | | | | |
| | | | | | | | ** |
| | | | | | | 6 | |

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - MEMORY UNIT

(X3) DATE SURVEY COMPLETED

245427

B. WING

04/30/2013

NAME OF PROVIDER OR SUPPLIER

BETHESDA NH PLEASANTVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE

901 SOUTHEAST WILLMAR AVENUE

| BETHESDA NA PLEASANTVIEW | | WILLMAR | | 6201 | |
|--------------------------|---|---|---------------------|---|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM | FULL F | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | | K 000 | | |
| - | Surveyor: 27200 FIRE SAFETY | | | | |
| | A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Marshal Division. At the time of this survice Bethesda Pleasant View New Additions 2 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Assoc (NFPA) Standard 101, Life Safety Code Chapter 18 New Health Care. | Fire ey, Building 2000 iation | | | |
| | The facility was inspected as 2 separate buildings: Bethesda Pleasant View New Additions 2 is a 1-story building with basement. The building was constructed at 2 different time. Memory Care Unit was added in 2005 to and connected B & C Wings and was deto be of Type II(000) construction. The saddition was added to the north in 2010 determined to be of Type II(000) construction. | mes. The the west stermined second and was ction. | | | |
| | The facility is sprinklered throughout and fire alarm system with smoke detection i corridors that is monitored for automatic department notification. The facility has a capacity of 123 beds and had a census of the time of the survey. | n the fire a | | | |
| | * | | | | |
| LABORATOR | RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE | NTATIVE'S SIGNA | TURE | TITLE | (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.