MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0663

December 23, 2016

Ms. Jaime Hess-Mitchell, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Re: Essentia Health Northern Pines Medical Center - Independent Informal Dispute Resolution (IIDR)
CMS Certification Number (CCN): 245469
Project Number: S5469026

Dear Ms. Hess-Mitchell:

In a request dated April 8, 2016, Essentia Health Northern Pines Medical Center requested removal of deficiency at F323 cited as a result of an extended survey completed on March 8, 2016 by the Health Regulation Division, Licensing and Certification Program of the Minnesota Department of Health. The Statement of Deficiencies (CMS 2567) has been revised to correct a typographical error on page 32 of 54, which mistakenly referred to R19 as R83. The remainder of the 2567 reflects the Administrative Law Judge's recommendation and Commissioner's letter dated November 22, 2016.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz

Holly Kranz

CC: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Pam Kerssen, Assistant Program Manager
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted on March 2, 2016, through March 8, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to complete ongoing assessments to determine causal factors and implement interventions for resident (R19) who had falls and had sustained a fractured clavicle as a result of a fall on January 8, 2016. The IJ began on January 8, 2016, and was removed on March 8, 2016, at 11:23 a.m., following the implementation of an acceptable removal plan. However, non-compliance remained at a scope and severity level of G, which indicated actual harm.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		5/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/08/2016

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F 225	Continued From page 1 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure injuries of unknown origin were thoroughly investigated and/or immediately reported to the state agency prior to an investigation for 3 of 4 residents (R25, R11, R16)	F 225	Element 1 R16, R11, & R25 have been re-assessed and are care planned for risk factors and non-suspicious, skin alterations in areas that are generally vulnerable to trauma.	

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F 225	Continued From page 2 who sustained bruises of unknown origin. Findings include: R25's quarterly Minimum Data Set (MDS) dated 1/4/16, indicated R25 had a severe cognitive impairment, was sometimes understood and sometimes understood others, required extensive assist of one with bed mobility, dressing, and personal hygiene, required extensive assist of two with transfers, and required total assistance for wheelchair locomotion. R25's MDS further indicated R25 had no falls. R25's Face Sheet printed 3/7/16, indicated R25's diagnoses included diabetes mellitus, anemia, erythema intertrigo (red rash-like inflammation in the skin folds caused by friction, increased warmth or moisture), dementia and edema (swelling). R25's Care Area Assessment (CAA) for cognitive loss and dementia for assessment date of 9/28/15, indicated R25 was unable to make needs known, had decreased balance with an inability to transfer or walk safely, and was at increased risk for falls. R25's care plan for skin, edited 11/21/15, identified a potential for alteration in skin integrity with edema, skin rashes and irritations, and history of scabs and open areas, though did not address risk of bruising. R25's care plan for psychosocial well-being created 10/22/15, indicated R25 was at risk for being unable to make her needs known, falls, and increased confusion. The goal was for R25 to be safe in the environment.	F 225	Other skin alterations that are in areas not vulnerable to trauma and that are suspicious because of the extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency. Element 2 All residents with skin alterations (injuries) that were not observed by any person or the source could not be explained by the resident have been re-assessed and are care planned for risk factors related to non-suspicious skin alterations in areas that are generally vulnerable to trauma. Skin alterations in areas that are not generally vulnerable to trauma and that are suspicious because of extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency. Element 3 Our policy has been reviewed and updated and nursing home staff has been educated regarding reporting injuries. Injuries of unknown origin that cannot be explained by the resident or that are suspicious because the injury is in an area that is not generally vulnerable to trauma or because of extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated. The investigation will include, but not be limited to, utilizing the forms provided in our electronic medical record. Element 4	

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F 225	Continued From page 3 The physician's nursing home visit note dated 12/1/15, indicated R25 was able to speak a few words but unable to answer questions appropriately due to advanced dementia. The physician's documentation indicated staff denied any new skin concerns. The physician's family practice visit note dated 1/4/16, indicated R25 was unable to give verbal responses and had no skin issues. R25's skin documentation dated 12/13/15, indicated R25 had redness on the arm and elbow. R25's skin documentation dated 12/1/15 through 12/12/15, indicated R25's skin was clear and without redness or bruising. An incident report dated 12/13/15, at 10:45 a.m. indicated R25 was noticed to have a red/bruised area on the top of the right arm when gotten up that morning. The incident report indicated R25 had possibly bumped the arm on a table or lift. The Investigation of Injury of Unknown Origin form dated 12/13/15, indicated R25 had a bruise on the top of the right arm and wrist. The investigation form identified pertinent diagnoses and medical conditions of dementia and dependent transfers. The investigation form indicated the cause of R25's bruise was unable to be determined and R25 was unable to verbalize the cause of the bruise. The investigation form indicated R25 could have bumped it on the lift, but lacked witness of R25 bumping it on the lift or on the table. An undated entry on the investigation form indicated R25 had been witnessed bumping arm on the table. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.	F 225	All skin is observed daily by the NAR and issues reported as soon as practicable to the licensed nurse. Skin is observed weekly and skin condition is documented weekly by a licensed nurse. Alterations are reported immediately to the RN. Non-pressure related bruises and potential injuries will be added to be reviewed during the weekly IDT skin rounds and documented by the RN in the resident chart ongoing. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. All variances in the process and/or reporting will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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F 225	Continued From page 4 R11's significant change MDS dated 1/4/16, indicated R11 had severe cognitive impairment, was sometimes understood and sometimes understood others. R11's MDS further indicated R25 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one assist for wheelchair locomotion, dressing and personal hygiene, had no falls, and no behaviors. R11's Resident Admission Record printed 3/7/16, indicated R11's diagnoses included dementia, severe chronic kidney disease, anemia, and history of falling. R11's CAA for cognitive loss and dementia for assessment date 12/29/15, indicated R11 had a decline in safety awareness which put R11 at risk for disorientation, pain, and decline in function. R11's care plan for safety edited 4/13/15, indicated R11 had a potential for injury related to dementia. R11's care plan directed staff to observe leg positioning when at the table to avoid injury, and to monitor for any unexplained bruises, skin impairments, allegations, or other unexplained injury. Physician's nursing home notes dated 6/30/15, 10/8/15, and 12/3/15, indicated R11 had no skin concerns during any of the visits. A review of nursing progress notes dated 5/1/15 through 5/14/15, did not indicate any incidents involving bruising for R11. A review of nursing progress notes dated 11/7/15 through 11/22/15, did not indicate evidence of incidents involving bruising or injury of unknown origin.	F 225		

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F 225	Continued From page 5	F 225		

R11's skin documentation from 5/1/15 through 5/30/15, lacked documentation of bruising. R11's skin documentation from 11/17/15 through 11/22/15, indicated R11 had bruising on a leg on 11/17/15, at 1:33 p.m.

An incident report dated 5/7/15, at 10:40 a.m. indicated R11 had a purple bruise on the left forearm measuring 9 centimeters (cm) x 12 cm. The Investigation of Injury of Unknown Origin dated 5/7/15, indicated the injury was first noted on 5/6/15 at 11:00 a.m. The investigation form indicated R11 had been attempting to propel the wheelchair through closed double doors and was agitated and was trying to leave. In addition, the investigation indicated R11 did not know the cause of the injury. The investigation form further indicated the investigation was completed and the cause of the injury was determined to be elopement attempts on 5/5/15, as resident had attempted to leave and was getting stuck in between the closed double doors. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

An incident report dated 11/15/15, at 8:00 p.m. indicated R11 had a purple area found to the left inner knee measuring 6 cm x 2 cm. The incident report referred to the investigation. The Investigation of Injury of Unknown Origin dated 11/15/15, indicated R11 did not know what had caused the injury. The investigation form indicated R11 self propelled in the wheelchair and took a daily aspirin. R11's investigation form indicated an investigation was complete, and the determination was that the table legs and arm chairs were at the height for location and nature

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F 225	Continued From page 6 of the bruise and R11 had a history of bumping into things. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation. On 3/7/16, at 11:02 a.m. the DON stated bruises are reported to the DON if they are determined to be suspicious, as determined by size, shape, and location. The DON stated the Investigation of Injury of Unknown Origin form is started, which is used to help the staff determine the cause. If they are unable to determine the cause, the DON stated they would report it to the state agency, but if after the investigation there is a reasonable explanation, the facility would not report it. The DON verified R25's and R11's bruises were investigated first and were determined to not be suspicious, so were not reported. The DON verified they do not track and trend injuries of unknown injury to assist in determination of patterns of injuries. R16's annual MDS dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The MDS further indicated R16 displayed no behaviors directed at self, including physical behaviors such as hitting or scratching her self, and no rejection of care. R16's care plan dated 2/1/16, indicated she was often resistive to cares and picks at her chest to the point of bruising and bleeding under the skin. The care plan further indicated she received aspirin and had fragile	F 225		

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F 225	Continued From page 7 skin that bruised easily. A review of Essentia Health - Northern Pines Care Center Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incident reports related to bruising to R16's body. - 5/29/15, staff noted bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. Staff investigated the incident and determined it was "likely" caused by use of a mechanical lift sling. The injury was not reported to the state agency. - 7/8/15, R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. staff investigated and determined the injury was caused from R16 "picking at her own chest." The injury was not reported to the state agency. - 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. Staff determined the cause of injury was due to "fragile skin" and indicated R16 "often flails arms causing bruising." The injury was not reported to the state agency. - 9/20/15, R16 had a 5 cm x 5 cm purple area to her left cheek. Staff determined the cause of injury as "could potentially be from her glasses." The injury was not reported to the state agency. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. The cause of injury was described as follows: Noted to have a small area of skin missing from center of bruise- and appears [R16] had scraped away. She often picks as skin. The injury was not reported to the state agency. - 10/7/15, staff noted a hematoma on R16's left forearm from her wrist to her upper arm. The cause of injury was noted as "flailing arms during care and in daily propelling." The injury was not	F 225		

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F 225	Continued From page 8	F 225		

reported to the state agency.
- 1/6/16, R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. Staff determined the cause of injury related to R16 picking at her chest. The injury was not reported to the state agency.
- 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. The cause of the injury was listed as: she [R16] may have bumped her hand on the door frame. The injury was not reported to the state agency.
In each incident report, R16 was described as" unable to answer" how the injuries occurred.

On 3/2/16, at 9:53 a.m. the DON stated all incidents including, abuse, falls, bruises or injuries of unknown origin start with an incident form. She stated if the injury is unknown in origin, there is an investigation worksheet that gets filled out by the nurse on duty. She stated if the nurse finds the injury to be suspicious in nature they call and report it to the DON. She stated an example of bruising that is suspicious would be bruising to thighs, face without a fall, or if it looked like fingerprints. The DON did not feel any of R16's bruises were suspicious in nature.

During a subsequent interview on 3/3/16, at 12:30 p.m., the DON stated, "We know [R16] really well." The DON further stated R16 "has personality changes if someone is bothering her."

On 3/3/16, at 12:38 p.m., registered nurse (RN)-C stated when determining whether a bruise was considered suspicious in nature, staff look at the extent of the bruising and investigate if there was an altercation with another resident, a lab draw, whether the resident was in the facility or whether

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F 225	Continued From page 9	F 225		

injury was related to cares. RN-C stated she did not feel any of R16's bruises were suspicious in nature.

On 3/4/16, at 9:30 a.m., nursing assistant (NA)-H stated R16 can be a little resistive to cares. She stated R16 "scoots" around in her chair and may bump her arms on objects. NA-H stated, "I've never really seen her [R16] pick at her upper half."

On 3/4/16, licensed practical nurse (LPN)-C stated R16 is resistive to care at times and will try to swat staff hand away, but had not observed R16 "flailing her arms."

On 3/4/16, at 10:43 a.m. RN-A stated she has noticed R16 will flail her arms when she is agitated. RN-A stated R16's bruises were often due to the "flailing."

Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, and was unable to verbalize how the bruising had occurred, there was no in depth investigation completed to determine the actual cause of R16's bruising. Further, while the administrator was notified of the bruises, none of the injuries of unknown origin were reported immediately to the state agency.

A facility policy labeled Abuse Prevention Program, undated, indicated: "should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source) the nurse supervisor on duty must complete and Investigation of Injuries of

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F 225	Continued From page 10 Unknown Source form. An injury of unknown source is identified as: "the source of the injury was not observed by any person or the source of the injury could not be explained by the resident;" and the injury is suspicious because of , "the extent of the injury;or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time." The policy further indicated when an an injury of unknown source is reportable, the facility administrator or his/her designee will report to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to thoroughly investigate and/or immediately report injuries of unknown origin to the state agency for 3 of 4 residents (R25, R11, R16) who sustained bruises of unknown origin. Findings include: An undated facility policy labeled: Abuse Prevention Program, directed staff to report incidents or suspected incidents of resident	F 226	Element 1 Refer to F225 for specifics. The facility has reviewed, updated and signed its abuse prevention program policy. Policy provides that the facility will immediately report to the State Agency allegations of mistreatment that have the potential to affect all residents according to state and federal guidelines. R25, R11, and R16 have been assessed and care planned for risk factors related to skin alterations and injury of unknown origin.	5/2/16

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F 226	Continued From page 11 abuse, mistreatment, or injuries of unknown source immediately to the administrator. The policy indicated the administrator or designee would immediately begin an investigation and report to the state agency. The policy further indicated "should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source) the nurse supervisor on duty must complete and Investigation of Injuries of Unknown Source form. An injury of unknown source is identified as: "the source of the injury was not observed by any person or the source of the injury could not be explained by the resident;" and the injury is suspicious because of , "the extent of the injury;or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time." The policy further indicated when an an injury of unknown source is reportable, the facility administrator or his/her designee will report to the state agency. R25's quarterly Minimum Data Set (MDS) dated 1/4/16, indicated R25 had a severe cognitive impairment, was sometimes understood and sometimes understood others, required extensive assist of one with bed mobility, dressing, and personal hygiene, required extensive assist of two with transfers, and required total assistance for wheelchair locomotion. R25's MDS further indicated R25 had no falls. R25's Face Sheet printed 3/7/16, indicated R25's diagnoses included diabetes mellitus, anemia, erythema intertrigo (red rash-like inflammation in the skin folds caused by friction, increased warmth or moisture), dementia and edema	F 226	Element 2 All residents with skin alterations (injuries) that were not observed by any person or the source could not be explained by the resident have been re-assessed and are care planned for risk factors related to non-suspicious, skin alterations in areas that are generally vulnerable to trauma. Other skin alteration that are in areas not vulnerable to trauma and are suspicious by extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated per policy. Element 3 Our policy has been reviewed and updated as necessary and nursing home staff has been educated regarding reporting injuries. In addition, all staff has been educated regarding the facility's abuse prevention policy. Injuries that are not observed by any person or the source could not be explained by the resident and that are in areas that are not generally vulnerable to trauma or because of the location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated. The investigation will include, but not be limited to, utilizing the forms provided in our electronic medical record and following the protocol stated in the abuse prevention policy. Element 4 All skin is observed daily by the NAR and issues are brought to the attention of licensed nurses as soon as practicable.	

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F 226	Continued From page 12 (swelling). R25's Care Area Assessment (CAA) for cognitive loss and dementia for assessment date of 9/28/15, indicated R25 was unable to make needs known, had decreased balance with an inability to transfer or walk safely, and was at increased risk for falls. R25's care plan for skin, edited 11/21/15, identified a potential for alteration in skin integrity with edema, skin rashes and irritations, and history of scabs and open areas, though did not address risk of bruising. R25's care plan for psychosocial well-being created 10/22/15, indicated R25 was at risk for being unable to make her needs known, falls, and increased confusion. The goal was for R25 to be safe in the environment. The physician's nursing home visit note dated 12/1/15, indicated R25 was able to speak a few words but unable to answer questions appropriately due to advanced dementia. The physician's documentation indicated staff denied any new skin concerns. The physician's family practice visit note dated 1/4/16, indicated R25 was unable to give verbal responses and had no skin issues. R25's skin documentation dated 12/13/15, indicated R25 had redness on the arm and elbow. R25's skin documentation dated 12/1/15 through 12/12/15, indicated R25's skin was clear and without redness or bruising. An incident report dated 12/13/15, at 10:45 a.m. indicated R25 was noticed to have a red/bruised area on the top of the right arm when gotten up	F 226	Skin is observed weekly or more often as needed by a licensed nurse who will document in the electronic medical record. Alterations are reported immediately to the RN for follow up. Non pressure related bruises and potential injuries will be added to weekly IDT skin rounds and documented by the RN in the resident chart ongoing. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. All variances in the process and/or reporting will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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that morning. The incident report indicated R25 had possibly bumped the arm on a table or lift. The Investigation of Injury of Unknown Origin form dated 12/13/15, indicated R25 had a bruise on the top of the right arm and wrist. The investigation form identified pertinent diagnoses and medical conditions of dementia and dependent transfers. The investigation form indicated the cause of R25's bruise was unable to be determined and R25 was unable to verbalize the cause of the bruise. The investigation form indicated R25 could have bumped it on the lift, but lacked witness of R25 bumping it on the lift or on the table. An undated entry on the investigation form indicated R25 had been witnessed bumping arm on the table. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

R11's significant change MDS dated 1/4/16, indicated R11 had severe cognitive impairment, was sometimes understood and sometimes understood others. R11's MDS further indicated R25 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one assist for wheelchair locomotion, dressing and personal hygiene, had no falls, and no behaviors.

R11's Resident Admission Record printed 3/7/16, indicated R11's diagnoses included dementia, severe chronic kidney disease, anemia, and history of falling.

R11's CAA for cognitive loss and dementia for assessment date 12/29/15, indicated R11 had a decline in safety awareness which put R11 at risk

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F 226	Continued From page 14 for disorientation, pain, and decline in function. R11's care plan for safety edited 4/13/15, indicated R11 had a potential for injury related to dementia. R11's care plan directed staff to observe leg positioning when at the table to avoid injury, and to monitor for any unexplained bruises, skin impairments, allegations, or other unexplained injury. Physician's nursing home notes dated 6/30/15, 10/8/15, and 12/3/15, indicated R11 had no skin concerns during any of the visits. A review of nursing progress notes dated 5/1/15 through 5/14/15, did not indicate any incidents involving bruising for R11. A review of nursing progress notes dated 11/7/15 through 11/22/15, did not indicate evidence of incidents involving bruising or injury of unknown origin. R11's skin documentation from 5/1/15 through 5/30/15, lacked documentation of bruising. R11's skin documentation from 11/17/15 through 11/22/15, indicated R11 had bruising on a leg on 11/17/15, at 1:33 p.m. An incident report dated 5/7/15, at 10:40 a.m. indicated R11 had a purple bruise on the left forearm measuring 9 centimeters (cm) x 12 cm. The Investigation of Injury of Unknown Origin dated 5/7/15, indicated the injury was first noted on 5/6/15 at 11:00 a.m. The investigation form indicated R11 had been attempting to propel the wheelchair through closed double doors and was agitated and was trying to leave. In addition, the investigation indicated R11 did not know the cause of the injury. The investigation form further indicated the investigation was completed and	F 226		

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the cause of the injury was determined to be elopement attempts on 5/5/15, as resident had attempted to leave and was getting stuck in between the closed double doors. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

An incident report dated 11/15/15, at 8:00 p.m. indicated R11 had a purple area found to the left inner knee measuring 6 cm x 2 cm. The incident report referred to the investigation. The Investigation of Injury of Unknown Origin dated 11/15/15, indicated R11 did not know what had caused the injury. The investigation form indicated R11 self propelled in the wheelchair and took a daily aspirin. R11's investigation form indicated an investigation was complete, and the determination was that the table legs and arm chairs were at the height for location and nature of the bruise and R11 had a history of bumping into things. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

On 3/7/16, at 11:02 a.m. the DON stated bruises are reported to the DON if they are determined to be suspicious, as determined by size, shape, and location. The DON stated the Investigation of Injury of Unknown Origin form is started, which is used to help the staff determine the cause. If they are unable to determine the cause, the DON stated they would report it to the state agency, but if after the investigation there is a reasonable explanation, the facility would not report it. The DON verified R25's and R11's bruises were investigated first and were determined to not be suspicious, so were not reported. The DON

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F 226	Continued From page 16 verified they do not track and trend injuries of unknown injury to assist in determination of patterns of injuries. R16's annual MDS dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The MDS further indicated R16 displayed no behaviors directed at self, including physical behaviors such as hitting or scratching her self, and no rejection of care. R16's care plan dated 2/1/16, indicated she was often resistive to cares and picks at her chest to the point of bruising and bleeding under the skin. The care plan further indicated she received aspirin and had fragile skin that bruised easily. A review of Essentia Health - Northern Pines Care Center Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incident reports related to bruising to R16's body. - 5/29/15, staff noted bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. Staff investigated the incident and determined it was "likely" caused by use of a mechanical lift sling. The injury was not reported to the state agency. - 7/8/15, R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. staff investigated and determined the injury was caused from R16 "picking at her own chest." The injury was not reported to the state agency.	F 226		

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F 226	Continued From page 17 - 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. Staff determined the cause of injury was due to "fragile skin" and indicated R16 "often flails arms causing bruising." The injury was not reported to the state agency. - 9/20/15, R16 had a 5 cm x 5 cm purple area to her left cheek. Staff determined the cause of injury as "could potentially be from her glasses." The injury was not reported to the state agency. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. The cause of injury was described as follows: Noted to have a small area of skin missing from center of bruise- and appears [R16] had scraped away. She often picks as skin. The injury was not reported to the state agency. - 10/7/15, staff noted a hematoma on R16's left forearm from her wrist to her upper arm. The cause of injury was noted as "flailing arms during care and in daily propelling." The injury was not reported to the state agency. - 1/6/16, R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. Staff determined the cause of injury related to R16 picking at her chest. The injury was not reported to the state agency. - 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. The cause of the injury was listed as: she [R16] may have bumped her hand on the door frame. The injury was not reported to the state agency. In each incident report, R16 was described as" unable to answer" how the injuries occurred. On 3/2/16, at 9:53 a.m. the DON stated all incidents including, abuse, falls, bruises or	F 226		

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injuries of unknown origin start with an incident form. She stated if the injury is unknown in origin, there is an investigation worksheet that gets filled out by the nurse on duty. She stated if the nurse finds the injury to be suspicious in nature they call and report it to the DON. She stated an example of bruising that is suspicious would be bruising to thighs, face without a fall, or if it looked like fingerprints. The DON did not feel any of R16's bruises were suspicious in nature.

During a subsequent interview on 3/3/16, at 12:30 p.m., the DON stated, "We know [R16] really well." The DON further stated R16 "has personality changes if someone is bothering her."

On 3/3/16, at 12:38 p.m., registered nurse (RN)-C stated when determining whether a bruise was considered suspicious in nature, staff look at the extent of the bruising and investigate if there was an altercation with another resident, a lab draw, whether the resident was in the facility or whether injury was related to cares. RN-C stated she did not feel any of R16's bruises were suspicious in nature.

On 3/4/16, at 9:30 a.m., nursing assistant (NA)-H stated R16 can be a little resistive to cares. She stated R16 "scoots" around in her chair and may bump her arms on objects. NA-H stated, "I've never really seen her [R16] pick at her upper half."

On 3/4/16, licensed practical nurse (LPN)-C stated R16 is resistive to care at times and will try to swat staff hand away, but had not observed R16 "flailing her arms."

On 3/4/16, at 10:43 a.m. RN-A stated she has

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F 226	Continued From page 19 noticed R16 will flail her arms when she is agitated. RN-A stated R16's bruises were often due to the "flailing." Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, and was unable to verbalize how the bruising had occurred, there was no in depth investigation completed to determine the actual cause of R16's bruising. Further, while the administrator was notified of the bruises, none of the injuries of unknown origin were reported immediately to the state agency.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activity engagement for 1 of 3 resident's (R26) reviewed for activities. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was moderately cognitively impaired. His care plan dated 9/3/15, indicated R26 needed to be informed of activities. The care	F 248	Element 1 Resident #26 was re-assessed by the Activity Director/SW to assure his care plan is current and coincides with the resident□s desires. He is reminded of activities that he enjoys and participation is recorded. Staff will encourage Resident #26 to attend the activities he likes and assist him to attend. Element 2	5/2/16

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F 248	Continued From page 20 plan further indicated R26 was a social person who was up and out of his room. The care plan directed staff to go to R26's room, invite and encourage him to attend activities that do not require good hearing or vision, assist with bingo and card bingo. R26's care plan further indicated he enjoyed exercise and going to mass and enjoyed a "cocktail" at 2:05 p.m. daily. His care plan goal was to participate in 1 activity daily, spend 2 days per week outside if weather permitted and join 3-4 exercise classes per week. R26's behavior care plan indicated he "needs to be reminded of activities and daily events several times a day." A facility document titled: Activity Interview Sheet, dated 7/10/12, indicated R26 used to read a lot, played the accordion, sang in the church choir and loved dancing. The document further indicated R26 had a cabin, a vegetable garden, hunted, played cards, and loved dogs. His past professions included social positions requiring significant interaction with others. A nurse practitioner's nursing home progress note dated 10/8/15, indicated, R26 stated he wishes staff would tell him when activities are because he feels like he does not get to go often enough. A review of R26's activity records indicated in 10/15, he participated in games 6 times, music 1 time and a resident group 1 time. During the month of 11/15, R26 participated in sports 7 days, exercise 4 days. In 12/15, R26 participated in games 9 days and exercise 3 days. During the month of 1/16, R26 participated in sports 2 days, and games 6 days, and in 2/16 he participated in games 5 times and exercise 4 times.	F 248	All residents have been re-assessed to ensure that his or her desires regarding activities and care plans have been updated as necessary. All residents receive comprehensive assessment of preferences for customary, routine activities on admission and at least annually thereafter. Care plans are developed, reviewed, and updated quarterly as necessary to be meaningful to each resident. Element 3 Our policy has been reviewed and updated as necessary. Activity, SW and nursing staff have been educated regarding meaningful activity assessment and care planning. Documentation of group and one on one activity is being recorded. Element 4 Each resident's activity log will be monitored by DON/designee to assure meaningful activities occur as care planned daily x 7 days, weekly x 3 weeks, monthly x 2 months and quarterly thereafter. DON/designee will audit 5 residents daily for 1 week, then 5 residents weekly for three weeks, then 5 residents monthly for two months, then five residents quarterly ongoing to ensure that they are offered and receiving activities of choice. Variances in the process will be reported to the administrator for immediate follow up and discussed at the QAPI meeting at least quarterly.	

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F 248	Continued From page 21 On 3/1/16, at 1:59 p.m. R26 was sitting in a recliner in his room alone. At 3:33 p.m., he was again observed alone in his room sitting in his recliner. On 3/2/16, at 9:41 a.m. R26 was sitting alone in his room. At 11:48 a.m., he was sitting in his room alone. There was no television, no radio and no independent activity supplies present. On 3/3/16, at 10:05 a.m. a staff led exercise group was occurring in the dining room, R26 was not present. At 2:16 p.m., R26 was sitting in a recliner in his room while his wife was assisting with bingo in the dining room. On 3/3/16, at 2:17 p.m. nursing assistant (NA)-B stated she asked R26 earlier in the day if he wanted to go to bingo. She stated she did not return to offer prior to the activity even though his care plan indicated he required reminders several times per day. On 3/4/16, at 9:26 a.m. R26 was in the dining room participating in a group activity. He was actively engaged, smiling and conversing with staff. At 10:25 a.m., R26 had returned to his room and was sitting alone. On 3/2/16, at 2:17 p.m. activity assistant (AA)-A stated R26 liked to play dice and card bingo. She stated, "Other games, he can't play, so he doesn't enjoy them." AA-A further stated R26 frequently stated "oh, I'm so bored, I'm so bored." During a subsequent interview on 3/3/16, at 10:06 a.m., AA-A stated R26 used to come out of his room a lot. She stated, "About six months ago he started hallucinating a lot, now he doesn't come	F 248		

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out." AA-A further stated R26 makes statements like "I'm bored and I don't feel good." She stated R26 used to love to play the harmonica. She stated the harmonica was broken but no one looked into replacing it. She further stated no activity supplies had been offered to R26 to engage him in his room but stated, "that's a good idea."

On 3/3/16, at 10:41 a.m. R26 stated, "Nothing is fun anymore." R26 stated he did a lot of gardening in the past and stated, "I got a lot of my education in the garden working with Mother, " and added, "I don't do any of that here." He said he still did some exercise. He further stated he used to play the harmonica and play the piano but he "can't do that here."

On 3/3/16, at 1:17 a.m. family member (FM)-D stated R26 had certain activities he could take part in. She stated if they tell him too early he can't remember and stated, "they are supposed to come and get him, but I don't think they always do." She also stated R26 used to visit with a friend in the facility "all the time," but didn't think staff was offering to take him to see his friend. FM-D further stated, "He gets too little of being around other people."

On 3/4/16, at 10:34 a.m. NA-I stated R26 attended games. She stated he enjoyed dice games, shuffle board, bingo and some exercise. She further stated if she went to get him he usually attended.

An undated facility policy titled Activities and Social Services, indicated the interdisciplinary team would evaluate the individual's personal history and preferences to identify relevant

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ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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F 248	Continued From page 23 recreational activities. The policy further indicated, as much as possible, the facility would provide activities that are compatible with the resident's interests.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R26) reviewed for social services who demonstrated isolative behaviors. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was severely cognitively impaired, required minimal staff assistance for activities of daily living and verbalized indicators of depression which had increased since his last MDS. R26'S PHQ-9 (an instrument used for screening, diagnosing, monitoring, and measuring the severity of depression) score on 8/24/15, was a seven, indicating mild depression. On 11/24/15, R26's PHQ-9 score increased to a 12, indicating moderate depression. The MDS section for mood indicated R26 had indicated "little interest or pleasure in doing things," nearly every day, "Feeling down, depressed or	F 250	Element 1 R26 was re-assessed using the PHQ9 and his care plan was updated to address potential isolative and other behaviors that may be related to depression. Interventions include but are not limited to: large print activity calendar; daily reminders with encouragement to join activities; and, one on one visits when he declines to attend activities outside of his room. A new assessment was performed asking what items are very important to him. We are providing those things he indicated as important to him such as music, pet visits, card bingo and other games he favors. We offer and encourage use of a pocket talker because he refuses hearing aids. Although we have offered the services of a psychologist, which he has declined, we will continue to offer those services. Resident is legally blind and we will continue to offer activities and	5/2/16

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F 250	Continued From page 24 hopeless," nearly every day and "feeling tired or having little energy," nearly every day. A review of resident progress note dated 8/6/15, indicated, "in the month of July [R26] has been in his room and not coming out due to a decline in condition." A note dated 8/21/15, indicated R26 was "keeping to his room most of the day." A note dated 8/26/15, indicated R26 was spending more time in his room. Progress note dated 11/24/15, indicated R26 expressed concern regarding his wife's health and felt he would be getting bad news about her. He stated he felt this was every day. Notes indicated on 1/13/16, R26 was making statements that "he is going to die." On 2/17/16, the notes indicated R26 had "recently begun declining his daily Happy Hour." A note dated 2/21/16, indicated R26 stated, "I keep getting instructions and I don't know if I'm doing good or if I am doing bad." R26's care plan dated 12/19/15, identified, "very poor vision and hearing" and indicated behavioral symptoms related to psychosis. The care plan identified behaviors of inappropriate comments, false accusations, and disrobing. The care plan did not address depression or risk for isolation, even though R26's assessments indicated an increase in signs and symptoms of depression and resident progress notes indicated isolative behaviors. Although the care plan identified R26's legal blindness there were no individualized interventions identified to assist him in engaging with his environment and other people. There were no interventions identified to assist with minimizing the symptoms of psychosis that may have been related to his visual and hearing deficits.	F 250	books with larger print and items such as books on tape. Element 2 We have reviewed all resident's PHQ9 scores and made comparison of the last two assessments. All residents who have a score displaying an increase in depressive symptoms have been reassessed and the care plans were updated as needed to reflect their current state and to implement interventions. We have assessed all residents to determine if the resident has had mood changes, including but not limited to isolative behaviors. Any resident that may have had a mood change has had his or her care plan updated to reflect current interventions and monitoring. Element 3 Protocol was created that addresses mood changes, including but not limited to, observing and reporting isolative behaviors so that interventions can be implemented. Protocol was educated to nursing home staff. A protocol was created to ensure that each new PHQ9 assessment is compared to the previous PHQ9 assessment and interventions are added when needed to reflect increases in depressive symptoms, including but not limited to, isolative behaviors. The protocol has been educated to SW and RNs. Staff has been educated to report mood changes to the RN or SW for follow up and implementations of additional interventions, when appropriate.	

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F 250	Continued From page 25 On 3/1/16, at 12:37 p.m. R26 was up in his room, ambulating to the bathroom. A tray of food was sitting untouched on a table in his room. On 3/1/16, at 1:59 p.m. and 3:33 p.m., R26 was sitting alone in a recliner chair in his room with his eyes closed. On 3/2/15, at 8:03 a.m. R26 was sitting at a tray table in his room. He was eating breakfast alone in the room. At 8:09 a.m., staff entered R26's room and removed his meal tray. R26 was sitting in a recliner. No television present in room, no music playing and no recreational activities present. At 11:48 a.m., R26 continued to sit in a recliner in his room. On 3/3/16, at 8:50 a.m. R26 was sitting alone in his room in a recliner. At 10:05 a.m., staff was leading an exercise group in the large dining room, however, R26 was not present. At 1:17 p.m., family member (FM)-D was present and visiting with R26 in his room. At 2:16 p.m., FM- D was observed assisting with bingo in the large dining room. R26 was sitting in his room alone. On 3/4/16, at 8:35 a.m. R26 was sitting alone in his room eating breakfast. The lights in R26's room were off and the shade was drawn. At 9:26 a.m., R26 was engaged in a dice game in the dining room. He was smiling and interacting with staff. At 10:26 a.m., R26 had returned to his room and was again sitting alone in a recliner. On 3/2/16, at 10:41 a.m. licensed practical nurse (LPN)-C stated R26 does not come out of his room often, "only to be weighed and for exercise once in a while." She further stated a lot of the time he sits in his chair and sleeps.	F 250	Element 4 Adherence to the new protocol will be audited by the DON or designee weekly x 4 weeks on each MDS that is due, monthly x 2 months, and quarterly on going. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. Variances will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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F 250	Continued From page 26	F 250		

On 3/3/16, at 10:41 a.m. R26 stated, "I'm terrible." R26 indicated he was no longer able to to things for himself that he could in the past. R26 stated, "You can live too long, that's me." He further stated, "Nothing is fun anymore" and "right now I am not clean, I used to be." R26 added, "I ain't what I used to be."

On 3/3/16, at 10:08 a.m. activity aide (AA)-A stated R26 used to come out of his room a lot. She stated, "Around six months ago, he started hallucinating and now he doesn't come out."

On 3/3/16, at 12:26 p.m., LPN-C stated R26 used to enjoy his happy hour but had been refusing lately. She stated, "He doesn't seem to want to do it anymore."

On 3/3/16, at 1:17 p.m. FM- D stated R26 "has slowed down." FM- D stated R26 went through a period of "very bad behavior" last summer. She stated the behaviors improved but said "he has not gotten back to where he was before." FM- D stated R26 is doing less. She stated he used to visit a friend in the facility all the time but was no longer doing that. FM-D stated she did not think staff was offering to take him to see his friend. She further stated R26 gets "too little of being around other people" and "says he [R26] wants to die."

On 3/3/16, at 3:05 p.m. licensed social worker (LSW)-A stated R26's mood and behaviors were "pretty much baseline" since his acute psychotic episode last year. She stated when she administered the PHQ-9, R26 responded to the question about having little interest or pleasure in doing things as nearly everyday and indicated it was related to his poor eye sight. She further

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F 250	Continued From page 27 stated R26 indicated he felt more tired and feeling down. She stated those answers caused his score to increase. The LSW further stated the interdisciplinary team (IDT) looked at R26's medications to see if he was receiving any medications that may be effecting his mood, however, IDT progress notes do not indicate R26's increase in depression had been addressed during the medication review. She further stated the facility had a house psychologist available but she had not referred R26 to the psychologist, and while the LSW indicated one to one visits with R26, there was no evidence the visits had occurred. During a subsequent interview on 3/4/16, at 1:23 p.m. the LSW stated she had not notified the physician regarding R26's increase in depressive symptoms. She further stated she had not updated R26's care plan in regard to his psychosocial needs. On 3/4/16, at 1:37 p.m., registered nurse (RN)-A stated R26 used to come out to the dining room for meals and sit with the other men at the table. She stated he stopped coming "around the time when he was having the hallucinations." She stated while the hallucinations have stopped, she was not sure if staff invited R26 out to meals. A policy titled Social Services, dated June 2005, indicated the facility provides medically-related social services to assure each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well- being. The policy indicated the director of social services was responsible for consultation with other departments regarding programming, consultation to allied professional health	F 250		

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F 250	Continued From page 28 personnel regarding provisions for the social and emotional needs of the resident, and assistance in meeting the social and emotional needs of the resident. The social services department was further responsible for identifying individual social and emotional needs as well as making supportive visits to the resident.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor bruising for 1 of 4 residents (R16) reviewed for accidents. Findings include: R16's annual minimum data set (MDS) dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The care plan further indicated she received aspirin and had fragile skin that bruised easily. Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, there was	F 309	Element 1 R16, R25, R11and R27 have been assessed for alterations in skin and monitored as needed. Element 2 A baseline audit was performed on all residents which entailed head to toe skin observations by licensed staff. Also, all residents who are not able to accurately explain an how an injury occurred have been care planned for potential abuse. NARs are observing skin for alterations daily during morning care and report findings to licensed staff. Licensed staff are performing head to toe skin observations weekly, skin alterations are	5/2/16

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F 309	Continued From page 29 no evidence of ongoing monitoring of R16's bruising. Nor was there evidence of frequent small bruises that would suggest R16 bruised easily. A review of Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incidents of bruising to R16's body. On 5/29/15 staff documented bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. An incident report dated 7/8/15 indicated R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. On 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. A report dated 9/20/15,indicated R16 had a 5 cm x 5 cm purple area to her left cheek. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. On 10/7/15 staff noted a hematoma on R16's left forearm from her wrist to her upper arm. An incident reported dated 1/6/16 indicated R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. On 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. A physicians Nursing Home progress noted indicated R16 was seen due to staff reports of frequent bruising all over her body. The progress note indicated staff were to monitor bruising, however there was no evidence of monitoring. During an observation on 3/1/16, at 12:30 a.m., R16 was sitting in her wheel chair in a common area of the unit. She was holding a stuffed animal and making nonsensical statements. During an observation on 3/2/16, at 7:27 a.m., R16 was	F 309	reported and documented in the medical record. Alterations such as bruises will be measured/monitored weekly during IDT wound rounds and more often if necessary. Element 3 Our skin protocol has been updated as necessary to include documented weekly skin assessments by a licensed nurse and weekly monitoring of bruises. Element 4 All skin is observed daily by the NAR and issues brought to the licensed nurse as soon as practicable. Skin is observed and documented weekly by a licensed nurse. Alterations are reported immediately to the RN. Non-pressure related bruises and potential injuries will be added to weekly IDT skin rounds and documented by the RN in the resident chart ongoing. The DON/Designee will monitor skin observations weekly to assure accurate monitoring/reporting occur. Variances in this process will be reported to the administrator for immediate follow up and discussed at the QAPI meeting at least quarterly.	

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F 309	Continued From page 30 sitting in a common area of the facility with her eyes closed. During an observation on 3/2/16, at 12:59 p.m., R16 was sitting in a common area in her wheel chair. During an observation on 3/3/16, at 8:48 a.m., R16 was sitting in her wheel chair in a common area of the unit reading a newspaper. During an interview on 3/4/16, at 8:39 a.m., the director of nursing (DON) stated a nurse observed R16's skin at least weekly. She stated there is no follow up done for bruising. The DON stated, "I think the policy says, report if problems." She stated R16 received aspirin daily but had no bleeding disorders. During an interview on 3/4/16, at 9:36 a.m., licensed practical nurse (LPN)-C stated, weekly skin checks should be done on shower day. She stated she had not completed R16's skin check due to her bath being scheduled on the evening shift. An assessment titled Observation Report, dated 2/16/16, indicated character and color of R16's skin was "per usual." A record of R16's weekly skin observation was requested, but none received. A facility policy titled Skin Risk assessment, undated, outlined a procedure to proved for the assessment and identification of resident's at risk for developing skin impairments. The policy directed licensed nurses to conduct skin assessments at least weekly to identify changes.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		5/5/16

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F 323	Continued From page 31 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing assessments to determine causal factors, and implement appropriate interventions in an attempt to prevent falls for 2 of 3 residents (R19, R39) reviewed for accidents. The facility failed to investigate and comprehensively assess resident falls to determine if new interventions could be implemented to prevent falls, which resulted in a significant injury for R19. The facility's failure resulted in an immediate jeopardy (IJ), with serious harm and injury for R19. The immediate jeopardy began on 1/8/16, when R19 fell, was sent to the emergency room and was diagnosed with a fractured clavicle. The facility failed to comprehensively assess and implement interventions to prevent ongoing falls. The administrator and the director of nursing were notified of the IJ for R19 on 3/2/16, at 5:42 p.m. The immediate jeopardy was removed on 3/8/16, at 11:23 a.m. but noncompliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy. Findings include: R19 sustained multiple falls, some with significant	F 323	Element 1 R19 and R39 have been comprehensively assessed. A fall risk score has been determined and interventions have been updated. Both residents' falls have been trended to inform the root cause analysis and interventions were updated. Interventions for R19 include, but are not limited to, elevated head of bed, re-introduce tool chest for activities, scheduled morphine, offering recliner and room adjustments. Element 2 All residents who have fallen in the last 30 days have been comprehensively re-evaluated to determine a fall risk score and interventions have been updated when appropriate. All residents who have 2 or more falls in a 30-day period are being analyzed for trends to further inform the root cause analysis and interventions are updated when appropriate. Element 3 The policy has been updated to reflect current practice, including but not limited to, assessment, pre-fall huddle to prevent falls, pharmacy review, fall scene	

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F 323	Continued From page 32 injury, and the facility failed to comprehensively assess risk factors related to the continued falls. In addition, interventions to prevent falls were not consistently implemented. R19's Admission Record identified diagnoses that included Alzheimer's disease, polymyalgia (muscle pain and weakness), congestive heart failure (CHF), gait and mobility abnormalities, and history of falling. The annual Minimum Data Set (MDS) dated 9/8/15, identified R19 had significant cognitive impairment, had no behavioral issues, required no transfer help or assistance ambulating in his room, was on no toileting plan but occasionally incontinent, and did not ambulate in the hallway. The significant change MDS dated 2/2/16, indicated R19 had severe cognitive impairment, required extensive assistance of two staff with transfers, required extensive assistance of one staff for wheelchair mobility, and did not ambulate. The MDS also indicated R19 had occasional incontinence of bowel and bladder, required extensive assistance of two staff for toileting, and was not on a toileting program. The MDS further identified R19's balance during transfers (moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfers) as not steady, only able to stabilize with assistance. The MDS also identified R19 had falls since the prior assessment, with no injuries. R19's Care Area Assessment (CAA) dated 2/5/16, identified R19 had a hearing deficit, poor balance and a history of falls, with no diuretic or psychotropic medication use. The CAA indicated to follow up with the fall and safety committee, to modify interventions as needed, and to see the care plan for safety interventions. R19's fall risk	F 323	investigation to inform the root cause analysis, interventions, and trending falls. The root cause analysis tool has been updated. The updated policy has been signed and dated. Education has been provided to nursing home staff regarding the policy updates and updated root cause analysis tool. Element 4 All falls will be reviewed by the DON/designee daily/5 days per week ongoing. Each fall will be followed by the IDT at its weekly meeting, or as needed, for 4 weeks ongoing. At each IDT post-fall meeting, the team will review the root cause to ensure it has been appropriately identified and addressed with corresponding interventions and the efficacy of those interventions. This process will continue and variations will be reported to the administrator for immediate follow up and discussed at QAPI meetings at least quarterly.	

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F 323	Continued From page 33	F 323		

assessment dated 1/31/16, identified R19 was at risk for falls, had 3 or more falls in the last quarter, had a weakened state, and to continue current plan of care. However, the assessments failed to comprehensively assess R19's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions.

R19's care plan dated 12/22/15, identified a goal: R19 will remain free from injury from falls. The care plan identified the following interventions: check frequently after assisting to bed to assure he is settled in and not restless; if restless offer to assist to wheelchair; assure staff is attentive in main dining room during events such as the walk of honor; change wheelchair cushion; if propels near room assess for needs; if he wheels himself to room, assist to lie down or stay with him; redirect him to areas of better supervision; sit/stand lift for transfers; anticipate needs for toileting, rest and intakes; assess pain, reassure and cue; attempt to assist him with a.m. cares and transfer prior to 7:00 a.m. to hinder self-transfers; cue and assist when symptomatic, place in areas of high visibility; offer nightlight, cue for fluids, snacks and toileting when awake at night; regular mattress, bed at standard height, no siderails; keep wheelchair locked at bedside at night; anti-rollbacks on wheelchair; toilet daily at 10:00 a.m., and by 1:30 p.m. and 4:30 p.m. also toilet before bed and upon rising.

Review of R19's fall incident reports since 9/15, indicated the following:

- 9/7/15, at 4:30 a.m. R19 was found on the floor in his room. R19 stated he fell out of bed. R19 sustained a 5 centimeter (cm) x 4 cm red area to

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his right upper forehead and was transported to the emergency room (ER). The ER provider diagnosed R19 with a scalp contusion. New interventions implemented: keep wheelchair locked at bedside as able.
An inter-disciplinary team (IDT) meeting was held on 9/8/15, with the following conclusion: will continue to monitor, observe orthostatic blood pressures. On 3/2/16, at 12:58 p.m. registered nurse (RN)-A was interviewed and stated no root cause analysis of the fall had been completed.

- 9/24/15, at 11:35 p.m. staff was alerted by roommate that R19 had fallen in his room. Staff indicated the fall was caused by R19 attempting to self-transfer, and only one wheelchair brake was locked. R19 did not sustain an injury. New interventions implemented: continue to check on resident at various times making sure both wheelchair brakes were locked. Remind resident to lock both wheelchair brakes.
An IDT meeting was held on 9/14/15, with the following: R19 was functioning at his baseline, he propelled himself in his wheelchair and transferred independently. Attempt keeping wheelchair locked at bedside and cue to toilet at night before sleep. On 3/2/16, at 12:58 p.m. RN-A stated no root cause analysis of the fall had been completed.

- 10/20/15, at 12:25 a.m. R19 was in his wheelchair in the hallway when he attempted to stand up, lost his balance and fell. Staff indicated the fall was caused by increased confusion, impulsiveness and attempts to self-transfer. R19 did not sustain an injury. New interventions implemented: none.
An IDT meeting was held on 10/26/15, with the following: this recent fall seems to be isolated and

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related to acute illness. Res is back to his baseline. On 3/2/16, at 1:11 p.m. RN-A was interviewed and stated the root cause of the fall was isolated and related to R19's acute illness.

- 10/27/15, at 10:15 p.m. staff witnessed R19 attempt to stand up and walk into another resident's room "to go to bed" when he went to sit back down on his wheelchair and fell. Staff indicated the fall was caused by attempting to go to bed, restless movements. No injury. New interventions implemented: anti-rollbacks to wheelchair.
An IDT meeting was held on 10/27/15, with the following: witnessed fall in hallway was attempting to stand up and walk into another resident's room to go to bed went to sit on wheelchair and landed on floor. On 3/2/16, at 1:20 p.m. RN-C stated the root cause analysis of the fall was completed; and it was determined R19 had an acute condition that resulted in weakness.

- 10/28/15, at 8:40 a.m. R19 was found face down on the floor of his room. Staff indicated the fall was caused by urgency of bowel movement. R19 sustained a head contusion, was transported to the ER, and was diagnosed with a scalp hematoma and pneumonia. New interventions implemented: none.
An IDT meeting was held 12 days later on 11/9/16, with the following: R19 was screened by therapy and orders received for physical therapy (PT) 3 times a week to improve transfers, standing and ambulation with walker. Continue to follow up as needed. On 3/2/16, at 1:25 p.m. RN-A stated the root cause analysis of the fall had not been completed.

- 1/8/16, at 7:20 a.m. R19 was found on the floor

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in his room. Staff indicated the fall was caused by weakness secondary to pleural effusion (a buildup of fluid between the tissues that line the lungs and chest). R19 was transported to the ER, where he was diagnosed with a fracture of the right clavicle (collarbone). New interventions implemented: rearranged furniture in room.
An IDT meeting was held on 1/8/16, and a review of the fall was completed, but no conclusion. On 3/2/16, at 1:35 p.m. RN-C was interviewed and stated the root cause analysis of the fall was completed with the conclusion R19 fell because he gets acute respiratory issues and he falls.

- 1/11/16, at 3:50 p.m. R19 was found on the floor in his room. R19 stated he was moving his car out of the way. R19 did not sustain an injury. New interventions implemented: none.

- 1/11/16, at 6:30 p.m. R19 was found on the floor in his room. Staff indicated the fall was caused by R19 trying to transfer self to bed and slid off of the bed to the floor. No injury. New interventions implemented: assess pain, reassure and cue.

- 1/12/16, at 11:40 p.m. R19 was found on the floor in his room. Staff indicated the fall was caused by resident attempting to self-transfer out of bed. R19's right hand was bleeding, he had a laceration to the 5th finger, and he was transported to the ER. The ER record indicated R19 received sutures to the right 5th finger. New interventions implemented: consider room design changes.
An IDT meeting was held on 1/12/16, reviewing the falls of 1/11/16, and 1/12/16, with the following: will have physical therapy (PT) and occupational therapy (OT) screen for transfers in room, adjustment to room layout may need to be

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made, and will have pharmacy perform a medication review. On 3/2/16, at 1:45 p.m. RN-C verified a root cause analysis was not completed.

- 1/30/16, at 8:00 p.m. R19 was found on the floor of his bathroom. R19 did not sustain an injury. Staff indicated the fall was caused by a general decline. R19 did not sustain an injury. New interventions implemented: attempt to assist to recliner or bed after supper, use sit/stand lift for transfers.
An IDT meeting was held on 2/1/16, with the following: R19 has had a general decline in condition and was now enrolled in hospice. He was more sleepy and interacted less. He was on a scheduled toileting plan. Staff to anticipate needs and offer toileting and rest periods at frequent intervals. If he seemed restless offer food, fluids, rest and toileting. May need to go to bed earlier in the evening or relax in the recliner.
On 3/2/16, at 1:49 p.m. RN-C stated R19 got weak, short of breath and didn't know what to do. RN-A stated the scheduled toileting plan didn't work, and now staff just asked him if he needed to go to the bathroom.
-2/4/16, at 10:30 a.m. R19 was found on the floor in his room. No injury. Staff indicated the fall was caused by impulsiveness, resident believed he was capable of transfers. New interventions implemented: continue to keep in area of high visibility and check/redirect frequently. An IDT meeting was held 5 days later on 2/9/16, with the following: staff have been redirecting him with success that morning was impulsive, thought he was capable to rise on his own and shouldn't be alone in room without staff nearby to view him. Very alert that day compared to others. Try not to leave him alone in room, stay with him or redirect to area of supervision and visibility. On 3/2/16, at

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F 323	Continued From page 38 1:54 p.m. RN-A verified there was no root cause analysis of the fall. - 2/14/16, at 8:40 p.m. R19 was found on the floor in his room. R19 sustained a small excoriation on his left buttock. Staff had not indicated what the fall was caused by. New interventions implemented: bed in lowest position, call light within reach. - 2/16/16, 2:00 p.m. R19 was in the dining room, sleeping in his wheelchair, when he slid out of the wheelchair and landed on the floor. R19 did not sustain an injury. Staff indicated the fall was caused by sleeping in the wheelchair. New interventions implemented: wheelchair cushion to offer more support at front of seat. An IDT meeting was held 8 and 6 days later on 2/22/16, reviewing the falls for 2/14/16, and 2/16/16, with the following:wheelchair cushion changed for better positioning and decided to have staff in the dining room during special events. On 3/2/16, at 2:19 p.m. RN-A verified there was not root cause analysis for either fall. - 2/26/16, at 5:40 a.m. R19 was found on the floor in his room. R19 stated the bed slipped. Staff indicated the fall was caused by self-transfer. R19 sustained a laceration to the left eyebrow, and was transported to the ER. The ER record indicated the laceration was treated with steri-strips. New interventions implemented: 1:1 when restless. An IDT meeting was held on 3/1/16, with the following: Staff to be aware to check frequently after assisting to bed to assure he is settled in and not restless. On 3/2/16, at 2:20 p.m. RN-A verified no root cause analysis of the fall was completed.	F 323		

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On 3/2/16, at 7:21 a.m. R19 was observed in his room. Nursing assistant (NA)-E was providing personal cares for R19, who was sitting on the side of his bed. At 7:23 a.m. NA-E told R19 she was going to leave the room to get the transfer lift. NA-E left the room, and shut the door, leaving R19 sitting on the side of the bed unattended. At 7:25 a.m. NA-E returned to the room, used the stand assist lift to transfer R19 into his wheelchair. NA-E stated R19 had a lot of falls. When asked what interventions were in place to prevent falls, NA-E stated the staff was supposed to keep an eye on him, see where he was at. NA-E stated R19 was not on a toileting program, he was supposed to have assistance to the bathroom, but R19 was quick, and they helped him if they noticed him going into the bathroom, he shouldn't be in there alone.

On 3/2/16, at 8:26 a.m. R19 was observed alone in his room, propelling himself in his wheelchair.

On 3/12/16, at 11:50 a.m. R19 was observed alone in his room.

On 3/2/16, at 12:26 p.m. R19 was observed alone in his room, going through his top dresser drawer.

On 3/2/16, at 1:05 p.m. R19 was observed in the dining room, sleeping in his wheelchair. There was no staff in the area monitoring R19 in the dining room.

On 3/2/16, at 11:48 a.m. activity director (AD)-A stated R19 did not come out for activities. R19 doesn't participate much in activities. R19 liked visiting with others so staff did 1:1 visits with him, but there were no specific activities for him. R19 had a book about his experience as a veteran he

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enjoyed looking at, however, family took that home. R19 was a mechanic and liked to "tinker with stuff." AD-A stated it would be nice to get an engine or something for R19 to work on but she was not sure where they would put it.

On 3/3/16, at 8:25 a.m. NA-A stated R19's fall interventions included looking in on him if passing his room and if alone in his room try and get him out or stay with him. However, now he was on a 1:1 and staff has been toileting him more often. NA-A acknowledged R19 was "quick".

On 3/3/16, at 8:32 a.m. NA-C stated interventions for R19 included safety checks, toileting him according to his schedule, ambulation to "get rid of excess energy," distract him - talk about World War II. NA-C acknowledged not being on the schedule for the last 8 days so was unaware of any changes in the plan of care for R19.

On 3/3/16, at 10:40 a.m. NA-B stated fall interventions for R19 included looking in on him whenever staff walked by, offer coffee and ice cream, going to the gathering place. NA-B stated R19 had a 1:1 right now and she didn't believe the toileting plan had changed.

On 3/2/16, at 5:15 p.m. licensed practical nurse (LPN)-A stated R19 was to be toileted every 2 hours, but he didn't always agree to go. Staff was to check on him often, leave the call light within reach and remind him to use it, try not to leave R19 alone in his room, and offer a nap. LPN-A stated R19 really didn't use the call light but staff still needed to remind him to use it.

On 3/2/16, at approximately 3:00 p.m. the director of nursing (DON) was interviewed. The DON

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F 323	Continued From page 41 stated the facility completed a post-fall huddle immediately after each fall, and immediate interventions were put into place. The DON also stated an IDT meeting was held at least weekly, and falls were reviewed at that time. During this meeting, a root cause analysis was completed on each fall. The immediate jeopardy that began on 1/8/16, was removed on 3/8/16, when the facility implemented the following interventions to minimize the risk of falls for R19: 1:1 supervision with removal plan Activities to provide interesting mechanic type tinkering toys Attempt positioning in recliner for comfort Coordinate with Hospice for fall prevention and volunteer 1:1 Extra bed removed from room to decrease clutter Wider bed to be delivered 3/9/16 Head of bed raised 30 degrees Morphine at bedtime Offer to sit on edge of bed and use urinal, or offer to toilet Provide an afternoon nap Transfer with one staff and contact guard assist When he appeared restless or attempting to stand ask if he was hungry, thirsty or needed to use the bathroom Use short understandable language to evoke yes or no answers Attempt to anticipate his basic needs and keep him comfortable However, noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy because R19 had	F 323		

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F 323	Continued From page 42 3 falls that resulted in injuries requiring medical intervention: a fractured clavicle, a laceration of the finger requiring sutures, and a laceration of the head requiring steri-strips,which identified him to be at high risk for significant injury. R39 had 12 falls in the past 6 months, and the facility failed to comprehensively assess and implement appropriate interventions to minimize the risk for ongoing falls. R39's Admission Record identified diagnoses that included dementia, dizziness, gait and mobility abnormalities, rheumatoid arthritis in right hip, and right hip and knee pain. The quarterly MDS dated 1/19/16, indicated R39 had severe cognitive impairment, required standby assistance of 1 staff for transfers, was independent with ambulation in his room, and required standby assistance of 1 staff for ambulation in the hallway. The MDS also indicated R39 was always continent of bowel and bladder, and was independent with toileting (with staff supervision/cues). The MDS further identified R39's balance during transfers (moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfers) was not steady, but able to stabilize without assistance. R39's CAA dated 8/19/15, identified R39 was at risk for falls, and had physical limitations such as weakness, limited range of motion, poor coordination and poor balance. The fall risk assessment dated 1/18/16, indicated R39 was at risk for falls, and had three or more falls in the	F 323		

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F 323	Continued From page 43 previous three months. R39's care plan dated 8/10/15, identified a goal: R39 will remain free from injury. The care plan identified the following interventions: remind him to use his walker and keep it next to him; once tucked into bed for the evening check on him often to cue him until asleep; keep call light within reach; keep pathways free of obstacles; gripper socks/bare feet when in bed; and non-skid footwear while up. Review of R39's fall incident reports since 9/15, indicated the following: - 9/22/15, at 4:10 p.m. R39 stated he had fallen when coming out of his bathroom, and had gotten himself up off the floor. R39 sustained a skin tear to his left elbow. New interventions implemented: add a toilet riser to toilet in bathroom. On 3/7/16, at 10:32 a.m. RN-C was interviewed and stated no root cause analysis of the fall had been completed. - 10/16/15, at 3:40 p.m. R39 stated had fallen when he came out of the bathroom, and had gotten himself up off the floor. R39 did not sustain an injury. New interventions implemented: monitor bowel movements, encourage him to use the call light. On 3/7/16, at 10:34 a.m. RN-C was interviewed and stated no root cause analysis of the fall had been completed. - 11/10/15, at 12:45 p.m. R39 stated he fell in his room, and had gotten himself up off the floor. R39 did not sustain an injury. New interventions implemented: bedside commode. On 3/7/16, at 10:36 a.m. RN-C verified no root cause analysis of the fall was done.	F 323		

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F 323	Continued From page 44 - 11/10/15, at 2:00 p.m. R39 was found sitting between the bed and the dresser in his room. R39 stated he had needed to go to the bathroom. R39 did not sustain an injury. New interventions implemented: R39 was given a stool softener. On 3/7/16, at 10:37 a.m. RN-C stated the root cause analysis for the fall was R39 had a suppository earlier that morning and had become dizzy. - 11/12/15, at 11:00 a.m. R39 was standing outside of his room only wearing his shirt. Staff asked if he was all right, and R39 stated he had fallen in the bathroom during an incontinent episode. R39 did not sustain any injury. New interventions implemented: room rearranged and commode placed in room. On 3/7/16, at 10:39 a.m. RN-C was interviewed and verified no root cause analysis of the fall was done. - 11/24/15, at 8:10 p.m.: R39 was standing in doorway of his room when he lost his balance and fell backward onto floor. R39 did not sustain an injury. New interventions implemented: none. On 3/7/16, at 10:41 a.m. RN-C verified no root cause analysis of the fall was done. - 12/26/15, at 9:30 a.m. R39 was walking down the hallway and stated he needed help. R39 stated he had fallen in his room, and gotten himself up. No injury. New interventions implemented: remind to use call light for assistance. On 3/7/16, at 10:44 a.m. RN-C verified no root cause analysis of the fall was done. - 12/28/15, at 5:30 p.m. R39 was ambulating in the hallway when he lost his balance and fell. R39 sustained lacerations and required a trip to the	F 323		

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F 323	Continued From page 45 ER (medical record lacked description of the injury). New interventions implemented: R39 was told to walk slower. On 3/7/16, at 10:48 a.m. RN-C stated the root cause analysis of the fall was gastroenteritis. - 1/30/16, at 5:50 p.m. R39 fell in his room. No injury. New interventions implemented: none. On 3/7/16, at 10:50 a.m. RN-B was interviewed and stated R39 was given a walker to use. RN-B stated no root cause analysis of the fall was done. - 2/3/16, at 1:30 p.m. R39 found in room, sitting next to his bed. R39 did not sustain an injury. New interventions implemented: comprehensive pain assessment. On 3/7/16, at 10:55 a.m. RN-C verified no root cause analysis of the fall was done. - 2/6/16, at 4:00 p.m. R39 was found on the floor in his room. R39 sustained a 3 cm skin tear to his left elbow. New interventions implemented: R39 was given a wheelchair to use until he could be re-evaluated. On 3/7/16, at 10:57 a.m. RN-C stated R39 had not been using his walker at the time, and was given a wheelchair, but only used for one day. RN-C verified no root cause analysis of the fall was done. - 2/6/16, at 6:30 p.m. R39 was found on floor in his room. R39 sustained contusions (medical record lacked description of the contusions) and was treated in the ER. New interventions implemented: resident will be in recliner at gathering place to ensure safety. On 3/7/16, at 10:59 a.m. RN-C was interviewed and verified a root cause analysis of the fall was not done. On 3/1/16, at 1:58 p.m. R39 was observed ambulating in the hall, using a walker.	F 323		

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	245469	A. BUILDING _____ B. WING _____	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 46 On 3/2/16, at approximately 3:00 p.m. the DON was interviewed. The DON stated the facility completes a post-fall huddle immediately after each fall, and immediate interventions are put into place. The DON also stated an IDT meeting is held at least weekly, and falls are reviewed at that time. During this meeting, a root cause analysis is completed on each fall. The clinical record lacked a comprehensive reassessment of R39's risk for falls. The undated facility policy and procedure on Fall Prevention, directed at the point of a fall, a fall scene investigation will be completed to determine the root cause of each fall. The licensed staff will put an immediate intervention in place to prevent further fall.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		5/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 47 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monitoring for adverse side effects of antipsychotic medication and nursing orders were followed by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: R23 was not assessed for tardive dyskinesia (adverse side effects related to the use of antipsychotic medication) after starting an antipsychotic medication. In addition, nursing orders were not followed as directed to monitor, recheck and report to the nurse practitioner (NP) pulses over 100. The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The annual Minimum Data Set (MDS) dated 12/9/15, indicated R23 had severe cognitive impairment. R23 did not have any behaviors, delirium, psychosis or change in behavior	F 329	Element 1 R23□s pulse was taken and found to be in normal limits and her parameter order was changed. R23 was assessed for Tardive Dyskinesia and found to have no symptoms. Element 2 A baseline audit was performed of all residents who take antipsychotic medications and AIMs assessments are current. Parameters have been set for all residents vital signs to alert and trigger on the Matrix dashboard. Element 3 The AIMS policy was updated and educated to the psychotropic IDT (SW, RNs, and Pharmacist). Policy includes, but is not limited to, screening and repeat screening of residents, testing using the AIMS scale, and notifying provider of changes in the AIMS score. A protocol has been implemented to set vital sign parameters for each resident and an alert is set to follow up with provider. Element 4 The psychotropic IDT will review need for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 48 symptoms. R23 needed assistance with activities of daily living (ADL's) and received an antidepressant and antipsychotic seven of the seven days during the assessment period. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106. 2/19/16, pulse of 105. 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. R23 was observed on 2/29/16, at supper, 3/1/16, from 1:15 p.m. to 1:30 p.m. and on 3/2/16, from 7:15 a.m. to 8:30 a.m. R23 did not exhibit any signs or symptoms of tardive dyskinesia, pain, discomfort, paranoia, psychosis or hallucinations.	F 329	AIMs assessments per policy weekly ongoing. An RN will audit Matrix dashboard daily for vital signs that are out of set parameter and follow up as necessary. Variances will be reported to the administrator for immediate follow up and reviewed at the QAPI meeting at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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F 329	Continued From page 49 On 3/3/16, at 9:30 a.m. registered nurse (RN)-A stated she tried to do tardive dyskinesia monitoring quarterly but believed it was to be done every six months. RN-A verified R23's AIMS was done last on 2/28/15, with no further assessments since that date. On 3/3/16, at 9:35 a.m. RN-C stated the order to recheck the pulse and notify the NP was added on 12/10/14. The RN stated she believed it was a nursing order. RN-C verified the medical record lacked a recheck and notification of the pulse when greater than 100 to the NP. On 3/3/16, at 9:40 a.m. the NP stated R23 had medication changes and a history of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) which intermittently went in and out but had been stable. The NP further stated she was not worried about the pulse until it was 120 or 130. The NP stated she would expect staff to check for tardive dyskinesia per the facility's protocol. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first dose of the medication. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. On 3/4/16, at 11:10 a.m. RN-A stated the instructions to monitor apical pulse with blood pressures and update the NP if the pulse was greater than 100 after a recheck of the pulse was	F 329		

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	245469	A. BUILDING _____ B. WING _____	03/08/2016

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F 329	Continued From page 50 for the medication nurses when checking the blood pressure prior to giving the antihypertensive medication. The RN stated the nursing assistants (NA) should be rechecking the pulse and or telling the nurse when R23's pulse was greater than 100. On 3/4/16, at 11:15 a.m. licensed practical nurse (LPN)-B stated after the NAs obtain the vital signs the NAs give the vital sign results to the nurse to document in the medical record. The LPN stated she was not aware of any pulses greater than 100 for R23. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to ensure monitoring for adverse side effects of	F 428	Element 1 The Pharmacist consultant has reviewed R23□s Aims and vital signs and found her	5/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 51 antipsychotic medication and nursing orders by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106. 2/19/16, pulse of 105.	F 428	to have no symptoms. Element 2 The pharmacist consultant has reviewed all residents who take antipsychotic medications and AIMs assessments are current. The consultant has also reviewed vital sign parameters and the alert system. Element 3 The pharmacy consultant reviewed his contract obligations. The AIMS policy was updated to provide, including but not limited to, screens and repeat screens, using the AIMS scale test and notifying the provider of any changes. Policy also provides that the pharmacist consultant will audit monthly to ensure completion of the AIMS assessments. The policy was educated to the psychotropic IDT (SW, RNs, and Pharmacist). A protocol has been implemented to set vital sign parameters for each resident and an alert is set to follow up with provider. Element 4 The psychotropic (Includes pharmacist) IDT will review need for AIMs assessments per policy weekly ongoing. The Pharmacy consultant will review vital sign parameters to the DON monthly. Variances will be reported to the administrator for immediate follow up and reviewed at the QAPI meeting at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 52 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. The consultant pharmacist's Resident Progress Notes for the pharmacist's monthly review of R23's medications in the months of 10/15 through 2/16 lacked evidence of recommendations to assess R23 for antipsychotic medications adverse side effects. In addition, there was no recommendation to recheck and notify the NP when R23's pulse was greater than 100. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first dose of the medication. The pharmacist stated he did not monitor if a tardive dyskinesia assessment had been completed because they were typically done. The pharmacist further stated he would not look for R23's pulses and notification to the NP because it was a day to day nursing order. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none. The Facility's Consultant Pharmacist Services Provider Requirements policy dated 8/6/12, indicated the consultant pharmacist would check and identify one or more current medication	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	**5211 HIGHWAY 110 AURORA, MN 55705**

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F 428	Continued From page 53 references to facilitate the identification of medications and information on contraindications, side effects and or adverse side effects, dosage levels and other pertinent information.	F 428		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WOWJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00604

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245469**
2.STATE VENDOR OR MEDICAID NO.
(L2) **173347801**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** (L6) **55705**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/12/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On May 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 2, 2016, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 8, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of May 5, 2016. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our extended survey, completed on March 8, 2016, as of May 2, 2016. As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective May 2, 2016.

In addition, the Department recommended to the CMS Revion V Office that the following remedy remain in effect:

Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444

The facility is subject to a two year loss of NATCEP beginning, would be subject to a two year loss of NATCEP, beginning March 8, 2016.

Refer to the CMS 2567b forms for both health and life safety code.

Effective May 2, 2016, the facility is certified for 50 skilled nursing facility beds.

- State Monitoring effective April 5, 2016. (42 CFR 488.422)

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245469

June 13, 2016

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Dear Ms. Ackman:

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

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

Effective May 2, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2016

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469026

Dear Ms. Ackman:

On March 31, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 5, 2016. (42 CFR 488.422)

On March 31, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement be imposed:

- Civil money penalty for deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on March 8, 2016, where at the time of the extended survey conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On May 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 2, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 5, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on March 8, 2016, as of May 2, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 2, 2016.

However, as we notified you in our letter of March 31, 2016 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, Essentia Health Northern Pines Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective March 8, 2016. 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.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of March 31, 2016:

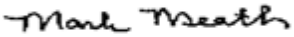
- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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.

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245469 Y1	A. Building B. Wing Y2	5/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0248	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.15(f)(1)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0250	Correction	ID Prefix	F0309	Correction	ID Prefix	F0323	Correction
Reg. #	483.15(g)(1)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(h)	Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		05/02/2016
ID Prefix	F0329	Correction	ID Prefix	F0428	Correction	ID Prefix		Correction
Reg. #	483.25(l)	Completed	Reg. #	483.60(c)	Completed	Reg. #		Completed
LSC		05/02/2016	LSC		05/02/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TA/mm	05/23/2016	29625	05/05/20161
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/8/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245469 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	04/25/2016	LSC K0029	04/25/2016	LSC K0056	04/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0075	04/25/2016	LSC K0076	04/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	05/23/2016	27200	05/02/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/2/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2016

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Re: Reinspection Results - Project Number S5469026

Dear Ms. Ackman:

On May 5, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 8, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00604 Y1	A. Building B. Wing Y2	5/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830	Correction	ID Prefix 21426	Correction	ID Prefix 21435	Correction
Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.0900 Subp. 1	Completed
LSC	05/02/2016	LSC	05/05/2016	LSC	05/02/2016
ID Prefix 21475	Correction	ID Prefix 21530	Correction	ID Prefix 21540	Correction
Reg. # MN Rule 4658.1005 Subp. 1	Completed	Reg. # MN Rule 4658.1310 A.B.C	Completed	Reg. # MN Rule 4658.1315 Subp. 2	Completed
LSC	05/02/2016	LSC	05/02/2016	LSC	05/02/2016
ID Prefix 21980	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/02/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	05/23/2016	29625	05/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WOWJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00604

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245469**
2.STATE VENDOR OR MEDICAID NO.
(L2) **173347801**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** (L6) **55705**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 04/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5469

On March 8, 2016, an extended survey was completed at the 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. The facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health
or safety. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. As a result of the survey findings, this Department imposed the following remedy:

• State Monitoring effective April 5, 2016. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444

Refer to the CMS 2567 for both health and life safety code along with the Facilitys plan of correctionl.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 31, 2016

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469026

Dear Ms. Ackman:

On March 8, 2016, 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.

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 isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - 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;

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

Substandard Quality of Care - 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;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 8, 2016, 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:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: pam.kerssen@state.mn.us
Phone: (218) 308-2129
Fax: (218) 308-2122

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 April 5, 2016. (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 F323 (S/S=J). (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, Essentia Health Northern Pines Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 8, 2016. 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: Karen R. Robinson, Director
330 Independence Avenue, SW
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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is

acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 8, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

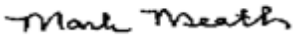
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted on March 2, 2016, through March 8, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to complete ongoing assessments to determine causal factors and implement interventions for resident (R19) who had falls and had sustained a fractured clavicle as a result of a fall on January 8, 2016. The IJ began on January 8, 2016, and was removed on March 8, 2016, at 11:23 a.m., following the implementation of an acceptable removal plan. However, non-compliance remained at a scope and severity level of G, which indicated actual harm.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		5/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/08/2016

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

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F 225	Continued From page 1 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure injuries of unknown origin were thoroughly investigated and/or immediately reported to the state agency prior to an investigation for 3 of 4 residents (R25, R11, R16)	F 225	Element 1 R16, R11, & R25 have been re-assessed and are care planned for risk factors and non-suspicious, skin alterations in areas that are generally vulnerable to trauma.	

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F 225	Continued From page 2 who sustained bruises of unknown origin. Findings include: R25's quarterly Minimum Data Set (MDS) dated 1/4/16, indicated R25 had a severe cognitive impairment, was sometimes understood and sometimes understood others, required extensive assist of one with bed mobility, dressing, and personal hygiene, required extensive assist of two with transfers, and required total assistance for wheelchair locomotion. R25's MDS further indicated R25 had no falls. R25's Face Sheet printed 3/7/16, indicated R25's diagnoses included diabetes mellitus, anemia, erythema intertrigo (red rash-like inflammation in the skin folds caused by friction, increased warmth or moisture), dementia and edema (swelling). R25's Care Area Assessment (CAA) for cognitive loss and dementia for assessment date of 9/28/15, indicated R25 was unable to make needs known, had decreased balance with an inability to transfer or walk safely, and was at increased risk for falls. R25's care plan for skin, edited 11/21/15, identified a potential for alteration in skin integrity with edema, skin rashes and irritations, and history of scabs and open areas, though did not address risk of bruising. R25's care plan for psychosocial well-being created 10/22/15, indicated R25 was at risk for being unable to make her needs known, falls, and increased confusion. The goal was for R25 to be safe in the environment.	F 225	Other skin alterations that are in areas not vulnerable to trauma and that are suspicious because of the extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency. Element 2 All residents with skin alterations (injuries) that were not observed by any person or the source could not be explained by the resident have been re-assessed and are care planned for risk factors related to non-suspicious skin alterations in areas that are generally vulnerable to trauma. Skin alterations in areas that are not generally vulnerable to trauma and that are suspicious because of extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency. Element 3 Our policy has been reviewed and updated and nursing home staff has been educated regarding reporting injuries. Injuries of unknown origin that cannot be explained by the resident or that are suspicious because the injury is in an area that is not generally vulnerable to trauma or because of extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated. The investigation will include, but not be limited to, utilizing the forms provided in our electronic medical record. Element 4	

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F 225	Continued From page 3 The physician's nursing home visit note dated 12/1/15, indicated R25 was able to speak a few words but unable to answer questions appropriately due to advanced dementia. The physician's documentation indicated staff denied any new skin concerns. The physician's family practice visit note dated 1/4/16, indicated R25 was unable to give verbal responses and had no skin issues. R25's skin documentation dated 12/13/15, indicated R25 had redness on the arm and elbow. R25's skin documentation dated 12/1/15 through 12/12/15, indicated R25's skin was clear and without redness or bruising. An incident report dated 12/13/15, at 10:45 a.m. indicated R25 was noticed to have a red/bruised area on the top of the right arm when gotten up that morning. The incident report indicated R25 had possibly bumped the arm on a table or lift. The Investigation of Injury of Unknown Origin form dated 12/13/15, indicated R25 had a bruise on the top of the right arm and wrist. The investigation form identified pertinent diagnoses and medical conditions of dementia and dependent transfers. The investigation form indicated the cause of R25's bruise was unable to be determined and R25 was unable to verbalize the cause of the bruise. The investigation form indicated R25 could have bumped it on the lift, but lacked witness of R25 bumping it on the lift or on the table. An undated entry on the investigation form indicated R25 had been witnessed bumping arm on the table. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.	F 225	All skin is observed daily by the NAR and issues reported as soon as practicable to the licensed nurse. Skin is observed weekly and skin condition is documented weekly by a licensed nurse. Alterations are reported immediately to the RN. Non-pressure related bruises and potential injuries will be added to be reviewed during the weekly IDT skin rounds and documented by the RN in the resident chart ongoing. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. All variances in the process and/or reporting will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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F 225	Continued From page 4 R11's significant change MDS dated 1/4/16, indicated R11 had severe cognitive impairment, was sometimes understood and sometimes understood others. R11's MDS further indicated R25 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one assist for wheelchair locomotion, dressing and personal hygiene, had no falls, and no behaviors. R11's Resident Admission Record printed 3/7/16, indicated R11's diagnoses included dementia, severe chronic kidney disease, anemia, and history of falling. R11's CAA for cognitive loss and dementia for assessment date 12/29/15, indicated R11 had a decline in safety awareness which put R11 at risk for disorientation, pain, and decline in function. R11's care plan for safety edited 4/13/15, indicated R11 had a potential for injury related to dementia. R11's care plan directed staff to observe leg positioning when at the table to avoid injury, and to monitor for any unexplained bruises, skin impairments, allegations, or other unexplained injury. Physician's nursing home notes dated 6/30/15, 10/8/15, and 12/3/15, indicated R11 had no skin concerns during any of the visits. A review of nursing progress notes dated 5/1/15 through 5/14/15, did not indicate any incidents involving bruising for R11. A review of nursing progress notes dated 11/7/15 through 11/22/15, did not indicate evidence of incidents involving bruising or injury of unknown origin.	F 225		

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F 225	Continued From page 5	F 225		

R11's skin documentation from 5/1/15 through 5/30/15, lacked documentation of bruising. R11's skin documentation from 11/17/15 through 11/22/15, indicated R11 had bruising on a leg on 11/17/15, at 1:33 p.m.

An incident report dated 5/7/15, at 10:40 a.m. indicated R11 had a purple bruise on the left forearm measuring 9 centimeters (cm) x 12 cm. The Investigation of Injury of Unknown Origin dated 5/7/15, indicated the injury was first noted on 5/6/15 at 11:00 a.m. The investigation form indicated R11 had been attempting to propel the wheelchair through closed double doors and was agitated and was trying to leave. In addition, the investigation indicated R11 did not know the cause of the injury. The investigation form further indicated the investigation was completed and the cause of the injury was determined to be elopement attempts on 5/5/15, as resident had attempted to leave and was getting stuck in between the closed double doors. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

An incident report dated 11/15/15, at 8:00 p.m. indicated R11 had a purple area found to the left inner knee measuring 6 cm x 2 cm. The incident report referred to the investigation. The Investigation of Injury of Unknown Origin dated 11/15/15, indicated R11 did not know what had caused the injury. The investigation form indicated R11 self propelled in the wheelchair and took a daily aspirin. R11's investigation form indicated an investigation was complete, and the determination was that the table legs and arm chairs were at the height for location and nature

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F 225	Continued From page 6 of the bruise and R11 had a history of bumping into things. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation. On 3/7/16, at 11:02 a.m. the DON stated bruises are reported to the DON if they are determined to be suspicious, as determined by size, shape, and location. The DON stated the Investigation of Injury of Unknown Origin form is started, which is used to help the staff determine the cause. If they are unable to determine the cause, the DON stated they would report it to the state agency, but if after the investigation there is a reasonable explanation, the facility would not report it. The DON verified R25's and R11's bruises were investigated first and were determined to not be suspicious, so were not reported. The DON verified they do not track and trend injuries of unknown injury to assist in determination of patterns of injuries. R16's annual MDS dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The MDS further indicated R16 displayed no behaviors directed at self, including physical behaviors such as hitting or scratching her self, and no rejection of care. R16's care plan dated 2/1/16, indicated she was often resistive to cares and picks at her chest to the point of bruising and bleeding under the skin. The care plan further indicated she received aspirin and had fragile	F 225		

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F 225	Continued From page 7 skin that bruised easily. A review of Essentia Health - Northern Pines Care Center Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incident reports related to bruising to R16's body. - 5/29/15, staff noted bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. Staff investigated the incident and determined it was "likely" caused by use of a mechanical lift sling. The injury was not reported to the state agency. - 7/8/15, R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. staff investigated and determined the injury was caused from R16 "picking at her own chest." The injury was not reported to the state agency. - 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. Staff determined the cause of injury was due to "fragile skin" and indicated R16 "often flails arms causing bruising." The injury was not reported to the state agency. - 9/20/15, R16 had a 5 cm x 5 cm purple area to her left cheek. Staff determined the cause of injury as "could potentially be from her glasses." The injury was not reported to the state agency. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. The cause of injury was described as follows: Noted to have a small area of skin missing from center of bruise- and appears [R16] had scraped away. She often picks as skin. The injury was not reported to the state agency. - 10/7/15, staff noted a hematoma on R16's left forearm from her wrist to her upper arm. The cause of injury was noted as "flailing arms during care and in daily propelling." The injury was not	F 225		

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F 225	Continued From page 8 reported to the state agency. - 1/6/16, R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. Staff determined the cause of injury related to R16 picking at her chest. The injury was not reported to the state agency. - 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. The cause of the injury was listed as: she [R16] may have bumped her hand on the door frame. The injury was not reported to the state agency. In each incident report, R16 was described as" unable to answer" how the injuries occurred. On 3/2/16, at 9:53 a.m. the DON stated all incidents including, abuse, falls, bruises or injuries of unknown origin start with an incident form. She stated if the injury is unknown in origin, there is an investigation worksheet that gets filled out by the nurse on duty. She stated if the nurse finds the injury to be suspicious in nature they call and report it to the DON. She stated an example of bruising that is suspicious would be bruising to thighs, face without a fall, or if it looked like fingerprints. The DON did not feel any of R16's bruises were suspicious in nature. During a subsequent interview on 3/3/16, at 12:30 p.m., the DON stated, "We know [R16] really well." The DON further stated R16 "has personality changes if someone is bothering her." On 3/3/16, at 12:38 p.m., registered nurse (RN)-C stated when determining whether a bruise was considered suspicious in nature, staff look at the extent of the bruising and investigate if there was an altercation with another resident, a lab draw, whether the resident was in the facility or whether	F 225		

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F 225	Continued From page 9	F 225		

injury was related to cares. RN-C stated she did not feel any of R16's bruises were suspicious in nature.

On 3/4/16, at 9:30 a.m., nursing assistant (NA)-H stated R16 can be a little resistive to cares. She stated R16 "scoots" around in her chair and may bump her arms on objects. NA-H stated, "I've never really seen her [R16] pick at her upper half."

On 3/4/16, licensed practical nurse (LPN)-C stated R16 is resistive to care at times and will try to swat staff hand away, but had not observed R16 "flailing her arms."

On 3/4/16, at 10:43 a.m. RN-A stated she has noticed R16 will flail her arms when she is agitated. RN-A stated R16's bruises were often due to the "flailing."

Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, and was unable to verbalize how the bruising had occurred, there was no in depth investigation completed to determine the actual cause of R16's bruising. Further, while the administrator was notified of the bruises, none of the injuries of unknown origin were reported immediately to the state agency.

A facility policy labeled Abuse Prevention Program, undated, indicated: "should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source) the nurse supervisor on duty must complete and Investigation of Injuries of

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F 225	Continued From page 10 Unknown Source form. An injury of unknown source is identified as: "the source of the injury was not observed by any person or the source of the injury could not be explained by the resident;" and the injury is suspicious because of , "the extent of the injury;or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time." The policy further indicated when an an injury of unknown source is reportable, the facility administrator or his/her designee will report to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to thoroughly investigate and/or immediately report injuries of unknown origin to the state agency for 3 of 4 residents (R25, R11, R16) who sustained bruises of unknown origin. Findings include: An undated facility policy labeled: Abuse Prevention Program, directed staff to report incidents or suspected incidents of resident	F 226	Element 1 Refer to F225 for specifics. The facility has reviewed, updated and signed its abuse prevention program policy. Policy provides that the facility will immediately report to the State Agency allegations of mistreatment that have the potential to affect all residents according to state and federal guidelines. R25, R11, and R16 have been assessed and care planned for risk factors related to skin alterations and injury of unknown origin.	5/2/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 11 abuse, mistreatment, or injuries of unknown source immediately to the administrator. The policy indicated the administrator or designee would immediately begin an investigation and report to the state agency. The policy further indicated "should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source) the nurse supervisor on duty must complete and Investigation of Injuries of Unknown Source form. An injury of unknown source is identified as: "the source of the injury was not observed by any person or the source of the injury could not be explained by the resident;" and the injury is suspicious because of , "the extent of the injury;or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time." The policy further indicated when an an injury of unknown source is reportable, the facility administrator or his/her designee will report to the state agency. R25's quarterly Minimum Data Set (MDS) dated 1/4/16, indicated R25 had a severe cognitive impairment, was sometimes understood and sometimes understood others, required extensive assist of one with bed mobility, dressing, and personal hygiene, required extensive assist of two with transfers, and required total assistance for wheelchair locomotion. R25's MDS further indicated R25 had no falls. R25's Face Sheet printed 3/7/16, indicated R25's diagnoses included diabetes mellitus, anemia, erythema intertrigo (red rash-like inflammation in the skin folds caused by friction, increased warmth or moisture), dementia and edema	F 226	Element 2 All residents with skin alterations (injuries) that were not observed by any person or the source could not be explained by the resident have been re-assessed and are care planned for risk factors related to non-suspicious, skin alterations in areas that are generally vulnerable to trauma. Other skin alteration that are in areas not vulnerable to trauma and are suspicious by extent, location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated per policy. Element 3 Our policy has been reviewed and updated as necessary and nursing home staff has been educated regarding reporting injuries. In addition, all staff has been educated regarding the facility's abuse prevention policy. Injuries that are not observed by any person or the source could not be explained by the resident and that are in areas that are not generally vulnerable to trauma or because of the location, number, or incidences of injuries over time will be immediately reported to the State Agency and then investigated. The investigation will include, but not be limited to, utilizing the forms provided in our electronic medical record and following the protocol stated in the abuse prevention policy. Element 4 All skin is observed daily by the NAR and issues are brought to the attention of licensed nurses as soon as practicable.	

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F 226	Continued From page 12 (swelling). R25's Care Area Assessment (CAA) for cognitive loss and dementia for assessment date of 9/28/15, indicated R25 was unable to make needs known, had decreased balance with an inability to transfer or walk safely, and was at increased risk for falls. R25's care plan for skin, edited 11/21/15, identified a potential for alteration in skin integrity with edema, skin rashes and irritations, and history of scabs and open areas, though did not address risk of bruising. R25's care plan for psychosocial well-being created 10/22/15, indicated R25 was at risk for being unable to make her needs known, falls, and increased confusion. The goal was for R25 to be safe in the environment. The physician's nursing home visit note dated 12/1/15, indicated R25 was able to speak a few words but unable to answer questions appropriately due to advanced dementia. The physician's documentation indicated staff denied any new skin concerns. The physician's family practice visit note dated 1/4/16, indicated R25 was unable to give verbal responses and had no skin issues. R25's skin documentation dated 12/13/15, indicated R25 had redness on the arm and elbow. R25's skin documentation dated 12/1/15 through 12/12/15, indicated R25's skin was clear and without redness or bruising. An incident report dated 12/13/15, at 10:45 a.m. indicated R25 was noticed to have a red/bruised area on the top of the right arm when gotten up	F 226	Skin is observed weekly or more often as needed by a licensed nurse who will document in the electronic medical record. Alterations are reported immediately to the RN for follow up. Non pressure related bruises and potential injuries will be added to weekly IDT skin rounds and documented by the RN in the resident chart ongoing. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. All variances in the process and/or reporting will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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that morning. The incident report indicated R25 had possibly bumped the arm on a table or lift. The Investigation of Injury of Unknown Origin form dated 12/13/15, indicated R25 had a bruise on the top of the right arm and wrist. The investigation form identified pertinent diagnoses and medical conditions of dementia and dependent transfers. The investigation form indicated the cause of R25's bruise was unable to be determined and R25 was unable to verbalize the cause of the bruise. The investigation form indicated R25 could have bumped it on the lift, but lacked witness of R25 bumping it on the lift or on the table. An undated entry on the investigation form indicated R25 had been witnessed bumping arm on the table. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

R11's significant change MDS dated 1/4/16, indicated R11 had severe cognitive impairment, was sometimes understood and sometimes understood others. R11's MDS further indicated R25 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one assist for wheelchair locomotion, dressing and personal hygiene, had no falls, and no behaviors.

R11's Resident Admission Record printed 3/7/16, indicated R11's diagnoses included dementia, severe chronic kidney disease, anemia, and history of falling.

R11's CAA for cognitive loss and dementia for assessment date 12/29/15, indicated R11 had a decline in safety awareness which put R11 at risk

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F 226	Continued From page 14 for disorientation, pain, and decline in function. R11's care plan for safety edited 4/13/15, indicated R11 had a potential for injury related to dementia. R11's care plan directed staff to observe leg positioning when at the table to avoid injury, and to monitor for any unexplained bruises, skin impairments, allegations, or other unexplained injury. Physician's nursing home notes dated 6/30/15, 10/8/15, and 12/3/15, indicated R11 had no skin concerns during any of the visits. A review of nursing progress notes dated 5/1/15 through 5/14/15, did not indicate any incidents involving bruising for R11. A review of nursing progress notes dated 11/7/15 through 11/22/15, did not indicate evidence of incidents involving bruising or injury of unknown origin. R11's skin documentation from 5/1/15 through 5/30/15, lacked documentation of bruising. R11's skin documentation from 11/17/15 through 11/22/15, indicated R11 had bruising on a leg on 11/17/15, at 1:33 p.m. An incident report dated 5/7/15, at 10:40 a.m. indicated R11 had a purple bruise on the left forearm measuring 9 centimeters (cm) x 12 cm. The Investigation of Injury of Unknown Origin dated 5/7/15, indicated the injury was first noted on 5/6/15 at 11:00 a.m. The investigation form indicated R11 had been attempting to propel the wheelchair through closed double doors and was agitated and was trying to leave. In addition, the investigation indicated R11 did not know the cause of the injury. The investigation form further indicated the investigation was completed and	F 226		

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the cause of the injury was determined to be elopement attempts on 5/5/15, as resident had attempted to leave and was getting stuck in between the closed double doors. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

An incident report dated 11/15/15, at 8:00 p.m. indicated R11 had a purple area found to the left inner knee measuring 6 cm x 2 cm. The incident report referred to the investigation. The Investigation of Injury of Unknown Origin dated 11/15/15, indicated R11 did not know what had caused the injury. The investigation form indicated R11 self propelled in the wheelchair and took a daily aspirin. R11's investigation form indicated an investigation was complete, and the determination was that the table legs and arm chairs were at the height for location and nature of the bruise and R11 had a history of bumping into things. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

On 3/7/16, at 11:02 a.m. the DON stated bruises are reported to the DON if they are determined to be suspicious, as determined by size, shape, and location. The DON stated the Investigation of Injury of Unknown Origin form is started, which is used to help the staff determine the cause. If they are unable to determine the cause, the DON stated they would report it to the state agency, but if after the investigation there is a reasonable explanation, the facility would not report it. The DON verified R25's and R11's bruises were investigated first and were determined to not be suspicious, so were not reported. The DON

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F 226	Continued From page 16 verified they do not track and trend injuries of unknown injury to assist in determination of patterns of injuries. R16's annual MDS dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The MDS further indicated R16 displayed no behaviors directed at self, including physical behaviors such as hitting or scratching her self, and no rejection of care. R16's care plan dated 2/1/16, indicated she was often resistive to cares and picks at her chest to the point of bruising and bleeding under the skin. The care plan further indicated she received aspirin and had fragile skin that bruised easily. A review of Essentia Health - Northern Pines Care Center Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incident reports related to bruising to R16's body. - 5/29/15, staff noted bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. Staff investigated the incident and determined it was "likely" caused by use of a mechanical lift sling. The injury was not reported to the state agency. - 7/8/15, R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. staff investigated and determined the injury was caused from R16 "picking at her own chest." The injury was not reported to the state agency.	F 226		

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F 226	Continued From page 17 - 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. Staff determined the cause of injury was due to "fragile skin" and indicated R16 "often flails arms causing bruising." The injury was not reported to the state agency. - 9/20/15, R16 had a 5 cm x 5 cm purple area to her left cheek. Staff determined the cause of injury as "could potentially be from her glasses." The injury was not reported to the state agency. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. The cause of injury was described as follows: Noted to have a small area of skin missing from center of bruise- and appears [R16] had scraped away. She often picks as skin. The injury was not reported to the state agency. - 10/7/15, staff noted a hematoma on R16's left forearm from her wrist to her upper arm. The cause of injury was noted as "flailing arms during care and in daily propelling." The injury was not reported to the state agency. - 1/6/16, R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. Staff determined the cause of injury related to R16 picking at her chest. The injury was not reported to the state agency. - 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. The cause of the injury was listed as: she [R16] may have bumped her hand on the door frame. The injury was not reported to the state agency. In each incident report, R16 was described as" unable to answer" how the injuries occurred. On 3/2/16, at 9:53 a.m. the DON stated all incidents including, abuse, falls, bruises or	F 226		

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injuries of unknown origin start with an incident form. She stated if the injury is unknown in origin, there is an investigation worksheet that gets filled out by the nurse on duty. She stated if the nurse finds the injury to be suspicious in nature they call and report it to the DON. She stated an example of bruising that is suspicious would be bruising to thighs, face without a fall, or if it looked like fingerprints. The DON did not feel any of R16's bruises were suspicious in nature.

During a subsequent interview on 3/3/16, at 12:30 p.m., the DON stated, "We know [R16] really well." The DON further stated R16 "has personality changes if someone is bothering her."

On 3/3/16, at 12:38 p.m., registered nurse (RN)-C stated when determining whether a bruise was considered suspicious in nature, staff look at the extent of the bruising and investigate if there was an altercation with another resident, a lab draw, whether the resident was in the facility or whether injury was related to cares. RN-C stated she did not feel any of R16's bruises were suspicious in nature.

On 3/4/16, at 9:30 a.m., nursing assistant (NA)-H stated R16 can be a little resistive to cares. She stated R16 "scoots" around in her chair and may bump her arms on objects. NA-H stated, "I've never really seen her [R16] pick at her upper half."

On 3/4/16, licensed practical nurse (LPN)-C stated R16 is resistive to care at times and will try to swat staff hand away, but had not observed R16 "flailing her arms."

On 3/4/16, at 10:43 a.m. RN-A stated she has

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F 226	Continued From page 19 noticed R16 will flail her arms when she is agitated. RN-A stated R16's bruises were often due to the "flailing." Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, and was unable to verbalize how the bruising had occurred, there was no in depth investigation completed to determine the actual cause of R16's bruising. Further, while the administrator was notified of the bruises, none of the injuries of unknown origin were reported immediately to the state agency.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activity engagement for 1 of 3 resident's (R26) reviewed for activities. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was moderately cognitively impaired. His care plan dated 9/3/15, indicated R26 needed to be informed of activities. The care	F 248	Element 1 Resident #26 was re-assessed by the Activity Director/SW to assure his care plan is current and coincides with the resident□s desires. He is reminded of activities that he enjoys and participation is recorded. Staff will encourage Resident #26 to attend the activities he likes and assist him to attend. Element 2	5/2/16

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F 248	Continued From page 20 plan further indicated R26 was a social person who was up and out of his room. The care plan directed staff to go to R26's room, invite and encourage him to attend activities that do not require good hearing or vision, assist with bingo and card bingo. R26's care plan further indicated he enjoyed exercise and going to mass and enjoyed a "cocktail" at 2:05 p.m. daily. His care plan goal was to participate in 1 activity daily, spend 2 days per week outside if weather permitted and join 3-4 exercise classes per week. R26's behavior care plan indicated he "needs to be reminded of activities and daily events several times a day." A facility document titled: Activity Interview Sheet, dated 7/10/12, indicated R26 used to read a lot, played the accordion, sang in the church choir and loved dancing. The document further indicated R26 had a cabin, a vegetable garden, hunted, played cards, and loved dogs. His past professions included social positions requiring significant interaction with others. A nurse practitioner's nursing home progress note dated 10/8/15, indicated, R26 stated he wishes staff would tell him when activities are because he feels like he does not get to go often enough. A review of R26's activity records indicated in 10/15, he participated in games 6 times, music 1 time and a resident group 1 time. During the month of 11/15, R26 participated in sports 7 days, exercise 4 days. In 12/15, R26 participated in games 9 days and exercise 3 days. During the month of 1/16, R26 participated in sports 2 days, and games 6 days, and in 2/16 he participated in games 5 times and exercise 4 times.	F 248	All residents have been re-assessed to ensure that his or her desires regarding activities and care plans have been updated as necessary. All residents receive comprehensive assessment of preferences for customary, routine activities on admission and at least annually thereafter. Care plans are developed, reviewed, and updated quarterly as necessary to be meaningful to each resident. Element 3 Our policy has been reviewed and updated as necessary. Activity, SW and nursing staff have been educated regarding meaningful activity assessment and care planning. Documentation of group and one on one activity is being recorded. Element 4 Each resident'□s activity log will be monitored by DON/designee to assure meaningful activities occur as care planned daily x 7 days, weekly x 3 weeks, monthly x 2 months and quarterly thereafter. DON/designee will audit 5 residents daily for 1 week, then 5 residents weekly for three weeks, then 5 residents monthly for two months, then five residents quarterly ongoing to ensure that they are offered and receiving activities of choice. Variances in the process will be reported to the administrator for immediate follow up and discussed at the QAPI meeting at least quarterly.	

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F 248	Continued From page 21 On 3/1/16, at 1:59 p.m. R26 was sitting in a recliner in his room alone. At 3:33 p.m., he was again observed alone in his room sitting in his recliner. On 3/2/16, at 9:41 a.m. R26 was sitting alone in his room. At 11:48 a.m., he was sitting in his room alone. There was no television, no radio and no independent activity supplies present. On 3/3/16, at 10:05 a.m. a staff led exercise group was occurring in the dining room, R26 was not present. At 2:16 p.m., R26 was sitting in a recliner in his room while his wife was assisting with bingo in the dining room. On 3/3/16, at 2:17 p.m. nursing assistant (NA)-B stated she asked R26 earlier in the day if he wanted to go to bingo. She stated she did not return to offer prior to the activity even though his care plan indicated he required reminders several times per day. On 3/4/16, at 9:26 a.m. R26 was in the dining room participating in a group activity. He was actively engaged, smiling and conversing with staff. At 10:25 a.m., R26 had returned to his room and was sitting alone. On 3/2/16, at 2:17 p.m. activity assistant (AA)-A stated R26 liked to play dice and card bingo. She stated, "Other games, he can't play, so he doesn't enjoy them." AA-A further stated R26 frequently stated "oh, I'm so bored, I'm so bored." During a subsequent interview on 3/3/16, at 10:06 a.m., AA-A stated R26 used to come out of his room a lot. She stated, "About six months ago he started hallucinating a lot, now he doesn't come	F 248		

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F 248	Continued From page 22 out." AA-A further stated R26 makes statements like "I'm bored and I don't feel good." She stated R26 used to love to play the harmonica. She stated the harmonica was broken but no one looked into replacing it. She further stated no activity supplies had been offered to R26 to engage him in his room but stated, "that's a good idea." On 3/3/16, at 10:41 a.m. R26 stated, "Nothing is fun anymore." R26 stated he did a lot of gardening in the past and stated, "I got a lot of my education in the garden working with Mother, " and added, "I don't do any of that here." He said he still did some exercise. He further stated he used to play the harmonica and play the piano but he "can't do that here." On 3/3/16, at 1:17 a.m. family member (FM)-D stated R26 had certain activities he could take part in. She stated if they tell him too early he can't remember and stated, "they are supposed to come and get him, but I don't think they always do." She also stated R26 used to visit with a friend in the facility "all the time," but didn't think staff was offering to take him to see his friend. FM-D further stated, "He gets too little of being around other people." On 3/4/16, at 10:34 a.m. NA-I stated R26 attended games. She stated he enjoyed dice games, shuffle board, bingo and some exercise. She further stated if she went to get him he usually attended. An undated facility policy titled Activities and Social Services, indicated the interdisciplinary team would evaluate the individual's personal history and preferences to identify relevant	F 248		

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F 248	Continued From page 23 recreational activities. The policy further indicated, as much as possible, the facility would provide activities that are compatible with the resident's interests.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R26) reviewed for social services who demonstrated isolative behaviors. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was severely cognitively impaired, required minimal staff assistance for activities of daily living and verbalized indicators of depression which had increased since his last MDS. R26'S PHQ-9 (an instrument used for screening, diagnosing, monitoring, and measuring the severity of depression) score on 8/24/15, was a seven, indicating mild depression. On 11/24/15, R26's PHQ-9 score increased to a 12, indicating moderate depression. The MDS section for mood indicated R26 had indicated "little interest or pleasure in doing things," nearly every day, "Feeling down, depressed or	F 250	Element 1 R26 was re-assessed using the PHQ9 and his care plan was updated to address potential isolative and other behaviors that may be related to depression. Interventions include but are not limited to: large print activity calendar; daily reminders with encouragement to join activities; and, one on one visits when he declines to attend activities outside of his room. A new assessment was performed asking what items are very important to him. We are providing those things he indicated as important to him such as music, pet visits, card bingo and other games he favors. We offer and encourage use of a pocket talker because he refuses hearing aids. Although we have offered the services of a psychologist, which he has declined, we will continue to offer those services. Resident is legally blind and we will continue to offer activities and	5/2/16

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F 250	Continued From page 24 hopeless," nearly every day and "feeling tired or having little energy," nearly every day. A review of resident progress note dated 8/6/15, indicated, "in the month of July [R26] has been in his room and not coming out due to a decline in condition." A note dated 8/21/15, indicated R26 was "keeping to his room most of the day." A note dated 8/26/15, indicated R26 was spending more time in his room. Progress note dated 11/24/15, indicated R26 expressed concern regarding his wife's health and felt he would be getting bad news about her. He stated he felt this was every day. Notes indicated on 1/13/16, R26 was making statements that "he is going to die." On 2/17/16, the notes indicated R26 had "recently begun declining his daily Happy Hour." A note dated 2/21/16, indicated R26 stated, "I keep getting instructions and I don't know if I'm doing good or if I am doing bad." R26's care plan dated 12/19/15, identified, "very poor vision and hearing" and indicated behavioral symptoms related to psychosis. The care plan identified behaviors of inappropriate comments, false accusations, and disrobing. The care plan did not address depression or risk for isolation, even though R26's assessments indicated an increase in signs and symptoms of depression and resident progress notes indicated isolative behaviors. Although the care plan identified R26's legal blindness there were no individualized interventions identified to assist him in engaging with his environment and other people. There were no interventions identified to assist with minimizing the symptoms of psychosis that may have been related to his visual and hearing deficits.	F 250	books with larger print and items such as books on tape. Element 2 We have reviewed all resident's PHQ9 scores and made comparison of the last two assessments. All residents who have a score displaying an increase in depressive symptoms have been reassessed and the care plans were updated as needed to reflect their current state and to implement interventions. We have assessed all residents to determine if the resident has had mood changes, including but not limited to isolative behaviors. Any resident that may have had a mood change has had his or her care plan updated to reflect current interventions and monitoring. Element 3 Protocol was created that addresses mood changes, including but not limited to, observing and reporting isolative behaviors so that interventions can be implemented. Protocol was educated to nursing home staff. A protocol was created to ensure that each new PHQ9 assessment is compared to the previous PHQ9 assessment and interventions are added when needed to reflect increases in depressive symptoms, including but not limited to, isolative behaviors. The protocol has been educated to SW and RNs. Staff has been educated to report mood changes to the RN or SW for follow up and implementations of additional interventions, when appropriate.	

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F 250	Continued From page 25 On 3/1/16, at 12:37 p.m. R26 was up in his room, ambulating to the bathroom. A tray of food was sitting untouched on a table in his room. On 3/1/16, at 1:59 p.m. and 3:33 p.m., R26 was sitting alone in a recliner chair in his room with his eyes closed. On 3/2/15, at 8:03 a.m. R26 was sitting at a tray table in his room. He was eating breakfast alone in the room. At 8:09 a.m., staff entered R26's room and removed his meal tray. R26 was sitting in a recliner. No television present in room, no music playing and no recreational activities present. At 11:48 a.m., R26 continued to sit in a recliner in his room. On 3/3/16, at 8:50 a.m. R26 was sitting alone in his room in a recliner. At 10:05 a.m., staff was leading an exercise group in the large dining room, however, R26 was not present. At 1:17 p.m., family member (FM)-D was present and visiting with R26 in his room. At 2:16 p.m., FM- D was observed assisting with bingo in the large dining room. R26 was sitting in his room alone. On 3/4/16, at 8:35 a.m. R26 was sitting alone in his room eating breakfast. The lights in R26's room were off and the shade was drawn. At 9:26 a.m., R26 was engaged in a dice game in the dining room. He was smiling and interacting with staff. At 10:26 a.m., R26 had returned to his room and was again sitting alone in a recliner. On 3/2/16, at 10:41 a.m. licensed practical nurse (LPN)-C stated R26 does not come out of his room often, "only to be weighed and for exercise once in a while." She further stated a lot of the time he sits in his chair and sleeps.	F 250	Element 4 Adherence to the new protocol will be audited by the DON or designee weekly x 4 weeks on each MDS that is due, monthly x 2 months, and quarterly on going. DON/designee will monitor by completing daily audits on four residents for 1 week, then four residents weekly for two months, then four residents quarterly ongoing. Variances will be reported to the administrator for immediate follow up and reported on at the QAPI meeting at least quarterly.	

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F 250	Continued From page 26 On 3/3/16, at 10:41 a.m. R26 stated, "I'm terrible." R26 indicated he was no longer able to to things for himself that he could in the past. R26 stated, "You can live too long, that's me." He further stated, "Nothing is fun anymore" and "right now I am not clean, I used to be." R26 added, "I ain't what I used to be." On 3/3/16, at 10:08 a.m. activity aide (AA)-A stated R26 used to come out of his room a lot. She stated, "Around six months ago, he started hallucinating and now he doesn't come out." On 3/3/16, at 12:26 p.m., LPN-C stated R26 used to enjoy his happy hour but had been refusing lately. She stated, "He doesn't seem to want to do it anymore." On 3/3/16, at 1:17 p.m. FM- D stated R26 "has slowed down." FM- D stated R26 went through a period of "very bad behavior" last summer. She stated the behaviors improved but said "he has not gotten back to where he was before." FM- D stated R26 is doing less. She stated he used to visit a friend in the facility all the time but was no longer doing that. FM-D stated she did not think staff was offering to take him to see his friend. She further stated R26 gets "too little of being around other people" and "says he [R26] wants to die." On 3/3/16, at 3:05 p.m. licensed social worker (LSW)-A stated R26's mood and behaviors were "pretty much baseline" since his acute psychotic episode last year. She stated when she administered the PHQ-9, R26 responded to the question about having little interest or pleasure in doing things as nearly everyday and indicated it was related to his poor eye sight. She further	F 250		

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F 250	Continued From page 27	F 250		

stated R26 indicated he felt more tired and feeling down. She stated those answers caused his score to increase. The LSW further stated the interdisciplinary team (IDT) looked at R26's medications to see if he was receiving any medications that may be effecting his mood, however, IDT progress notes do not indicate R26's increase in depression had been addressed during the medication review. She further stated the facility had a house psychologist available but she had not referred R26 to the psychologist, and while the LSW indicated one to one visits with R26, there was no evidence the visits had occurred.

During a subsequent interview on 3/4/16, at 1:23 p.m. the LSW stated she had not notified the physician regarding R26's increase in depressive symptoms. She further stated she had not updated R26's care plan in regard to his psychosocial needs.

On 3/4/16, at 1:37 p.m., registered nurse (RN)-A stated R26 used to come out to the dining room for meals and sit with the other men at the table. She stated he stopped coming "around the time when he was having the hallucinations." She stated while the hallucinations have stopped, she was not sure if staff invited R26 out to meals.

A policy titled Social Services, dated June 2005, indicated the facility provides medically-related social services to assure each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well- being. The policy indicated the director of social services was responsible for consultation with other departments regarding programming, consultation to allied professional health

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F 250	Continued From page 28 personnel regarding provisions for the social and emotional needs of the resident, and assistance in meeting the social and emotional needs of the resident. The social services department was further responsible for identifying individual social and emotional needs as well as making supportive visits to the resident.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor bruising for 1 of 4 residents (R16) reviewed for accidents. Findings include: R16's annual minimum data set (MDS) dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The care plan further indicated she received aspirin and had fragile skin that bruised easily. Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, there was	F 309	Element 1 R16, R25, R11and R27 have been assessed for alterations in skin and monitored as needed. Element 2 A baseline audit was performed on all residents which entailed head to toe skin observations by licensed staff. Also, all residents who are not able to accurately explain an how an injury occurred have been care planned for potential abuse. NARs are observing skin for alterations daily during morning care and report findings to licensed staff. Licensed staff are performing head to toe skin observations weekly, skin alterations are	5/2/16

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F 309	Continued From page 29 no evidence of ongoing monitoring of R16's bruising. Nor was there evidence of frequent small bruises that would suggest R16 bruised easily. A review of Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incidents of bruising to R16's body. On 5/29/15 staff documented bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. An incident report dated 7/8/15 indicated R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. On 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. A report dated 9/20/15,indicated R16 had a 5 cm x 5 cm purple area to her left cheek. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. On 10/7/15 staff noted a hematoma on R16's left forearm from her wrist to her upper arm. An incident reported dated 1/6/16 indicated R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. On 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. A physicians Nursing Home progress noted indicated R16 was seen due to staff reports of frequent bruising all over her body. The progress note indicated staff were to monitor bruising, however there was no evidence of monitoring. During an observation on 3/1/16, at 12:30 a.m., R16 was sitting in her wheel chair in a common area of the unit. She was holding a stuffed animal and making nonsensical statements. During an observation on 3/2/16, at 7:27 a.m., R16 was	F 309	reported and documented in the medical record. Alterations such as bruises will be measured/monitored weekly during IDT wound rounds and more often if necessary. Element 3 Our skin protocol has been updated as necessary to include documented weekly skin assessments by a licensed nurse and weekly monitoring of bruises. Element 4 All skin is observed daily by the NAR and issues brought to the licensed nurse as soon as practicable. Skin is observed and documented weekly by a licensed nurse. Alterations are reported immediately to the RN. Non-pressure related bruises and potential injuries will be added to weekly IDT skin rounds and documented by the RN in the resident chart ongoing. The DON/Designee will monitor skin observations weekly to assure accurate monitoring/reporting occur. Variances in this process will be reported to the administrator for immediate follow up and discussed at the QAPI meeting at least quarterly.	

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F 309	Continued From page 30 sitting in a common area of the facility with her eyes closed. During an observation on 3/2/16, at 12:59 p.m., R16 was sitting in a common area in her wheel chair. During an observation on 3/3/16, at 8:48 a.m., R16 was sitting in her wheel chair in a common area of the unit reading a newspaper. During an interview on 3/4/16, at 8:39 a.m., the director of nursing (DON) stated a nurse observed R16's skin at least weekly. She stated there is no follow up done for bruising. The DON stated, "I think the policy says, report if problems." She stated R16 received aspirin daily but had no bleeding disorders. During an interview on 3/4/16, at 9:36 a.m., licensed practical nurse (LPN)-C stated, weekly skin checks should be done on shower day. She stated she had not completed R16's skin check due to her bath being scheduled on the evening shift. An assessment titled Observation Report, dated 2/16/16, indicated character and color of R16's skin was "per usual." A record of R16's weekly skin observation was requested, but none received. A facility policy titled Skin Risk assessment, undated, outlined a procedure to proved for the assessment and identification of resident's at risk for developing skin impairments. The policy directed licensed nurses to conduct skin assessments at least weekly to identify changes.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		5/5/16

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F 323	Continued From page 31 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing assessments to determine causal factors, and implement appropriate interventions in an attempt to prevent falls for 2 of 3 residents (R19, R39) reviewed for accidents. The facility failed to investigate and comprehensively assess resident falls to determine if new interventions could be implemented to prevent falls, which resulted in a significant injury for R83. The facility's failure resulted in an immediate jeopardy (IJ), with serious harm and injury for R83. The immediate jeopardy began on 1/8/16, when R19 fell, was sent to the emergency room and was diagnosed with a fractured clavicle. The facility failed to comprehensively assess and implement interventions to prevent ongoing falls. The administrator and the director of nursing were notified of the IJ for R19 on 3/2/16, at 5:42 p.m. The immediate jeopardy was removed on 3/8/16, at 11:23 a.m. but noncompliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy. Findings include: R19 sustained multiple falls, some with significant	F 323	Element 1 R19 and R39 have been comprehensively assessed. A fall risk score has been determined and interventions have been updated. Both residents' falls have been trended to inform the root cause analysis and interventions were updated. Interventions for R19 include, but are not limited to, elevated head of bed, re-introduce tool chest for activities, scheduled morphine, offering recliner and room adjustments. Element 2 All residents who have fallen in the last 30 days have been comprehensively re-evaluated to determine a fall risk score and interventions have been updated when appropriate. All residents who have 2 or more falls in a 30-day period are being analyzed for trends to further inform the root cause analysis and interventions are updated when appropriate. Element 3 The policy has been updated to reflect current practice, including but not limited to, assessment, pre-fall huddle to prevent falls, pharmacy review, fall scene	

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F 323	Continued From page 32 injury, and the facility failed to comprehensively assess risk factors related to the continued falls. In addition, interventions to prevent falls were not consistently implemented. R19's Admission Record identified diagnoses that included Alzheimer's disease, polymyalgia (muscle pain and weakness), congestive heart failure (CHF), gait and mobility abnormalities, and history of falling. The annual Minimum Data Set (MDS) dated 9/8/15, identified R19 had significant cognitive impairment, had no behavioral issues, required no transfer help or assistance ambulating in his room, was on no toileting plan but occasionally incontinent, and did not ambulate in the hallway. The significant change MDS dated 2/2/16, indicated R19 had severe cognitive impairment, required extensive assistance of two staff with transfers, required extensive assistance of one staff for wheelchair mobility, and did not ambulate. The MDS also indicated R19 had occasional incontinence of bowel and bladder, required extensive assistance of two staff for toileting, and was not on a toileting program. The MDS further identified R19's balance during transfers (moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfers) as not steady, only able to stabilize with assistance. The MDS also identified R19 had falls since the prior assessment, with no injuries. R19's Care Area Assessment (CAA) dated 2/5/16, identified R19 had a hearing deficit, poor balance and a history of falls, with no diuretic or psychotropic medication use. The CAA indicated to follow up with the fall and safety committee, to modify interventions as needed, and to see the care plan for safety interventions. R19's fall risk	F 323	investigation to inform the root cause analysis, interventions, and trending falls. The root cause analysis tool has been updated. The updated policy has been signed and dated. Education has been provided to nursing home staff regarding the policy updates and updated root cause analysis tool. Element 4 All falls will be reviewed by the DON/designee daily/5 days per week ongoing. Each fall will be followed by the IDT at its weekly meeting, or as needed, for 4 weeks ongoing. At each IDT post-fall meeting, the team will review the root cause to ensure it has been appropriately identified and addressed with corresponding interventions and the efficacy of those interventions. This process will continue and variations will be reported to the administrator for immediate follow up and discussed at QAPI meetings at least quarterly.	

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assessment dated 1/31/16, identified R19 was at risk for falls, had 3 or more falls in the last quarter, had a weakened state, and to continue current plan of care. However, the assessments failed to comprehensively assess R19's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions.

R19's care plan dated 12/22/15, identified a goal: R19 will remain free from injury from falls. The care plan identified the following interventions: check frequently after assisting to bed to assure he is settled in and not restless; if restless offer to assist to wheelchair; assure staff is attentive in main dining room during events such as the walk of honor; change wheelchair cushion; if propels near room assess for needs; if he wheels himself to room, assist to lie down or stay with him; redirect him to areas of better supervision; sit/stand lift for transfers; anticipate needs for toileting, rest and intakes; assess pain, reassure and cue; attempt to assist him with a.m. cares and transfer prior to 7:00 a.m. to hinder self-transfers; cue and assist when symptomatic, place in areas of high visibility; offer nightlight, cue for fluids, snacks and toileting when awake at night; regular mattress, bed at standard height, no siderails; keep wheelchair locked at bedside at night; anti-rollbacks on wheelchair; toilet daily at 10:00 a.m., and by 1:30 p.m. and 4:30 p.m. also toilet before bed and upon rising.

Review of R19's fall incident reports since 9/15, indicated the following:

- 9/7/15, at 4:30 a.m. R19 was found on the floor in his room. R19 stated he fell out of bed. R19 sustained a 5 centimeter (cm) x 4 cm red area to

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F 323	Continued From page 34 his right upper forehead and was transported to the emergency room (ER). The ER provider diagnosed R19 with a scalp contusion. New interventions implemented: keep wheelchair locked at bedside as able. An inter-disciplinary team (IDT) meeting was held on 9/8/15, with the following conclusion: will continue to monitor, observe orthostatic blood pressures. On 3/2/16, at 12:58 p.m. registered nurse (RN)-A was interviewed and stated no root cause analysis of the fall had been completed. - 9/24/15, at 11:35 p.m. staff was alerted by roommate that R19 had fallen in his room. Staff indicated the fall was caused by R19 attempting to self-transfer, and only one wheelchair brake was locked. R19 did not sustain an injury. New interventions implemented: continue to check on resident at various times making sure both wheelchair brakes were locked. Remind resident to lock both wheelchair brakes. An IDT meeting was held on 9/14/15, with the following: R19 was functioning at his baseline, he propelled himself in his wheelchair and transferred independently. Attempt keeping wheelchair locked at bedside and cue to toilet at night before sleep. On 3/2/16, at 12:58 p.m. RN-A stated no root cause analysis of the fall had been completed. - 10/20/15, at 12:25 a.m. R19 was in his wheelchair in the hallway when he attempted to stand up, lost his balance and fell. Staff indicated the fall was caused by increased confusion, impulsiveness and attempts to self-transfer. R19 did not sustain an injury. New interventions implemented: none. An IDT meeting was held on 10/26/15, with the following: this recent fall seems to be isolated and	F 323		

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F 323	Continued From page 35 related to acute illness. Res is back to his baseline. On 3/2/16, at 1:11 p.m. RN-A was interviewed and stated the root cause of the fall was isolated and related to R19's acute illness. - 10/27/15, at 10:15 p.m. staff witnessed R19 attempt to stand up and walk into another resident's room "to go to bed" when he went to sit back down on his wheelchair and fell. Staff indicated the fall was caused by attempting to go to bed, restless movements. No injury. New interventions implemented: anti-rollbacks to wheelchair. An IDT meeting was held on 10/27/15, with the following: witnessed fall in hallway was attempting to stand up and walk into another resident's room to go to bed went to sit on wheelchair and landed on floor. On 3/2/16, at 1:20 p.m. RN-C stated the root cause analysis of the fall was completed; and it was determined R19 had an acute condition that resulted in weakness. - 10/28/15, at 8:40 a.m. R19 was found face down on the floor of his room. Staff indicated the fall was caused by urgency of bowel movement. R19 sustained a head contusion, was transported to the ER, and was diagnosed with a scalp hematoma and pneumonia. New interventions implemented: none. An IDT meeting was held 12 days later on 11/9/16, with the following: R19 was screened by therapy and orders received for physical therapy (PT) 3 times a week to improve transfers, standing and ambulation with walker. Continue to follow up as needed. On 3/2/16, at 1:25 p.m. RN-A stated the root cause analysis of the fall had not been completed. - 1/8/16, at 7:20 a.m. R19 was found on the floor	F 323		

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F 323	Continued From page 36 in his room. Staff indicated the fall was caused by weakness secondary to pleural effusion (a buildup of fluid between the tissues that line the lungs and chest). R19 was transported to the ER, where he was diagnosed with a fracture of the right clavicle (collarbone). New interventions implemented: rearranged furniture in room. An IDT meeting was held on 1/8/16, and a review of the fall was completed, but no conclusion. On 3/2/16, at 1:35 p.m. RN-C was interviewed and stated the root cause analysis of the fall was completed with the conclusion R19 fell because he gets acute respiratory issues and he falls. - 1/11/16, at 3:50 p.m. R19 was found on the floor in his room. R19 stated he was moving his car out of the way. R19 did not sustain an injury. New interventions implemented: none. - 1/11/16, at 6:30 p.m. R19 was found on the floor in his room. Staff indicated the fall was caused by R19 trying to transfer self to bed and slid off of the bed to the floor. No injury. New interventions implemented: assess pain, reassure and cue. - 1/12/16, at 11:40 p.m. R19 was found on the floor in his room. Staff indicated the fall was caused by resident attempting to self-transfer out of bed. R19's right hand was bleeding, he had a laceration to the 5th finger, and he was transported to the ER. The ER record indicated R19 received sutures to the right 5th finger. New interventions implemented: consider room design changes. An IDT meeting was held on 1/12/16, reviewing the falls of 1/11/16, and 1/12/16, with the following: will have physical therapy (PT) and occupational therapy (OT) screen for transfers in room, adjustment to room layout may need to be	F 323		

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F 323	Continued From page 37 made, and will have pharmacy perform a medication review. On 3/2/16, at 1:45 p.m. RN-C verified a root cause analysis was not completed. - 1/30/16, at 8:00 p.m. R19 was found on the floor of his bathroom. R19 did not sustain an injury. Staff indicated the fall was caused by a general decline. R19 did not sustain an injury. New interventions implemented: attempt to assist to recliner or bed after supper, use sit/stand lift for transfers. An IDT meeting was held on 2/1/16, with the following: R19 has had a general decline in condition and was now enrolled in hospice. He was more sleepy and interacted less. He was on a scheduled toileting plan. Staff to anticipate needs and offer toileting and rest periods at frequent intervals. If he seemed restless offer food, fluids, rest and toileting. May need to go to bed earlier in the evening or relax in the recliner. On 3/2/16, at 1:49 p.m. RN-C stated R19 got weak, short of breath and didn't know what to do. RN-A stated the scheduled toileting plan didn't work, and now staff just asked him if he needed to go to the bathroom. -2/4/16, at 10:30 a.m. R19 was found on the floor in his room. No injury. Staff indicated the fall was caused by impulsiveness, resident believed he was capable of transfers. New interventions implemented: continue to keep in area of high visibility and check/redirect frequently. An IDT meeting was held 5 days later on 2/9/16, with the following: staff have been redirecting him with success that morning was impulsive, thought he was capable to rise on his own and shouldn't be alone in room without staff nearby to view him. Very alert that day compared to others. Try not to leave him alone in room, stay with him or redirect to area of supervision and visibility. On 3/2/16, at	F 323		

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F 323	Continued From page 38 1:54 p.m. RN-A verified there was no root cause analysis of the fall. - 2/14/16, at 8:40 p.m. R19 was found on the floor in his room. R19 sustained a small excoriation on his left buttock. Staff had not indicated what the fall was caused by. New interventions implemented: bed in lowest position, call light within reach. - 2/16/16, 2:00 p.m. R19 was in the dining room, sleeping in his wheelchair, when he slid out of the wheelchair and landed on the floor. R19 did not sustain an injury. Staff indicated the fall was caused by sleeping in the wheelchair. New interventions implemented: wheelchair cushion to offer more support at front of seat. An IDT meeting was held 8 and 6 days later on 2/22/16, reviewing the falls for 2/14/16, and 2/16/16, with the following:wheelchair cushion changed for better positioning and decided to have staff in the dining room during special events. On 3/2/16, at 2:19 p.m. RN-A verified there was not root cause analysis for either fall. - 2/26/16, at 5:40 a.m. R19 was found on the floor in his room. R19 stated the bed slipped. Staff indicated the fall was caused by self-transfer. R19 sustained a laceration to the left eyebrow, and was transported to the ER. The ER record indicated the laceration was treated with steri-strips. New interventions implemented: 1:1 when restless. An IDT meeting was held on 3/1/16, with the following: Staff to be aware to check frequently after assisting to bed to assure he is settled in and not restless. On 3/2/16, at 2:20 p.m. RN-A verified no root cause analysis of the fall was completed.	F 323		

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F 323	Continued From page 39 On 3/2/16, at 7:21 a.m. R19 was observed in his room. Nursing assistant (NA)-E was providing personal cares for R19, who was sitting on the side of his bed. At 7:23 a.m. NA-E told R19 she was going to leave the room to get the transfer lift. NA-E left the room, and shut the door, leaving R19 sitting on the side of the bed unattended. At 7:25 a.m. NA-E returned to the room, used the stand assist lift to transfer R19 into his wheelchair. NA-E stated R19 had a lot of falls. When asked what interventions were in place to prevent falls, NA-E stated the staff was supposed to keep an eye on him; see where he was at. NA-E stated R19 was not on a toileting program, he was supposed to have assistance to the bathroom, but R19 was quick, and they helped him if they noticed him going into the bathroom, he shouldn't be in there alone. On 3/2/16, at 8:26 a.m. R19 was observed alone in his room, propelling himself in his wheelchair. On 3/12/16, at 11:50 a.m. R19 was observed alone in his room. On 3/2/16, at 12:26 p.m. R19 was observed alone in his room, going through his top dresser drawer. On 3/2/16, at 1:05 p.m. R19 was observed in the dining room, sleeping in his wheelchair. There was no staff in the area monitoring R19 in the dining room. On 3/2/16, at 11:48 a.m. activity director (AD)-A stated R19 did not come out for activities. R19 doesn't participate much in activities. R19 liked visiting with others so staff did 1:1 visits with him, but there were no specific activities for him. R19 had a book about his experience as a veteran he	F 323		

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F 323	Continued From page 40 enjoyed looking at, however, family took that home. R19 was a mechanic and liked to "tinker with stuff." AD-A stated it would be nice to get an engine or something for R19 to work on but she was not sure where they would put it. On 3/3/16, at 8:25 a.m. NA-A stated R19's fall interventions included looking in on him if passing his room and if alone in his room try and get him out or stay with him. However, now he was on a 1:1 and staff has been toileting him more often. NA-A acknowledged R19 was "quick". On 3/3/16, at 8:32 a.m. NA-C stated interventions for R19 included safety checks, toileting him according to his schedule, ambulation to "get rid of excess energy," distract him - talk about World War II. NA-C acknowledged not being on the schedule for the last 8 days so was unaware of any changes in the plan of care for R19. On 3/3/16, at 10:40 a.m. NA-B stated fall interventions for R19 included looking in on him whenever staff walked by, offer coffee and ice cream, going to the gathering place. NA-B stated R19 had a 1:1 right now and she didn't believe the toileting plan had changed. On 3/2/16, at 5:15 p.m. licensed practical nurse (LPN)-A stated R19 was to be toileted every 2 hours, but he didn't always agree to go. Staff was to check on him often, leave the call light within reach and remind him to use it, try not to leave R19 alone in his room, and offer a nap. LPN-A stated R19 really didn't use the call light but staff still needed to remind him to use it. On 3/2/16, at approximately 3:00 p.m. the director of nursing (DON) was interviewed. The DON	F 323		

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F 323	Continued From page 41 stated the facility completed a post-fall huddle immediately after each fall, and immediate interventions were put into place. The DON also stated an IDT meeting was held at least weekly, and falls were reviewed at that time. During this meeting, a root cause analysis was completed on each fall. The immediate jeopardy that began on 1/8/16, was removed on 3/8/16, when the facility implemented the following interventions to minimize the risk of falls for R19: 1:1 supervision with removal plan Activities to provide interesting mechanic type tinkering toys Attempt positioning in recliner for comfort Coordinate with Hospice for fall prevention and volunteer 1:1 Extra bed removed from room to decrease clutter Wider bed to be delivered 3/9/16 Head of bed raised 30 degrees Morphine at bedtime Offer to sit on edge of bed and use urinal, or offer to toilet Provide an afternoon nap Transfer with one staff and contact guard assist When he appeared restless or attempting to stand ask if he was hungry, thirsty or needed to use the bathroom Use short understandable language to evoke yes or no answers Attempt to anticipate his basic needs and keep him comfortable However, noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy because R19 had	F 323		

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F 323	Continued From page 42 3 falls that resulted in injuries requiring medical intervention: a fractured clavicle, a laceration of the finger requiring sutures, and a laceration of the head requiring steri-strips,which identified him to be at high risk for significant injury. R39 had 12 falls in the past 6 months, and the facility failed to comprehensively assess and implement appropriate interventions to minimize the risk for ongoing falls. R39's Admission Record identified diagnoses that included dementia, dizziness, gait and mobility abnormalities, rheumatoid arthritis in right hip, and right hip and knee pain. The quarterly MDS dated 1/19/16, indicated R39 had severe cognitive impairment, required standby assistance of 1 staff for transfers, was independent with ambulation in his room, and required standby assistance of 1 staff for ambulation in the hallway. The MDS also indicated R39 was always continent of bowel and bladder, and was independent with toileting (with staff supervision/cues). The MDS further identified R39's balance during transfers (moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfers) was not steady, but able to stabilize without assistance. R39's CAA dated 8/19/15, identified R39 was at risk for falls, and had physical limitations such as weakness, limited range of motion, poor coordination and poor balance. The fall risk assessment dated 1/18/16, indicated R39 was at risk for falls, and had three or more falls in the	F 323		

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F 323	Continued From page 43 previous three months. R39's care plan dated 8/10/15, identified a goal: R39 will remain free from injury. The care plan identified the following interventions: remind him to use his walker and keep it next to him; once tucked into bed for the evening check on him often to cue him until asleep; keep call light within reach; keep pathways free of obstacles; gripper socks/bare feet when in bed; and non-skid footwear while up. Review of R39's fall incident reports since 9/15, indicated the following: - 9/22/15, at 4:10 p.m. R39 stated he had fallen when coming out of his bathroom, and had gotten himself up off the floor. R39 sustained a skin tear to his left elbow. New interventions implemented: add a toilet riser to toilet in bathroom. On 3/7/16, at 10:32 a.m. RN-C was interviewed and stated no root cause analysis of the fall had been completed. - 10/16/15, at 3:40 p.m. R39 stated had fallen when he came out of the bathroom, and had gotten himself up off the floor. R39 did not sustain an injury. New interventions implemented: monitor bowel movements, encourage him to use the call light. On 3/7/16, at 10:34 a.m. RN-C was interviewed and stated no root cause analysis of the fall had been completed. - 11/10/15, at 12:45 p.m. R39 stated he fell in his room, and had gotten himself up off the floor. R39 did not sustain an injury. New interventions implemented: bedside commode. On 3/7/16, at 10:36 a.m. RN-C verified no root cause analysis of the fall was done.	F 323		

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F 323	Continued From page 44 - 11/10/15, at 2:00 p.m. R39 was found sitting between the bed and the dresser in his room. R39 stated he had needed to go to the bathroom. R39 did not sustain an injury. New interventions implemented: R39 was given a stool softener. On 3/7/16, at 10:37 a.m. RN-C stated the root cause analysis for the fall was R39 had a suppository earlier that morning and had become dizzy. - 11/12/15, at 11:00 a.m. R39 was standing outside of his room only wearing his shirt. Staff asked if he was all right, and R39 stated he had fallen in the bathroom during an incontinent episode. R39 did not sustain any injury. New interventions implemented: room rearranged and commode placed in room. On 3/7/16, at 10:39 a.m. RN-C was interviewed and verified no root cause analysis of the fall was done. - 11/24/15, at 8:10 p.m.: R39 was standing in doorway of his room when he lost his balance and fell backward onto floor. R39 did not sustain an injury. New interventions implemented: none. On 3/7/16, at 10:41 a.m. RN-C verified no root cause analysis of the fall was done. - 12/26/15, at 9:30 a.m. R39 was walking down the hallway and stated he needed help. R39 stated he had fallen in his room, and gotten himself up. No injury. New interventions implemented: remind to use call light for assistance. On 3/7/16, at 10:44 a.m. RN-C verified no root cause analysis of the fall was done. - 12/28/15, at 5:30 p.m. R39 was ambulating in the hallway when he lost his balance and fell. R39 sustained lacerations and required a trip to the	F 323		

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F 323	Continued From page 45 ER (medical record lacked description of the injury). New interventions implemented: R39 was told to walk slower. On 3/7/16, at 10:48 a.m. RN-C stated the root cause analysis of the fall was gastroenteritis. - 1/30/16, at 5:50 p.m. R39 fell in his room. No injury. New interventions implemented: none. On 3/7/16, at 10:50 a.m. RN-B was interviewed and stated R39 was given a walker to use. RN-B stated no root cause analysis of the fall was done. - 2/3/16, at 1:30 p.m. R39 found in room, sitting next to his bed. R39 did not sustain an injury. New interventions implemented: comprehensive pain assessment. On 3/7/16, at 10:55 a.m. RN-C verified no root cause analysis of the fall was done. - 2/6/16, at 4:00 p.m. R39 was found on the floor in his room. R39 sustained a 3 cm skin tear to his left elbow. New interventions implemented: R39 was given a wheelchair to use until he could be re-evaluated. On 3/7/16, at 10:57 a.m. RN-C stated R39 had not been using his walker at the time, and was given a wheelchair, but only used for one day. RN-C verified no root cause analysis of the fall was done. - 2/6/16, at 6:30 p.m. R39 was found on floor in his room. R39 sustained contusions (medical record lacked description of the contusions) and was treated in the ER. New interventions implemented: resident will be in recliner at gathering place to ensure safety. On 3/7/16, at 10:59 a.m. RN-C was interviewed and verified a root cause analysis of the fall was not done. On 3/1/16, at 1:58 p.m. R39 was observed ambulating in the hall, using a walker.	F 323		

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	245469	A. BUILDING _____ B. WING _____	03/08/2016

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F 323	Continued From page 46 On 3/2/16, at approximately 3:00 p.m. the DON was interviewed. The DON stated the facility completes a post-fall huddle immediately after each fall, and immediate interventions are put into place. The DON also stated an IDT meeting is held at least weekly, and falls are reviewed at that time. During this meeting, a root cause analysis is completed on each fall. The clinical record lacked a comprehensive reassessment of R39's risk for falls. The undated facility policy and procedure on Fall Prevention, directed at the point of a fall, a fall scene investigation will be completed to determine the root cause of each fall. The licensed staff will put an immediate intervention in place to prevent further fall.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		5/2/16

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F 329	Continued From page 47 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monitoring for adverse side effects of antipsychotic medication and nursing orders were followed by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: R23 was not assessed for tardive dyskinesia (adverse side effects related to the use of antipsychotic medication) after starting an antipsychotic medication. In addition, nursing orders were not followed as directed to monitor, recheck and report to the nurse practitioner (NP) pulses over 100. The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The annual Minimum Data Set (MDS) dated 12/9/15, indicated R23 had severe cognitive impairment. R23 did not have any behaviors, delirium, psychosis or change in behavior	F 329	Element 1 R23□s pulse was taken and found to be in normal limits and her parameter order was changed. R23 was assessed for Tardive Dyskinesia and found to have no symptoms. Element 2 A baseline audit was performed of all residents who take antipsychotic medications and AIMs assessments are current. Parameters have been set for all residents vital signs to alert and trigger on the Matrix dashboard. Element 3 The AIMS policy was updated and educated to the psychotropic IDT (SW, RNs, and Pharmacist). Policy includes, but is not limited to, screening and repeat screening of residents, testing using the AIMS scale, and notifying provider of changes in the AIMS score. A protocol has been implemented to set vital sign parameters for each resident and an alert is set to follow up with provider. Element 4 The psychotropic IDT will review need for	

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F 329	Continued From page 48 symptoms. R23 needed assistance with activities of daily living (ADL's) and received an antidepressant and antipsychotic seven of the seven days during the assessment period. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106. 2/19/16, pulse of 105. 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. R23 was observed on 2/29/16, at supper, 3/1/16, from 1:15 p.m. to 1:30 p.m. and on 3/2/16, from 7:15 a.m. to 8:30 a.m. R23 did not exhibit any signs or symptoms of tardive dyskinesia, pain, discomfort, paranoia, psychosis or hallucinations.	F 329	AIMs assessments per policy weekly ongoing. An RN will audit Matrix dashboard daily for vital signs that are out of set parameter and follow up as necessary. Variances will be reported to the administrator for immediate follow up and reviewed at the QAPI meeting at least quarterly.	

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F 329	Continued From page 49 On 3/3/16, at 9:30 a.m. registered nurse (RN)-A stated she tried to do tardive dyskinesia monitoring quarterly but believed it was to be done every six months. RN-A verified R23's AIMS was done last on 2/28/15, with no further assessments since that date. On 3/3/16, at 9:35 a.m. RN-C stated the order to recheck the pulse and notify the NP was added on 12/10/14. The RN stated she believed it was a nursing order. RN-C verified the medical record lacked a recheck and notification of the pulse when greater than 100 to the NP. On 3/3/16, at 9:40 a.m. the NP stated R23 had medication changes and a history of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) which intermittently went in and out but had been stable. The NP further stated she was not worried about the pulse until it was 120 or 130. The NP stated she would expect staff to check for tardive dyskinesia per the facility's protocol. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first dose of the medication. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. On 3/4/16, at 11:10 a.m. RN-A stated the instructions to monitor apical pulse with blood pressures and update the NP if the pulse was greater than 100 after a recheck of the pulse was	F 329		

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F 329	Continued From page 50 for the medication nurses when checking the blood pressure prior to giving the antihypertensive medication. The RN stated the nursing assistants (NA) should be rechecking the pulse and or telling the nurse when R23's pulse was greater than 100. On 3/4/16, at 11:15 a.m. licensed practical nurse (LPN)-B stated after the NAs obtain the vital signs the NAs give the vital sign results to the nurse to document in the medical record. The LPN stated she was not aware of any pulses greater than 100 for R23. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to ensure monitoring for adverse side effects of	F 428	Element 1 The Pharmacist consultant has reviewed R23□s Aims and vital signs and found her	5/2/16

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F 428	Continued From page 51 antipsychotic medication and nursing orders by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106. 2/19/16, pulse of 105.	F 428	to have no symptoms. Element 2 The pharmacist consultant has reviewed all residents who take antipsychotic medications and AIMs assessments are current. The consultant has also reviewed vital sign parameters and the alert system. Element 3 The pharmacy consultant reviewed his contract obligations. The AIMS policy was updated to provide, including but not limited to, screens and repeat screens, using the AIMS scale test and notifying the provider of any changes. Policy also provides that the pharmacist consultant will audit monthly to ensure completion of the AIMS assessments. The policy was educated to the psychotropic IDT (SW, RNs, and Pharmacist). A protocol has been implemented to set vital sign parameters for each resident and an alert is set to follow up with provider. Element 4 The psychotropic (Includes pharmacist) IDT will review need for AIMs assessments per policy weekly ongoing. The Pharmacy consultant will review vital sign parameters to the DON monthly. Variances will be reported to the administrator for immediate follow up and reviewed at the QAPI meeting at least quarterly.	

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F 428	Continued From page 52 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. The consultant pharmacist's Resident Progress Notes for the pharmacist's monthly review of R23's medications in the months of 10/15 through 2/16 lacked evidence of recommendations to assess R23 for antipsychotic medications adverse side effects. In addition, there was no recommendation to recheck and notify the NP when R23's pulse was greater than 100. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first dose of the medication. The pharmacist stated he did not monitor if a tardive dyskinesia assessment had been completed because they were typically done. The pharmacist further stated he would not look for R23's pulses and notification to the NP because it was a day to day nursing order. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none. The Facility's Consultant Pharmacist Services Provider Requirements policy dated 8/6/12, indicated the consultant pharmacist would check and identify one or more current medication	F 428		

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F 428	Continued From page 53 references to facilitate the identification of medications and information on contraindications, side effects and or adverse side effects, dosage levels and other pertinent information.	F 428		

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	245469	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshla Division. At the time of this survey Essentia Health Northern Pine C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/07/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Essentia Northern Pines C & NC is a 1-story building with no basement. The original building was constructed in 1959, with an addition in 1970. Both buildings are of the same type construction, Type II (111). therefore the facility was inspected as one building. The nursing home is properly 2 hour fire separated from the attached hospital. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD	K 017		4/25/16

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K 017 SS=D	Continued From page 2 Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 8 of 32 residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:30 PM to 2:30 PM on 03/02/2016, observations revealed, that there was a 2 inch corner missing from a ceiling tile outside of the surgery waiting area; and there is a 2 1/2 inch hole in the ceiling outside of room 354. This deficient condition was verified by a Maintenance Supervisor.	K 017	K017 1. Correction: a. The 2 hole near the surgery waiting area was patched and caulked. b. A cover plate was installed over the 2 ¿ inch hole in the ceiling outside of room 354. 2. Completion Date: a. March 4, 2016 b. March 4, 2016 3. Person Responsible: Seth Mitchell, Facilities Manager, is responsible for the correction and monitoring to ensure that the corridors properly resist the passage of smoke.	

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ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	**5211 HIGHWAY 110** **AURORA, MN 55705**

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities 8 of 32 residents, staff and visitors. Findings include: On facility tour between 10:30 PM to 2:30 PM on 03/02/2016, observation revealed that the following deficient conditions were found affecting the facility's hazardous storage areas: 1. the utility room 419 had opening around the sprinkler pipes, and the door was not self-closing; and 2. the soiled utility room 219 was not equipped with a door closer and did not positivity latch into the frame.	K 029	1. Correction: a. Escutcheon rings installed on sprinkler pipes in the utility room 419 and a new door closer was installed. b. A door closer was installed in soiled utility room 219 and the door latch was adjusted. 2. Completion Date: a. March 18, 2016 b. March 31, 2016 3. Person Responsible: Seth Mitchell, Facilities Manager, is responsible for the correction and monitoring to ensure that the one hour fire construction is maintained.	4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2016**

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K 029	Continued From page 4 This deficient condition was verified by a Maintenance Supervisor.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 PM to 2:30 PM on 03/02/2016, observations reveled that there are two different type of heads located in the 400 wing. The sprinkler head that is located outside of resident room 407 was found to be a standard response sprinkler head and the rest of the sprinkler heads located in the corridor were quick response sprinkler heads.	K 056	1. Correction: The sprinkler head outside of resident room 407 was replaced with a quick response head by Viking Sprinkler. 2. Completion Date: April 5, 2016 3. Person Responsible: Seth Mitchell, Facilities Manager, is responsible for the correction and monitoring to ensure that the automatic sprinkler system is installed and maintained correctly	4/25/16

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K 056	Continued From page 5 This deficient condition was verified by a Maintenance Supervisor.	K 056		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 10:30 PM to 2:30 PM on 03/02/2016, it was found in that the facility was storing a wheeled soiled linen bin that was greater than 32 gallons in the corridors and spaces open to the corridor and not in the required hazardous storage areas. This deficient condition was verified by a Maintenance Supervisor.	K 075	1. Correction: The soiled linen collection receptacles have been replaced with soiled linen collection receptacles that are not over 32 gallons. 2. Completion Date: April 25, 2016 3. Person Responsible: Seth Mitchell, Facilities Manager, is responsible for the correction and monitoring to ensure that the receptacle capacity of 32 gallons is not exceeded with any 64 square foot area.	4/25/16
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		4/25/16

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K 076 SS=D	Continued From page 6 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:30 PM to 2:30 PM on 03/02/2016, observations revealed that there was a penetration above the door to the corridor around the sprinkler pipe. This deficient condition was verified by a Maintenance Supervisor.	K 076	1. Correction: Escutcheon ring was installed on sprinkler pipe in oxygen room 202. 2. Completion Date: March 18, 2016 3. Person Responsible: Seth Mitchell, Facilities Manager, is responsible for the correction and monitoring to ensure that the oxygen storage locations are protected with a one-hour separation.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 31, 2016

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5469026

Dear Ms. Ackman:

The above facility was surveyed on February 29, 2016 through March 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact one of the following:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: pam.kerssen@state.mn.us
Phone: (218) 308-2129
Fax: (218) 308-2122

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00604	A. BUILDING: _____ B. WING _____	03/08/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 29,through March 8, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor bruising for 1 of 4 residents (R16) reviewed for accidents. Findings include: R16's annual minimum data set (MDS) dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The care plan further indicated she received aspirin and had fragile skin that bruised easily.	2 830	Corrected	4/25/16

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2 830	Continued From page 3 Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, there was no evidence of ongoing monitoring of R16's bruising. Nor was there evidence of frequent small bruises that would suggest R16 bruised easily. A review of Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incidents of bruising to R16's body. On 5/29/15 staff documented bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. An incident report dated 7/8/15 indicated R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. On 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. A report dated 9/20/15,indicated R16 had a 5 cm x 5 cm purple area to her left cheek. An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. On 10/7/15 staff noted a hematoma on R16's left forearm from her wrist to her upper arm. An incident reported dated 1/6/16 indicated R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. On 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. A physicians Nursing Home progress noted indicated R16 was seen due to staff reports of frequent bruising all over her body. The progress note indicated staff were to monitor bruising, however there was no evidence of monitoring. During an observation on 3/1/16, at 12:30 a.m., R16 was sitting in her wheel chair in a common	2 830		

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2 830	Continued From page 4 area of the unit. She was holding a stuffed animal and making nonsensical statements. During an observation on 3/2/16, at 7:27 a.m., R16 was sitting in a common area of the facility with her eyes closed. During an observation on 3/2/16, at 12:59 p.m., R16 was sitting in a common area in her wheel chair. During an observation on 3/3/16, at 8:48 a.m., R16 was sitting in her wheel chair in a common area of the unit reading a newspaper. During an interview on 3/4/16, at 8:39 a.m., the director of nursing (DON) stated a nurse observed R16's skin at least weekly. She stated there is no follow up done for bruising. The DON stated, "I think the policy says, report if problems." She stated R16 received aspirin daily but had no bleeding disorders. During an interview on 3/4/16, at 9:36 a.m., licensed practical nurse (LPN)-C stated, weekly skin checks should be done on shower day. She stated she had not completed R16's skin check due to her bath being scheduled on the evening shift. An assessment titled Observation Report, dated 2/16/16, indicated character and color of R16's skin was "per usual." A record of R16's weekly skin observation was requested, but none received. A facility policy titled Skin Risk assessment, undated, outlined a procedure to proved for the assessment and identification of resident's at risk for developing skin impairments. The policy directed licensed nurses to conduct skin assessments at least weekly to identify changes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could	2 830		

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2 830	Continued From page 5 develop, review, and/or revise policies and procedures to ensure skin conditions are monitored for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		4/25/16

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21426	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure Tuberculin testing was provided for 1 of 5 residents (R20) upon admission. Findings include: R20 was admitted to the facility on 12/28/15. The medical record lacked evidence of skin or blood testing for tuberculosis (TB). On 3/6/16, at 9:00 a.m. registered nurse (RN)-A and the director of nursing (DON) stated all staff and residents were tested for TB using the QuantiFeron TB blood test. At 9:40 a.m. RN-A verified R20's QuantiFeron TB test had not been done. The staff member who had done the symptom screening was not the staff who usually did it. RN-A stated the health unit coordinator (HUC) put the order in per the facility's standing orders. The facility's electronic computer system cued staff to do the symptom screening and the blood test. A TB Risk Assessment Tool (not dated) indicated persons with any risk factors should be tested for TB infection unless there is written documentation of previous positive results. The assessment tool indicated R20 was a high risk due to living in a congregate setting such as a long term facility. The policy/guidelines were requested on 3/6/16, at 9:40 a.m. the DON stated there was not one and the facility followed the standing orders. The facility's Standing Orders amended 11/20/12, indicated latent (TB bacteria is present in the body but there are no symptoms) TB infection screening on admission per the facility's	21426	Corrected	

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21426	Continued From page 7 guidelines. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents and staff have appropriate documentation of Mantoux results according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activity engagement for 1 of 3 resident's (R26)	21435	Corrected	4/25/16

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ESSENTIA HEALTH NORTHERN PINES MEDIC	5211 HIGHWAY 110 AURORA, MN 55705

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21435	Continued From page 8 reviewed for activities. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was moderately cognitively impaired. His care plan dated 9/3/15, indicated R26 needed to be informed of activities. The care plan further indicated R26 was a social person who was up and out of his room. The care plan directed staff to go to R26's room, invite and encourage him to attend activities that do not require good hearing or vision, assist with bingo and card bingo. R26's care plan further indicated he enjoyed exercise and going to mass and enjoyed a "cocktail" at 2:05 p.m. daily. His care plan goal was to participate in 1 activity daily, spend 2 days per week outside if weather permitted and join 3-4 exercise classes per week. R26's behavior care plan indicated he "needs to be reminded of activities and daily events several times a day." A facility document titled: Activity Interview Sheet, dated 7/10/12, indicated R26 used to read a lot, played the accordion, sang in the church choir and loved dancing. The document further indicated R26 had a cabin, a vegetable garden, hunted, played cards, and loved dogs. His past professions included social positions requiring significant interaction with others. A nurse practitioner's nursing home progress note dated 10/8/15, indicated, R26 stated he wishes staff would tell him when activities are because he feels like he does not get to go often enough. A review of R26's activity records indicated in 10/15, he participated in games 6 times, music 1 time and a resident group 1 time. During the	21435		

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month of 11/15, R26 participated in sports 7 days, exercise 4 days. In 12/15, R26 participated in games 9 days and exercise 3 days. During the month of 1/16, R26 participated in sports 2 days, and games 6 days, and in 2/16 he participated in games 5 times and exercise 4 times.

On 3/1/16, at 1:59 p.m. R26 was sitting in a recliner in his room alone. At 3:33 p.m., he was again observed alone in his room sitting in his recliner.

On 3/2/16, at 9:41 a.m. R26 was sitting alone in his room. At 11:48 a.m., he was sitting in his room alone. There was no television, no radio and no independent activity supplies present.

On 3/3/16, at 10:05 a.m. a staff led exercise group was occurring in the dining room, R26 was not present. At 2:16 p.m., R26 was sitting in a recliner in his room while his wife was assisting with bingo in the dining room.

On 3/3/16, at 2:17 p.m. nursing assistant (NA)-B stated she asked R26 earlier in the day if he wanted to go to bingo. She stated she did not return to offer prior to the activity even though his care plan indicated he required reminders several times per day.

On 3/4/16, at 9:26 a.m. R26 was in the dining room participating in a group activity. He was actively engaged, smiling and conversing with staff. At 10:25 a.m., R26 had returned to his room and was sitting alone.

On 3/2/16, at 2:17 p.m. activity assistant (AA)-A stated R26 liked to play dice and card bingo. She stated, "Other games, he can't play, so he doesn't enjoy them." AA-A further stated R26 frequently

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21435	Continued From page 10 stated "oh, I'm so bored, I'm so bored." During a subsequent interview on 3/3/16, at 10:06 a.m., AA-A stated R26 used to come out of his room a lot. She stated, "About six months ago he started hallucinating a lot, now he doesn't come out." AA-A further stated R26 makes statements like "I'm bored and I don't feel good." She stated R26 used to love to play the harmonica. She stated the harmonica was broken but no one looked into replacing it. She further stated no activity supplies had been offered to R26 to engage him in his room but stated, "that's a good idea." On 3/3/16, at 10:41 a.m. R26 stated, "Nothing is fun anymore." R26 stated he did a lot of gardening in the past and stated, "I got a lot of my education in the garden working with Mother, " and added, "I don't do any of that here." He said he still did some exercise. He further stated he used to play the harmonica and play the piano but he "can't do that here." On 3/3/16, at 1:17 a.m. family member (FM)-D stated R26 had certain activities he could take part in. She stated if they tell him too early he can't remember and stated, "they are supposed to come and get him, but I don't think they always do." She also stated R26 used to visit with a friend in the facility "all the time," but didn't think staff was offering to take him to see his friend. FM-D further stated, "He gets too little of being around other people." On 3/4/16, at 10:34 a.m. NA-I stated R26 attended games. She stated he enjoyed dice games, shuffle board, bingo and some exercise. She further stated if she went to get him he usually attended.	21435		

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21435	Continued From page 11 An undated facility policy titled Activities and Social Services, indicated the interdisciplinary team would evaluate the individual's personal history and preferences to identify relevant recreational activities. The policy further indicated, as much as possible, the facility would provide activities that are compatible with the resident's interests. SUGGESTED METHOD OF CORRECTION: The Activity Director or designee could develop, review, and/or revise policies and procedures to ensure resident's have an indivdualized activity program that meets their needs. The Activity Director or designee could educate all appropriate staff on the policies and procedures. The Activity Director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced	21475		4/25/16

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21475	Continued From page 12 by: Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R26) reviewed for social services who demonstrated isolative behaviors. Findings include: R26's quarterly minimum data set (MDS) dated 11/24/15, indicated he was severely cognitively impaired, required minimal staff assistance for activities of daily living and verbalized indicators of depression which had increased since his last MDS. R26'S PHQ-9 (an instrument used for screening, diagnosing, monitoring, and measuring the severity of depression) score on 8/24/15, was a seven, indicating mild depression. On 11/24/15, R26's PHQ-9 score increased to a 12, indicating moderate depression. The MDS section for mood indicated R26 had indicated "little interest or pleasure in doing things," nearly every day, "Feeling down, depressed or hopeless," nearly every day and "feeling tired or having little energy," nearly every day. A review of resident progress note dated 8/6/15, indicated, "in the month of July [R26] has been in his room and not coming out due to a decline in condition." A note dated 8/21/15, indicated R26 was "keeping to his room most of the day." A note dated 8/26/15, indicated R26 was spending more time in his room. Progress note dated 11/24/15, indicated R26 expressed concern regarding his wife's health and felt he would be getting bad news about her. He stated he felt this was every day. Notes indicated on 1/13/16, R26 was making statements that "he is going to die." On 2/17/16, the notes indicated R26 had "recently begun declining his daily Happy Hour." A	21475	Corrected	

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note dated 2/21/16, indicated R26 stated, "I keep getting instructions and I don't know if I'm doing good or if I am doing bad."

R26's care plan dated 12/19/15, identified, "very poor vision and hearing" and indicated behavioral symptoms related to psychosis. The care plan identified behaviors of inappropriate comments, false accusations, and disrobing. The care plan did not address depression or risk for isolation, even though R26's assessments indicated an increase in signs and symptoms of depression and resident progress notes indicated isolative behaviors. Although the care plan identified R26's legal blindness there were no individualized interventions identified to assist him in engaging with his environment and other people. There were no interventions identified to assist with minimizing the symptoms of psychosis that may have been related to his visual and hearing deficits.

On 3/1/16, at 12:37 p.m. R26 was up in his room, ambulating to the bathroom. A tray of food was sitting untouched on a table in his room. On 3/1/16, at 1:59 p.m. and 3:33 p.m., R26 was sitting alone in a recliner chair in his room with his eyes closed.

On 3/2/15, at 8:03 a.m. R26 was sitting at a tray table in his room. He was eating breakfast alone in the room. At 8:09 a.m., staff entered R26's room and removed his meal tray. R26 was sitting in a recliner. No television present in room, no music playing and no recreational activities present. At 11:48 a.m., R26 continued to sit in a recliner in his room.

On 3/3/16, at 8:50 a.m. R26 was sitting alone in his room in a recliner. At 10:05 a.m., staff was

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21475	Continued From page 14 leading an exercise group in the large dining room, however, R26 was not present. At 1:17 p.m., family member (FM)-D was present and visiting with R26 in his room. At 2:16 p.m., FM- D was observed assisting with bingo in the large dining room. R26 was sitting in his room alone. On 3/4/16, at 8:35 a.m. R26 was sitting alone in his room eating breakfast. The lights in R26's room were off and the shade was drawn. At 9:26 a.m., R26 was engaged in a dice game in the dining room. He was smiling and interacting with staff. At 10:26 a.m., R26 had returned to his room and was again sitting alone in a recliner. On 3/2/16, at 10:41 a.m. licensed practical nurse (LPN)-C stated R26 does not come out of his room often, "only to be weighed and for exercise once in a while." She further stated a lot of the time he sits in his chair and sleeps. On 3/3/16, at 10:41 a.m. R26 stated, "I'm terrible." R26 indicated he was no longer able to to things for himself that he could in the past. R26 stated, "You can live too long, that's me." He further stated, "Nothing is fun anymore" and "right now I am not clean, I used to be." R26 added, "I ain't what I used to be." On 3/3/16, at 10:08 a.m. activity aide (AA)-A stated R26 used to come out of his room a lot. She stated, "Around six months ago, he started hallucinating and now he doesn't come out." On 3/3/16, at 12:26 p.m., LPN-C stated R26 used to enjoy his happy hour but had been refusing lately. She stated, "He doesn't seem to want to do it anymore." On 3/3/16, at 1:17 p.m. FM- D stated R26 "has	21475		

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21475	Continued From page 15	21475		

slowed down." FM- D stated R26 went through a period of "very bad behavior" last summer. She stated the behaviors improved but said "he has not gotten back to where he was before." FM- D stated R26 is doing less. She stated he used to visit a friend in the facility all the time but was no longer doing that. FM-D stated she did not think staff was offering to take him to see his friend. She further stated R26 gets "too little of being around other people" and "says he [R26] wants to die."

On 3/3/16, at 3:05 p.m. licensed social worker (LSW)-A stated R26's mood and behaviors were "pretty much baseline" since his acute psychotic episode last year. She stated when she administered the PHQ-9, R26 responded to the question about having little interest or pleasure in doing things as nearly everyday and indicated it was related to his poor eye sight. She further stated R26 indicated he felt more tired and feeling down. She stated those answers caused his score to increase. The LSW further stated the interdisciplinary team (IDT) looked at R26's medications to see if he was receiving any medications that may be effecting his mood, however, IDT progress notes do not indicate R26's increase in depression had been addressed during the medication review. She further stated the facility had a house psychologist available but she had not referred R26 to the psychologist, and while the LSW indicated one to one visits with R26, there was no evidence the visits had occurred.

During a subsequent interview on 3/4/16, at 1:23 p.m. the LSW stated she had not notified the physician regarding R26's increase in depressive symptoms. She further stated she had not updated R26's care plan in regard to his

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21475	Continued From page 16 psychosocial needs. On 3/4/16, at 1:37 p.m., registered nurse (RN)-A stated R26 used to come out to the dining room for meals and sit with the other men at the table. She stated he stopped coming "around the time when he was having the hallucinations." She stated while the hallucinations have stopped, she was not sure if staff invited R26 out to meals. A policy titled Social Services, dated June 2005, indicated the facility provides medically-related social services to assure each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well- being. The policy indicated the director of social services was responsible for consultation with other departments regarding programming, consultation to allied professional health personnel regarding provisions for the social and emotional needs of the resident, and assistance in meeting the social and emotional needs of the resident. The social services department was further responsible for identifying individual social and emotional needs as well as making supportive visits to the resident. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality	21475		

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21475	Continued From page 17 Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending	21530		4/25/16

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21530	Continued From page 18 physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to ensure monitoring for adverse side effects of antipsychotic medication and nursing orders by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100	21530	Corrected	

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21530	Continued From page 19 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106. 2/19/16, pulse of 105. 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. The consultant pharmacist's Resident Progress Notes for the pharmacist's monthly review of R23's medications in the months of 10/15 through 2/16 lacked evidence of recommendations to assess R23 for antipsychotic medications adverse side effects. In addition, there was no recommendation to recheck and notify the NP when R23's pulse was greater than 100. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first dose of the medication. The pharmacist stated he did not monitor if a tardive dyskinesia assessment had been completed because they were typically done. The pharmacist further stated he would not look for R23's pulses and notification to the NP because it was a day to day nursing order. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be	21530		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 20 done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none. The Facility's Consultant Pharmacist Services Provider Requirements policy dated 8/6/12, indicated the consultant pharmacist would check and identify one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and or adverse side effects, dosage levels and other pertinent information. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist monitors and reports irregularities in resident's medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing	21540		4/25/16

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	00604	A. BUILDING: _____ B. WING _____	03/08/2016

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21540	Continued From page 21 home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monitoring for adverse side effects of antipsychotic medication and nursing orders were followed by monitoring and reporting elevated pulses for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: R23 was not assessed for tardive dyskinesia (adverse side effects related to the use of antipsychotic medication) after starting an antipsychotic medication. In addition, nursing orders were not followed as directed to monitor, recheck and report to the nurse practitioner (NP) pulses over 100.	21540	Corrected	

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21540	Continued From page 22 The Resident Admission Record dated 3/3/16, indicated R23's diagnoses included delusional disorder, dysthymic disorder, hypertension, atrial fibrillation, cerebrovascular disease, chronic pain, unspecified psychosis not due to substance or unknown physiological condition and orthostatic hypotension. The annual Minimum Data Set (MDS) dated 12/9/15, indicated R23 had severe cognitive impairment. R23 did not have any behaviors, delirium, psychosis or change in behavior symptoms. R23 needed assistance with activities of daily living (ADL's) and received an antidepressant and antipsychotic seven of the seven days during the assessment period. The Physician's Order History from 9/3/15 to 3/3/16, indicated the physician ordered Zyprexa (an antipsychotic) 2.5 milligrams (mg) every day at bedtime on 10/8/15 for psychosis. On 10/13/15, the physician increased the Zyprexa to 5 mg every day at bedtime. An Administration History dated 3/3/16, indicated special instructions to monitor R23's apical pulse with blood pressures and update the nurse practitioner (NP) if the pulse was greater than 100 after a recheck of the pulse. An Abnormal Involuntary Movement Scale (AIMS, a tool used to assess for tardive dyskinesia) was completed on 2/28/15. The medical record lacked any further assessment for adverse side effects prior to or after starting the Zyprexa. The Vitals Results from 1/1/16, to 3/7/16, indicated R23 had a pulse greater than 100 on the following days: 1/23/16, pulse of 106.	21540		

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21540	Continued From page 23 2/19/16, pulse of 105. 2/24/16, pulse of 101. The medical record lacked evidence of a recheck of the pulse or notification of the NP when the pulse was greater than 100. R23 was observed on 2/29/16, at supper, 3/1/16, from 1:15 p.m. to 1:30 p.m. and on 3/2/16, from 7:15 a.m. to 8:30 a.m. R23 did not exhibit any signs or symptoms of tardive dyskinesia, pain, discomfort, paranoia, psychosis or hallucinations. On 3/3/16, at 9:30 a.m. registered nurse (RN)-A stated she tried to do tardive dyskinesia monitoring quarterly but believed it was to be done every six months. RN-A verified R23's AIMS was done last on 2/28/15, with no further assessments since that date. On 3/3/16, at 9:35 a.m. RN-C stated the order to recheck the pulse and notify the NP was added on 12/10/14. The RN stated she believed it was a nursing order. RN-C verified the medical record lacked a recheck and notification of the pulse when greater than 100 to the NP. On 3/3/16, at 9:40 a.m. the NP stated R23 had medication changes and a history of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) which intermittently went in and out but had been stable. The NP further stated she was not worried about the pulse until it was 120 or 130. The NP stated she would expect staff to check for tardive dyskinesia per the facility's protocol. On 3/3/16, at 12:30 p.m. the consultant pharmacist stated he would expect an assessment for tardive dyskinesia after a resident started an antipsychotic medication because adverse side effects can show up after the first	21540		

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21540	Continued From page 24 dose of the medication. On 3/3/16, at 1:00 p.m. the DON stated she would expect tardive dyskinesia monitoring to be done every six months. The DON verified R23's AIMS was not done after starting the Zyprexa. On 3/4/16, at 11:10 a.m. RN-A stated the instructions to monitor apical pulse with blood pressures and update the NP if the pulse was greater than 100 after a recheck of the pulse was for the medication nurses when checking the blood pressure prior to giving the antihypertensive medication. The RN stated the nursing assistants (NA) should be rechecking the pulse and or telling the nurse when R23's pulse was greater than 100. On 3/4/16, at 11:15 a.m. licensed practical nurse (LPN)-B stated after the NAs obtain the vital signs the NAs give the vital sign results to the nurse to document in the medical record. The LPN stated she was not aware of any pulses greater than 100 for R23. A policy for completing assessment for antipsychotic adverse side effects and following nursing orders was requested and was informed there was none. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's medications are monitored. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21540		

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21540	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	21980		4/25/16

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21980	Continued From page 26 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure injuries of unknown origin were thoroughly investigated and/or immediately reported to the state agency prior to an investigation for 3 of 4 residents (R25, R11, R16) who sustained bruises of unknown origin. Findings include: R25's quarterly Minimum Data Set (MDS) dated 1/4/16, indicated R25 had a severe cognitive impairment, was sometimes understood and sometimes understood others, required extensive assist of one with bed mobility, dressing, and personal hygiene, required extensive assist of two with transfers, and required total assistance for wheelchair locomotion. R25's MDS further indicated R25 had no falls. R25's Face Sheet printed 3/7/16, indicated R25's diagnoses included diabetes mellitus, anemia,	21980	Corrected	

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erythema intertrigo (red rash-like inflammation in the skin folds caused by friction, increased warmth or moisture), dementia and edema (swelling).

R25's Care Area Assessment (CAA) for cognitive loss and dementia for assessment date of 9/28/15, indicated R25 was unable to make needs known, had decreased balance with an inability to transfer or walk safely, and was at increased risk for falls.

R25's care plan for skin, edited 11/21/15, identified a potential for alteration in skin integrity with edema, skin rashes and irritations, and history of scabs and open areas, though did not address risk of bruising. R25's care plan for psychosocial well-being created 10/22/15, indicated R25 was at risk for being unable to make her needs known, falls, and increased confusion. The goal was for R25 to be safe in the environment.

The physician's nursing home visit note dated 12/1/15, indicated R25 was able to speak a few words but unable to answer questions appropriately due to advanced dementia. The physician's documentation indicated staff denied any new skin concerns. The physician's family practice visit note dated 1/4/16, indicated R25 was unable to give verbal responses and had no skin issues.

R25's skin documentation dated 12/13/15, indicated R25 had redness on the arm and elbow. R25's skin documentation dated 12/1/15 through 12/12/15, indicated R25's skin was clear and without redness or bruising.

An incident report dated 12/13/15, at 10:45 a.m.

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indicated R25 was noticed to have a red/bruised area on the top of the right arm when gotten up that morning. The incident report indicated R25 had possibly bumped the arm on a table or lift. The Investigation of Injury of Unknown Origin form dated 12/13/15, indicated R25 had a bruise on the top of the right arm and wrist. The investigation form identified pertinent diagnoses and medical conditions of dementia and dependent transfers. The investigation form indicated the cause of R25's bruise was unable to be determined and R25 was unable to verbalize the cause of the bruise. The investigation form indicated R25 could have bumped it on the lift, but lacked witness of R25 bumping it on the lift or on the table. An undated entry on the investigation form indicated R25 had been witnessed bumping arm on the table. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

R11's significant change MDS dated 1/4/16, indicated R11 had severe cognitive impairment, was sometimes understood and sometimes understood others. R11's MDS further indicated R25 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one assist for wheelchair locomotion, dressing and personal hygiene, had no falls, and no behaviors.

R11's Resident Admission Record printed 3/7/16, indicated R11's diagnoses included dementia, severe chronic kidney disease, anemia, and history of falling.

R11's CAA for cognitive loss and dementia for assessment date 12/29/15, indicated R11 had a

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decline in safety awareness which put R11 at risk for disorientation, pain, and decline in function.

R11's care plan for safety edited 4/13/15, indicated R11 had a potential for injury related to dementia. R11's care plan directed staff to observe leg positioning when at the table to avoid injury, and to monitor for any unexplained bruises, skin impairments, allegations, or other unexplained injury.

Physician's nursing home notes dated 6/30/15, 10/8/15, and 12/3/15, indicated R11 had no skin concerns during any of the visits.

A review of nursing progress notes dated 5/1/15 through 5/14/15, did not indicate any incidents involving bruising for R11. A review of nursing progress notes dated 11/7/15 through 11/22/15, did not indicate evidence of incidents involving bruising or injury of unknown origin.

R11's skin documentation from 5/1/15 through 5/30/15, lacked documentation of bruising. R11's skin documentation from 11/17/15 through 11/22/15, indicated R11 had bruising on a leg on 11/17/15, at 1:33 p.m.

An incident report dated 5/7/15, at 10:40 a.m. indicated R11 had a purple bruise on the left forearm measuring 9 centimeters (cm) x 12 cm. The Investigation of Injury of Unknown Origin dated 5/7/15, indicated the injury was first noted on 5/6/15 at 11:00 a.m. The investigation form indicated R11 had been attempting to propel the wheelchair through closed double doors and was agitated and was trying to leave. In addition, the investigation indicated R11 did not know the cause of the injury. The investigation form further indicated the investigation was completed and

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the cause of the injury was determined to be elopement attempts on 5/5/15, as resident had attempted to leave and was getting stuck in between the closed double doors. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

An incident report dated 11/15/15, at 8:00 p.m. indicated R11 had a purple area found to the left inner knee measuring 6 cm x 2 cm. The incident report referred to the investigation. The Investigation of Injury of Unknown Origin dated 11/15/15, indicated R11 did not know what had caused the injury. The investigation form indicated R11 self propelled in the wheelchair and took a daily aspirin. R11's investigation form indicated an investigation was complete, and the determination was that the table legs and arm chairs were at the height for location and nature of the bruise and R11 had a history of bumping into things. The incident report and injury of unknown origin investigation form lacked notification of the state agency of the injury of unknown origin prior to investigation.

On 3/7/16, at 11:02 a.m. the DON stated bruises are reported to the DON if they are determined to be suspicious, as determined by size, shape, and location. The DON stated the Investigation of Injury of Unknown Origin form is started, which is used to help the staff determine the cause. If they are unable to determine the cause, the DON stated they would report it to the state agency, but if after the investigation there is a reasonable explanation, the facility would not report it. The DON verified R25's and R11's bruises were investigated first and were determined to not be suspicious, so were not reported. The DON verified they do not track and trend injuries of

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21980	Continued From page 31 unknown injury to assist in determination of patterns of injuries. R16's annual MDS dated 12/15/15 indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. The MDS further indicated R16 displayed no behaviors directed at self, including physical behaviors such as hitting or scratching her self, and no rejection of care. R16's care plan dated 2/1/16, indicated she was often resistive to cares and picks at her chest to the point of bruising and bleeding under the skin. The care plan further indicated she received aspirin and had fragile skin that bruised easily. A review of Essentia Health - Northern Pines Care Center Incident/Accident Reports dated 5/29/15 to 2/21/16, indicated several incident reports related to bruising to R16's body. - 5/29/15, staff noted bruising to R16's upper left chest measuring 1/2 centimeter (cm) x 1.5 cm. Staff investigated the incident and determined it was "likely" caused by use of a mechanical lift sling. The injury was not reported to the state agency. - 7/8/15, R16 had a blood blister on her chest measuring approximately 4 cm x 2 cm. staff investigated and determined the injury was caused from R16 "picking at her own chest." The injury was not reported to the state agency. - 7/26/15, staff noted a 5.5 cm x 4 cm bruise to R16's right arm near her elbow. Staff determined the cause of injury was due to "fragile skin" and indicated R16 "often flails arms causing bruising." The injury was not reported to the state agency. - 9/20/15, R16 had a 5 cm x 5 cm purple area to her left cheek. Staff determined the cause of injury as "could potentially be from her glasses." The injury was not reported to the state agency.	21980		

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21980	Continued From page 32 An incident report dated 10/2/15 indicated staff found a "purple, reddened bruise noted to lower left side of neck extending into area of left upper chest." The area measured 26 cm x 11 cm. The cause of injury was described as follows: Noted to have a small area of skin missing from center of bruise- and appears [R16] had scraped away. She often picks as skin. The injury was not reported to the state agency. - 10/7/15, staff noted a hematoma on R16's left forearm from her wrist to her upper arm. The cause of injury was noted as "flailing arms during care and in daily propelling." The injury was not reported to the state agency. - 1/6/16, R16 had a pink/purple discoloration to her mid chest measuring 7 cm x 5 cm. Staff determined the cause of injury related to R16 picking at her chest. The injury was not reported to the state agency. - 2/21/16, staff reported a "large" bruise on the top of R16's right hand. The bruise measured 9 cm x 9 cm. The cause of the injury was listed as: she [R16] may have bumped her hand on the door frame. The injury was not reported to the state agency. In each incident report, R16 was described as" unable to answer" how the injuries occurred. On 3/2/16, at 9:53 a.m. the DON stated all incidents including, abuse, falls, bruises or injuries of unknown origin start with an incident form. She stated if the injury is unknown in origin, there is an investigation worksheet that gets filled out by the nurse on duty. She stated if the nurse finds the injury to be suspicious in nature they call and report it to the DON. She stated an example of bruising that is suspicious would be bruising to thighs, face without a fall, or if it looked like fingerprints. The DON did not feel any of R16's bruises were suspicious in nature.	21980		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 33 During a subsequent interview on 3/3/16, at 12:30 p.m., the DON stated, "We know [R16] really well." The DON further stated R16 "has personality changes if someone is bothering her." On 3/3/16, at 12:38 p.m., registered nurse (RN)-C stated when determining whether a bruise was considered suspicious in nature, staff look at the extent of the bruising and investigate if there was an altercation with another resident, a lab draw, whether the resident was in the facility or whether injury was related to cares. RN-C stated she did not feel any of R16's bruises were suspicious in nature. On 3/4/16, at 9:30 a.m., nursing assistant (NA)-H stated R16 can be a little resistive to cares. She stated R16 "scoots" around in her chair and may bump her arms on objects. NA-H stated, "I've never really seen her [R16] pick at her upper half." On 3/4/16, licensed practical nurse (LPN)-C stated R16 is resistive to care at times and will try to swat staff hand away, but had not observed R16 "flailing her arms." On 3/4/16, at 10:43 a.m. RN-A stated she has noticed R16 will flail her arms when she is agitated. RN-A stated R16's bruises were often due to the "flailing." Although R16 was identified to be moderately cognitively impaired, and had a pattern of bruises on her neck and chest area, as well as other large bruises on her upper extremities, and was unable to verbalize how the bruising had occurred, there was no in depth investigation completed to determine the actual cause of R16's	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00604	A. BUILDING: _____ B. WING _____	03/08/2016

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21980	Continued From page 34	21980		

bruising. Further, while the administrator was notified of the bruises, none of the injuries of unknown origin were reported immediately to the state agency.

A facility policy labeled Abuse Prevention Program, undated, indicated: "should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source) the nurse supervisor on duty must complete and Investigation of Injuries of Unknown Source form. An injury of unknown source is identified as: "the source of the injury was not observed by any person or the source of the injury could not be explained by the resident;" and the injury is suspicious because of , "the extent of the injury;or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time." The policy further indicated when an an injury of unknown source is reportable, the facility administrator or his/her designee will report to the state agency.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/neglect/injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.

TIME PERIOD FOR CORRECTION: Fourteen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 35 (14) days.	21980		