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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y3L4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**
2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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 **09/02/2015** (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)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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 :
Yvonne Switajewski, HFE NEII 09/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/21/2015 (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
12/30/1991
(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.
00400
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/06/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5535

On September 2nd and 3rd, 2015, the Minnesota Department of Health's, Licensing and Certification Program and Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on August 31, 2014 the Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 26, 2015 and an abbreviated standard survey (complaint Iinvestigation number H5535011) completed on July 8, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of August 12, 2015. Based on our PCR, we have determined that the has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2015 and an abbreviated standard survey completed on July 8, 2015, as of September 3, 2015. As a result of the revisit finds, this Department discontinued the Category 1 remedy of State monitoring.

In addition, we recommended the following remedy to the CMS Region V Office. CMS concurred and had authorized this Department to notify the facility of the imposition:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DPNA) effective September 26, 2015 be rescinded. (42 CFR 488.417 (b))

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP, beginning September 26, 2015.

Refer to the CMS 2567b forms for the results of the revisit.

Effective September 3, 2015 the facility is certified for 47 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245535

October 21, 2015

Ms. Yaneque Walker, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

Dear Ms. Walker:

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 September 3, 2015 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2015

Ms. Yaneque Walker, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535026, H5535011

Dear Ms. Walker:

On July 21, 2015, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective July 26, 2015. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 26, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of July 21, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 26, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on June 26, 2015 and an abbreviated standard survey completed on July 8, 2015. The surveys found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 2nd and 3rd, 2015, the Minnesota Department of Health's, Licensing and Certification Program and Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on August 31, 2014 the Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 26, 2015 and an abbreviated standard survey completed on July 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2015 and an abbreviated standard survey completed on July 8, 2015, as of September 3, 2015.

As a result of the PCR findings, this Department discontinued the following Category 1 remedy of State monitoring as of September 3, 2015.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of July 21, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 26, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 26, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 26, 2015, is to be rescinded.

In our letter of July 21, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 26, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 3, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	9/2/2015

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/05/2015**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **08/05/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/05/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/05/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **08/05/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	09/10/2015	18619	09/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	9/2/2015

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0365** Reg. # **483.35(d)(3)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **08/05/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/05/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/05/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **08/05/2015**

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/26/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing **01 - NURSING HOME**	8/31/2015

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0067	**08/05/2015**	ID Prefix Reg. # **NFPA 101** LSC K0154	**07/16/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	**07/16/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GS/mm	**Date:** 09/10/2015	**Signature of Surveyor:** 27200	**Date:** 08/31/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/23/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Electronically delivered
July 21, 2015

Ms Norma Brendle, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535026, H5535011

Dear Ms. Brendle:

On July 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 26, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 8, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed an abbreviated standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The abbreviated standard survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

As a result of our finding that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

- State Monitoring effective July 26, 2015. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 26, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 26, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 26, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Jourdain Perpich Extended Care Facility is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 26, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the **standard survey completed June 26, 2015**), i.e., the plan of correction should be directed to:

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

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from **the abbreviated standard survey completed July 8, 2015**), i.e., the plan of correction should be directed to:

Sarah Grebenc, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
Sarah.grebenc@state.mn.us

Phone: (651) 201-4135
Fax: (651) 281-9796

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Office of Health Facility Complaints 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 PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 26, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 electronic 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals

Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: Y3L4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245535**
2.STATE VENDOR OR MEDICAID NO.
(L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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 **06/26/2015** (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)
12/31

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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 :
Vienna Andresen, HFE NEII 08/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/04/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
12/30/1991
(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.
00400
(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 5535

On June 26, 2015 a standard survey was completed at this facility, The most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 8, 2015, an abbreviated standard survey (Complaint Investigation Number H5535011) was completed at this facility. The most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), where by corrections were required.

As a result of our finidng that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

- State Monitoring effective July 26, 2015. (42 CFR 488.422)

In addition, we recommended the following remedy to the CMS Region V Office. CMS concurred and had authorized this Department to notify the facility of the imposition:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DPNA) effective September 26, 2015. (42 CFR 488.417 (b))

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP, beginning September 26, 2015.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1720

July 14, 2015

Ms. Norma Brendle, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, Minnesota 56671

RE: Project Number S5535026

Dear Ms. Brendle:

On June 26, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 5, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 26, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

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

Enclosure

cc: Licensing and Certification File

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

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F000 Preparation, submission and implementation of this plan of correction does not constitute admission or, or agreement with, the facts and conclusions in the statement of deficiencies. This plan of correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable federal regulatory requirements, and it constitutes the facility's allegation of compliance.	
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159	F159 Jourdain Perpich Extended Care Center, hereafter called, JPECC, has developed a policy and procedure to hold, safeguard, manage and account for the personal funds of the resident that are deposited with JPECC. Quarterly statements will be distributed or mailed depending on the responsible party status of each resident. Interest is added monthly. Reports for the quarter ending June Approved w/ Addendum SB 7/29/15 See next page	7/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ~~Electronically Signed~~ Irma J Brundle | TITLE: Interim Administrator | (X6) DATE: 7-22-1

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.

RECEIVED
JUL 23 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24855 HOSPITAL DRIVE REDLAKE, MN 56671

(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
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F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159	F159 Jourdain Perpich Extended Care Center, hereafter called, JPECC, has developed a policy and procedure to hold, safeguard, manage and account for the personal funds of the resident that are deposited with JPECC. Quarterly statements will be distributed or mailed depending on the responsible party status of each resident. Interest is added monthly. Reports for the quarter ending June Approved See next page	7/10/15 SB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
~~Electronically Signed~~ Irma J Brindle	Interim Administrator	7-22-15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to make quarterly statements of the resident fund accounts available to residents and/or their legal representative for 4 of 4 residents (R2, R30, R31, R12) reviewed who had a resident account managed by the facility. Findings include: R2 was interviewed on 6/22/2015, at 12:51 p.m. and stated he thought someone was taking money from his resident trust account.	F 159	30 were distributed or mailed July 10. An audit of five residents to verify receipt of the quarterly statements has been completed. Future statements will be distributed on or about October 1st, January 1st, April 1st, and July 1st The administrator or designee is responsible to assure that statements are distributed and mailed. The audit of the July 10, 2015 distribution will be reported to Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 159	Continued From page 2 On 6/26/15, at 3:45 p.m. the Office Manager (OM) stated that quarterly statements of resident personal funds were not provided to any resident. The OM stated she provided the residents statements of their personal funds account activity only when requested, but quarterly statements of individual personal funds were not provided, as required. An accounting of R2's personal funds account had been reviewed from 3/2/15-6/26/15, when all deposits and withdrawals were reviewed and there were no personal funds missing. An accounting of R30's personal funds account had been reviewed from 3/2/15-6/26/15, when all deposits and withdrawals were reviewed and there were no personal funds missing. However, R30 had not been provided quarterly statements of all personal funds activity. An accounting of R31's personal funds account had been reviewed from 3/2/15-6/26/15, when all deposits and withdrawals were reviewed. It was noted that R31's personal funds account was not accurate and the account was missing $20.00 dollars that could not be accounted for by a receipt showing a withdrawal of $20.00. Additionally, R31 or their personal representative had not been provided quarterly statements of all personal funds activity. An accounting of R12's personal funds account had been reviewed from 3/2/15-6/26/15, when all deposits and withdrawals were reviewed. It was noted that R12's personal funds account was not accurate and the account was off by $20.00 dollars. R12 had withdrew $20.00 on 6/4/15, that had not been deducted from his personal fund	F 159		

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F 159	Continued From page 3 account. Additionally, R12 or their personal representative had not been provided a quarterly statement of all personal funds activity. The Administrator was interviewed on 6/26/15, at 4:00 p.m. during which she confirmed that all residents' or their representatives should have received quarterly statements of personal funds activity and verified the facility had not been providing any of the residents or their representatives quarterly personal funds statements. The Administrator also confirmed that R31's personal fund account was missing $20.00 dollars. The Administrator was again interviewed on 6/26/15, at 4:30 p.m. and stated that the error in R31's personal fund account had been found and explained that R31, and R12 had the same last name and $20.00 dollars had been deducted from the wrong resident personal fund and stated R31 was reimbursed the $20.00 dollars that was missing from the account. The Administrator stated the facility managed personal funds for 32 residents and confirmed the facility did not have a policy or procedure related to providing quarterly statements of resident personal funds.	F 159		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164	See next page	

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F 164	Continued From page 4 does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during personal cares for 1 of 6 resident's (R32) in the sample observed during personal care. Findings include: R32's quarterly Minimum Data Set (MDS) assessment, dated 3/21/15, indicated R32 had intact cognition, a physical functioning deficit related to self-care and mobility impairments and required extensive assistance with bed mobility, grooming and dressing. During observation on 6/24/2015, at 7:17 p.m. nursing assistant (NA)-B was observed to remove	F 164	F164 The policy and procedure to assur(that all aspects of resident privacy are honored has been developed. Training of staff occurred on July 22 and July 23. An audit of privacy with cares will occur at least three times weekly for four weeks with results reported to the QA committee, further auditing direction will determined by the Quality Assurance Committee. The DON or designee is responsible to assure resident privacy occurs during cares.	8/5/15

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F 164	Continued From page 5 R32's shirt in preparation to apply night clothes. R32's female breasts were fully exposed. The drapes on the outside window of R32's room were left open. The public sidewalk and courtyard were clearly observed from the window. R32 remained topless until 7:27 p.m. The courtyard and public sidewalk which residents and volunteers utilized remained in clear view of R32's room throughout this observation. During an interview on 6/24/2015, at 7:27 p.m. NA-B stated she should have closed R32's window drapes while personal cares were being performed and stated she knew better to close the window but felt nervous and forgot to close the drapes. During an interview with the facility Administrator and the director of nursing (DON) on 6/25/15, at 11:06 a.m. both stated they agreed there was a concern of privacy for R32. The Administrator confirmed the drapes on the window to the outside courtyard and public sidewalk should have been closed in R32's room to ensure personal privacy. A facility policy regarding resident privacy was requested, but none was provided.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced	F 176	See next page	

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F 176	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure medications were not left for resident self administration of medication for 1 of 1 resident (R30) who had medications left at bedside for self-administration (SAM) and was assessed to be unable to self administer medication. Findings include: R30's The Diseases Index Report (undated) identified R30 was diagnosed with diabetes mellitus type II, polyneuropathy, lumbago, high blood pressure and depressive disorder. R30's quarterly Minimum Data Set (MDS) dated 3/3/15, indicated R30 intact cognition. R30's The Assessment For Self-Administration of Medications (undated) was not completed. All area's of the assessment were marked as "N/A" which meant, not applicable. The assessment had not identified why this was "not applicable" to R30. On 6/24/15, at 4:38 p.m. R30 requested an interview with the surveyor. During the interview with R30 it was learned that medications including Benadryl and metfomin (medication used to treat type II diabetes) were left on the bedside table in R30's room. R30 and the surveyor entered R30's room and observed two tablets of metformin and one tablet of Benadryl in a medication cup that sat on the bedside table. Licensed practical nurse (LPN-C) was interviewed on 4:40 p.m. and confirmed he had left the medication in R30's room on the bedside	F 176	F176 At this time, JPECC has no residents with self-administration of medication orders. The medication administration policy and procedure were reviewed and revised. Persons who administer medications were trained on July 22, 2015 regarding leaving medications at bedside. The DON is responsible for the medication system and will audit medication administration three times weekly for four weeks, ultimately auditing each person who administers medications at JPECC. The results of the audit will be reported to the QA committee for further auditing direction.	8/5/15

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F 176	Continued From page 7 table. LPN-C stated he had left the medication in R30's room because when he brought the medication into the room R30 was very upset with him and started yelling at him so he just left it on the beside table and left the room. The director of nursing (DON) was interviewed on 06/25/2015, at 11:36 a.m. and stated that medication should not be left unsecured in any resident room. The DON confirmed R30 had been assessed as not able to independently self-administer medications. The facility policy for Self-Administration of Medications dated December 2012, identified that all residents will have their mental, and physical capabilities assessed to determine whether a resident is capable of self-administering medications. In addition, to general evaluations of decision making capacity, the staff and practitioner will perform a more specific skill assessment, including but not limited to the residents: A. Ability to read and understand medication labels; B. Comprehension of the purpose and proper dosage and administration time for his or her medications; C. Ability to remove medications from a container and to ingest and swallow them; and D. Ability to recognize risks major adverse consequences of his or her medications...	F 176		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and	F 244	See next page	

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F 244	Continued From page 8 life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve resident grievances in regards to hair care services for 2 of 6 monthly resident council meeting minutes reviewed for resident council. Findings include: Review of the Resident Council meeting minutes revealed the following: -2/25/15, meeting minutes indicated residents stated they wanted to set up a day for haircuts, 6 residents would like haircuts. The minutes also indicated the activity director would contact a beauty school and schedule. -3/31/15, meeting minutes indicated the residents stated they went to a lot of trouble getting haircuts and perms, residents mad and refused to pay. One resident council member suggested they get a stylist in house and they got paid through the nursing home. The facility failed to resolve or respond to the residents concern. On 6/25/2015 at 9:10 a.m. the administrator stated the previous activity director who conducted resident council meetings walked out in May. The administrator verified there was no documentation found that the concern from resident council wanting someone to come to the facility for hair care was not addressed. The	F 244	F244 Salon was cleaned and supplies obtained July 1, 2015. First service provided July 8th and July 10th and 11th. Salon hours will be posted on the door. A policy and procedure for the Salon has been established. An audit will be done weekly x 4 weeks to ensure residents have received services they requested. Results of the audit will be reported to the QA committee for further action as needed. JPECC has developed a resident council issue policy and procedure to be initiated by the activity coordinator when an issue is raised. A form has been created to outline issues raised at the council. The activity coordinator will distribute the issue form to the appropriate department and give the minutes to the administrator. The activity coordinator is responsible to see that issues are managed with the support of the See next page	8/5/15

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F 244	Continued From page 9 administrator stated for now residents are taken to Walmart for those services. On 6/26/15 at approximately 1:45 p.m. the resident council president was interviewed again and stated they still had a problem with residents getting their hair care completed and it would be so nice to have someone come into the facility to provide that service. The resident council president stated she had her own hairdresser and it was no problem for her to go out for services but it was difficult for some residents to leave the facility and they still needed to have their hair cut. On 6/26/15 at 11:39 a.m. the administrator stated the facility did not have policy and procedures related to resolution to resident council grievances.	F 244	administrator as necessary. Each issue raised at each council meeting will have a response maintained in the resident council response manual. Department supervisors will be educated on the new procedure. Audits of issues raised and responses will be conducted each month by the Administrator or designee. Each month the issues will continue to be reported to the QA committee.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	JPECC completes a comprehensive assessment of resident needs using the resident assessment instrument (RAI) designated by the state. The MDS coordinator will review the assessment tools used for completion prior to the last date of look back period. MDS schedule will be established by the MDS coordinator and reviewed by the DON and completion dates met. See next page	8/5/15

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F 272	Continued From page 10 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for 2 of 2 resident (R39, R2) who were due for a comprehensive MDS on 6/25/15. Findings include: R39's admission MDS dated 6/17/15, revealed the following areas of assessment were incomplete: · Mood · Cognitive patterns · Preferences for customary routine and activities · Participation in assessment and goal setting.	F 272	Nurses will be educated on completing the assessments within the timeframes necessary to complete the MDS. Training will take place July 22, 23, 2015. The DON will audit assigned assessments used to complete the MDS to ensure they are completed in a timely manner, thus allowing the MDS to be completed fully. The results of the audits will be reported to the QA committee for further action as needed. DON is responsible	

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F 272	Continued From page 11 On 6/26/15, at 10:01 a.m. licensed practical nurse (LPN)-B, MDS coordinator, confirmed R39's admission comprehensive MDS was due to be completed on 6/25/15. LPN-B stated she thought R39's MDS assessment had been completed by herself and the MDS consultant and was not. R2's annual MDS dated 5/30/15, revealed the following areas of assessment were incomplete: · Mood · Cognitive patterns · Preferences for customary routine and activities · Participation in assessment and goal setting. On 6/26/15, at 10:01 a.m. LPN-B confirmed R2's annual comprehensive MDS was due to be completed on 5/30/15, and verified the aforementioned areas were not completed. No policy regarding comprehensive MDS timely completion and completeness was provided.	F 272		
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete the required quarterly comprehensive Minimum Data Set (MDS) re-assessment for 4 of 7 residents (R26, R36, R14, R3) residing in the facility who were due for	F 276	F276 JPECC assesses a resident using the quarterly review instrument specified by the state and approved by CMS not less frequently than once every 3 months. The residents listed (R26, R36) and will have complete quarterly MDS assessments redone. R3 will have a See next page	8/5/15

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F 276	Continued From page 12 a quarterly re-assessment. Findings include: R26's quarterly MDS dated 6/9/15, indicated the following areas of the assessment were incomplete: B. Hearing, Speech, and Vision C. Cognitive Patterns D. Mood G. Functional Status J. Health Conditions Q. Participation in Assessment and Goal Setting. The MDS revealed licensed practical nurse (LPN)-B signed sections A, B, C, D, E, G, H, I, J, K, L, M, N, O, P and Q as complete on 6/18/15. The MDS also revealed the signature of the RN (registered nurse) assessment coordinator which verified the assessment was completed by the director of nursing (DON) on 6/18/15. R36's quarterly MDS dated 5/10/15, indicated the following areas of the assessment were incomplete: B. Hearing, Speech and Vision C. Cognitive Patterns D. Mood G. Functional Status J. Health Conditions O. Special Treatments Procedures and Programs Q. Participation in Assessment and Goal Setting. The MDS also revealed LPN-B signed sections A, B, C, D, E, G, H, I, J, K, L, M, N, O, P and Q as complete on 5/16/15. The MDS also identified the signature of the RN assessment coordinator	F 276	corrected MDS submitted. R14 is hospitalized and cannot be completed at this time. Nurses will be educated on completing the assessments within the timeframes necessary to complete the MDS on July 22 and 23, 2015. The DON will audit assigned assessments used to complete the MDS to ensure they are completed in a timely manner, thus allowing the MDS to be completed fully. The results of the audits will be reported to the QA committee for further action as needed. DON is responsible.	

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F 276	Continued From page 13 verifying assessment completion was completed by the MDS consultant on 5/16/15. On 6/26/15, at 10:03 a.m. LPN-B confirmed the quarterly MDS assessments for R26 and R36 were incomplete. LPN-B stated the mood and cognitive pattern sections were usually done by the social worker and they did not have one at the time the assessments were completed. LPN-B also stated the incomplete sections were given to the wing nurses who didn't have time to get them done. R14's quarterly MDS dated 5/15/15, indicated the following areas of the assessment were incomplete: B. Hearing, Speech, and Vision C. Cognitive Patterns D. Mood F. Preferences for Customary Routine and Activities G. Functional Status The MDS indicated LPN-B signed sections A, B, C, D, E, G, H, I, J, K, L, M, N, O, P and Q as complete on 5/16/15. The MDS also identified the signature of RN assessment coordinator which verified the assessment was completed by the director of nursing (DON) on 5/16/15. On 6/26/15, at 9:33 a.m. LPN-B confirmed the quarterly MDS assessment for R14 was incomplete. LPN-B stated she had just started completing MDS's and had expected other staff to assist with completing some of the sections and some of the sections did not get completed due to a lack of staff and time.	F 276		

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F 276	Continued From page 14 R3's quarterly MDS dated 5/26/15, revealed section G related to functional limitation in ROM was not completed. R3's quarterly MDS dated 5/26/15, indicated R3's assessment portion for functional limitation in ROM for upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) was not completed. On 6/26/15, at 10:01 a.m. LPN-B confirmed R3's quarterly MDS was incomplete. On 06/26/15, at 3:55 p.m. the administrator stated it was her expectation the MDS assessments would have been completed, as required. No policy regarding completion of the MDS was provided.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 It is JPECC's policy to complete assessments accurately and on time. R4 quarterly assessment has been corrected as of July 17, 2015. The MDS coordinator will be trained on completing the MDS accurately and in a timely fashion on July 22, 2015. Random audits will be completed weekly x 4 weeks. DON is responsible	8/5/15

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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 278	Continued From page 15 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately identified limitations in upper extremity range of motion (ROM) for 1 of 3 residents, (R4) reviewed for limitations in ROM / assessment accuracy. Findings include: R4's annual MDS dated 4/7/15, indicated R4 was diagnosed with dementia and had severely impaired cognition. The MDS also indicated R4 had no functional limitations in upper extremity (shoulder, elbow, wrist hand) ROM. R4's previous quarterly MDS dated 1/6/15, indicated R4 had functional limitations in upper extremity ROM with impairment on one side. On 06/24/2015, at 4:34 p.m. R4 was observed seated in the activity area. Both of R4's hands appeared contracted, however, R4 was able to fully open his left hand independently, when	F 278		

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	245535	A. BUILDING _____ B. WING _____	06/26/2015

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 278	Continued From page 16 asked. R4 was not able to open his right hand. On 6/26/15, at 10:01 a.m. licensed practical nurse (LPN)-B, MDS coordinator, confirmed R4 had a contracture of his right hand and also had limitations in ROM to his right arm as well. LPN-B confirmed R4's MDS was inaccurate. An MDS policy was request but none was provided.	F 278		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure written care plan interventions were followed related to pressure ulcer care and services, falls, positioning needs, bowel incontinence, range of motion (ROM) urinary incontinence, and/or nutrition 5 of 18 residents (R32, R37, R13, R15, R4) reviewed in stage II of the survey . Findings include: PRESSURE ULCER CARE AND SERVICES R32 had a stage IV (ulcer with full thickness tissue loss covered by dead tissue and/or eschar which is thick tan, brown, or black tissue in the wound bed) pressure ulcer and care planned	F 282	F282 Services at JPECC are provided by qualified persons in accordance with each resident's written plan of care. R32's care plan was reviewed and revised. The risks and benefits of refusal have been discussed with the resident and documented by the DON. R15 and R4's care plans were reviewed and revised as needed. See next page	8-5-15

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F 282	Continued From page 17 interventions were not consistently implemented in order to promote pressure ulcer healing. R32's care plan dated 6/9/15, indicated R32 had an alteration in skin integrity related to diabetes chronic pain and anemia manifested by coccyx pressure ulcer and vulnerable area to the right and left ankle. The care planned interventions included an air pressure mattress on bed, pressure redistribution cushion in wheelchair, medication and treatments as ordered, wound measurements weekly and prevalon boot to left foot while in bed. The care plan also directed staff to ensure R32 was up in the wheelchair for maximum of 20 for meals only and to provide extensive assistance of 1 to turn and reposition R32 every 2 hours. On 6/24/15, from 5:01 p.m. until 7:27 p.m. the following continuous observation was made: -At 5:01 p.m. R32 was observed in bed lying on the left side. -At 5:35 p.m. R32 remained in bed lying on the left side. R32 was provided the evening meal, however was not assisted to reposition. -At 6:26 p.m. R32 had remained in the same left lying position. At this time, nursing assistant (NA)-B was observed to enter R32's room, however, when NA-B left the room, R32 remained in the same left side lying position. -At 7:19 p.m. NA-C stated she was not a permanent employee of the facility, but rather was hired to work in the facility through a staffing agency and did not know the residents very well. NA-C confirmed she had not assisted R32 with repositioning since she had started her shift at 2:00 p.m. NA-C stated that she was working with NA-J to care for the residents on the wing R32 resided on and perhaps NA-J had repositioned	F 282	Staff will be educated on July 22 and 23, 2015 on repositioning residents according to their care plans. Audits will be performed on repositioning 3 x /week for 4 weeks. Results will be reported to the QA committee. R37 was discharged July 2015. R13 will be reassessed for safety devices and the care plan updated as needed. A procedure for moving residents and their safety devices is in place. A list will be maintained of devices used by each resident. The DON maintains the log with information from the IDT team for falls. The care plans will be reviewed and revised as necessary. All staff will be educated on ensuring each resident has the proper safety devices on July 22 and 23, 2015. Audits will be conducted 3 times per week x four weeks with results reported to the QA committee for further audits. DON is responsible	8-5-15

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F 282	Continued From page 18 R32. NA-C and NA-J were then interviewed together at 7:23 p.m. at which time NA-J stated there had been a miscommunication and NA-J had not been assigned to the care of R32 but rather to the residents on a different wing of the facility. -At 7:29 p.m. NA-C entered R32's room and repositioned him while providing evening cares. NA-C confirmed R32 had not been repositioned for 5 hours and 29 minutes. On 6/25/15, at 11:06 a.m. the administrator and director of nursing (DON) stated R32 should have been repositioned at least every two hours as directed by R32's care plan. R37 had an unstageable pressure ulcer (ulcer with full thickness tissue loss covered by dead tissue and/or eschar which is thick tan, brown, or black tissue in the wound bed) had developed at the facility, had increased in size, and had not been monitored and measured according to her care plan. R37's care plan dated 6/20/15, indicated R37 had a potential for pressure ulcer development and interventions directed staff to assess, record and monitor wound healing weekly. The care plan further directed staff to measure the length, width and depth where possible and to assess and document the status of the wound perimeter, wound bed and healing process. R37's Wound Assessment Flow Sheet assessment 6/9/15, indicated R37 had a wound identified on her coccyx measuring 0.7 cm in length and 0.6 cm in width and no depth. The wound assessment progress notes dated 6/9/15, indicated during cares a small opening area (0.7 cm by 0.6 cm) on R37's coccyx had been	F 282		

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F 282	Continued From page 19 identified. No further weekly wound assessments were documented on this flow sheet (for the weeks of 6/15/15, and 6/22/15. On 6/9/15, registered nurse (RN)-C sent a fax notification to the physician with notification that R37 had a small "pressure wound on her coccyx length 0.7, width 0.6". On 6/25/15, at 8:27 a.m. licensed practical nurse (LPN)-D completed R37's dressing change on her coccyx (tailbone). Upon request, LPN-D measured the wound and stated the coccyx wound measured 1.5 centimeters (cm) in length by 0.5 cm in width with a depth which was undetermined. These measurements indicated an increase in length of 0.8 cm. Visualization of R37's coccyx wound revealed darkened scar tissue around the wound with the wound bed filled with blackened eschar. LPN-A stated he was not certified to stage the wound and once the "scab" (eschar) came off the wound, the wound could actually be deep and stated "you just don't know." On 6/26/15, at 10:49 a.m. the administrator confirmed it was her expectation that resident wounds were measured and monitored weekly and that staff followed the care plan. The administrator stated in RN-C's absence, LPN-B was available to measure wounds. R13 was at risk for falls and the facility failed to implement fall interventions as directed by R13's care plan. R13's care plan dated 6/15/15, indicated R13 had a potential for falls and directed staff to conduct	F 282		

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F 282	Continued From page 20 hourly visual safety checks, assure R13 was in a hi-lo bed with a mat on the floor by the outside edge of the bed. The undated, CNA care sheet titled South Hall: CNA 1, directed staff to place a mat on R13's floor as she was a fall risk. On 6/24/15, at 12:30 p.m. R13 was observed seated in her wheelchair in the common area. -At 12:40 p.m. NA-B was observed to assist R13 to her room, transferred R13 to bed, placed the bed in the low position and assured R13's call light was within reach. R13 was in a double occupancy room with R13's bed located closest to the door. A floor mat was not placed beside R13's bed, nor was one visualized in R13's room. On 6/24/15, at 2:15 p.m. NA-D stated when she conducted safety checks on residents she checked to assure alarms were in place, the side rails were in the proper position and the resident was comfortable. NA-D confirmed safety checks also included assuring a fall mat was in place if it was ordered. NA-D verified R13 had not had a fall mat placed beside the bed, nor was there a fall mat even in R13's room. NA-D stated R13 had been temporarily moved to this new room as R13's room was being repaired. NA-D stated she bet when they moved R13 last night to the new room, they didn't move the mat with her. On 6/14/15, at 2:30 p.m. the DON reviewed R13's care plan and confirmed a floor mat should have been placed beside R13's bed and stated it probably did not get brought with R13 when they temporarily moved R13 into the different room. The DON stated it was her expectation staff followed the resident's care plan.	F 282		

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F 282	Continued From page 21 Falls and Fall Risk, Managing policy dated 4/24/13, specified interventions would be identified related to the resident's specific risks to prevent the resident from falling and to try to minimize complications from falling. Using the Care Plan policy [undated] specified the care plan was used to develop a resident's daily care and routines. In addition, documentation must be consistent with the residents' care plan. R15 was not provided repositioning assistance or ROM services as directed by the care plan. R15's care plan dated 4/11/15, indicated R15 had impaired physical mobility related to dementia, seizure disorder and paralysis. The care plan directed staff to reposition R15 every two hours and to complete ROM exercises to upper and lower extremities four times a week. On 6/24/15, from 12:45 p.m. until 3:45 p.m. R15 was continuously observed to be seated in a wheelchair without repositioning. From 3:50 p.m. until 7:00 p.m. R15 was observed in bed laying on the right side without being repositioned. In addition, R15's medical record failed to indicate R15 had received ROM services as directed by the care plan. On 6/24/15, at 7:25 p.m. the DON stated she was not sure who completed ROM exercises for R15. At this time the DON asked NA-H who completed R15's ROM exercises. NA-H stated the facility used to have a rehab department that provided the ROM services, but since that department was stopped there was no book in the facility to document that ROM had been completed.	F 282		

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F 282	Continued From page 22 On 6/25/15, at 8:20 a.m. the DON confirmed the facility had not documented the ROM exercises that were to be completed for R15 and verified R15's care plan was not followed. R4's care plan was not followed for contracture care, repositioning, bowel incontinence, bladder incontinence and nutrition interventions. Contracture care: R4's West Hall CNA 1 care sheet dated 5/20/15, directed staff to place a rolled washcloth in R4's right hand. On 6/22/15, at 9:07 a.m. no splint or rolled washcloth were observed in R4's hands. On 06/24/2015, at 4:34 p.m. R4 was observed to not have a rolled washcloth in the right hand. On 06/24/15, at 5:32 p.m. R4 was observed at supper and no washcloth was observed in his right hand. On 06/24/15, at 8:07 p.m. observed during evening cares. R4 did not have a washcloth in the right hand. On 06/25/15, at 8:32 a.m. R4 was observed in bed. R4 did not have a washcloth in the right hand. On 06/26/15, at 10:30 a.m. R4 was observed resting in bed. No washcloth was observed in R4's hand. On 06/26/15, at 11:35 a.m. RN-B stated R4 used a rolled washcloth in his right hand because he	F 282		

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F 282	Continued From page 23 had a contracture and his fingernails would dig into the palm of his hand. RN-B stated it was possible for R4 to not have the washcloth placed into his hand as he had recently had a temporary room change and new staff were working with him. On 6/26/15, at 2:00 p.m. R4 was observed in bed. A rolled washcloth was observed in R4's right hand. On 06/26/15, at 3:47 p.m. the administrator stated she would have expected R4 to have received services as directed on the care plan. Repositioning, incontinence care: R4's care plan dated 4/12/15, indicated R4 had decreased physical mobility, alteration in elimination and directed staff to provide all cares with the assistance of two staff and to reposition R4 every two hours with the use of bilateral upper side rails, to check/change R4 for bowel and bladder incontinence every two hours and provide peri cares. The West Hall CNA 1 care sheet dated 5/20/15, indicated R4 required assistance of two staff with bed mobility and directed staff to reposition R4 every two hours with the use of side rails. On 06/24/2015, at 2:44 p.m. R4 was observed at a Bingo activity. He was positioned on his back, fully reclined in geri chair. On 6/24/15, from 4:34 p.m. until 8:07 p.m. R4 was continuously observed reclined in a geri-chair without repositioning or toileting assistance. -At 7:46 p.m. NA-I was observed to wheel R4 to	F 282		

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F 282	Continued From page 24 his room. NA-I stated it was his first night working at the facility so he was unfamiliar with R4, however, stated he believed R4 was to be repositioned every two hours. NA-I was unsure when R4 was assisted into the chair. -At 8:07 p.m. NA-I was observed to provide R4 evening cares. NA-I and NA-B transferred R4 to bed with the use of a mechanical lift. R4 was observed to have been incontinent of bowel and bladder. R4's back, buttocks and bony prominence's were observed non-reddened, with intact skin. NA-I and NA-B both stated they had not repositioned or checked R4 for incontinence since the beginning of their shift at 2:00 p.m. and both verified this should have been done every two hours. On 06/26/15, at 3:47 p.m. the administrator confirmed R4 should have been repositioned and checked / changed for incontinence and provided peri cares every two hours as directed by the care plan. Nutrition services: R4's care plan dated 4/12/15, indicated R4 had an alteration in nutrition related to history of inadequate intake with a goal of weight stability. The care plan directed staff to provide R4 a regular mechanical soft diet with ground meat and extensive assistance of one staff to feed. The care plan also indicated R4 received the NIP [nutrition intervention program] diet which consisted of 1/2 sandwich with meal, 4 ounce Mighty Shake twice a day, weights, vital signs and labs as ordered. The West Hall CNA 1 care sheet dated 5/20/15, directed staff to provide R4 a regular mechanical	F 282		

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F 282	Continued From page 25 soft diet with ground meats and indicated R4 was unable to feed self and directed one staff to feed. The care sheet also indicated R4 was to be weighed on Mondays, Wednesdays and Fridays. On 6/24/15, at 5:32 p.m. NA-I was observed feeding R4 supper. R4 was observed to have three lower teeth and no upper teeth. Supper consisted of a burrito with scrambled eggs with ground meat inside a soft tortilla, a muffin, 8 oz of milk, coffee and watermelon. No sandwich was provided. NA-I fed R4 the contents of the burrito but not the tortilla. On 06/25/15, at 9:52 a.m. registered dietitian (RD) stated the nutrition intervention program (NIP) referred to a policy of specific nutritional interventions used for those residents who were more at a high nutritional risk. The RD stated the interventions were part of a system to encourage the use of real food first such as whole milk, butter, extra gravy and other high calorie items to assist with weight gain. On 06/25/15, at 1:00 p.m. the RD stated the NIP interventions were not as successful at this facility as she did not get compliance from the dietary supervisor (DS). The RD also stated it had been an ongoing issue getting compliance with diets such as mechanical soft. The RD confirmed the burrito served to R4 would probably not be part of a mechanical soft diet. On 6/26/15, at 10:35 a.m. the DS stated the kitchen did not offer any type of therapeutic diet. She stated everyone got the same diet and the same portion size. The DS confirmed they should have been following the individual special / therapeutic diets and was in the process of	F 282		

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F 282	Continued From page 26 working with another company to develop menus that were easier for kitchen staff to follow along with. On 06/26/15, at 3:47 p.m. the administrator confirmed a therapeutic diet had not been provided to R4 as directed by the care plan. Using the Care Plan policy [undated] specified the care plan was used to develop a resident's daily care and routines. In addition, documentation must be consistent with the residents' care plan.	F 282		
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 provide a safe and adequate eating position for 1 of 1 resident (R3) observed coughing while being fed in a reclined position. The facility also failed to provide a protective skin cloth in a contracted hand as ordered by the physician for 1 of 3 (R4) residents reviewed for activity's of daily living and had a physician's order for use of the protective cloth. Findings include:	F 309	F309 R3's family refused previous speech evaluation on 2/23/15. Infiltrates were noted on chest X-ray on 5/7/15 with ABX ordered. Family will be contacted to obtain permission for speech evaluation. All other residents who are at risk for choking related to positioning will be evaluated by speech therapy. Pending speech evaluation report/direction, residents will be positioned as tolerated at no less than 45 degrees. Staff will be educated on July 22 and 2, 2015 on proper positioning of residents at mealtimes. A policy and procedure is in place for feeding residents with dysphagia. Audits of positioning at meals will See next page	8/5/15

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F 309	Continued From page 27 R3 was observed positioned at a 45 degree angle in a tilt-back wheelchair while being provided eating assistance with his meals. R3's undated Admission Face Sheet identified R3's diagnoses included quadriplegia (paralysis of all four limbs), contracture (deformity resulted from a stiffness or constriction in joints, tendons, or ligaments which restricted normal movement) of joints and dysphagia (difficulty swallowing). R3's Medical Nutritional Therapy Notes dated 2/23/15, indicated R3's family did not desire R3 have a swallowing evaluation completed. R3's quarterly Minimum Data Set (MDS) dated 5/26/15, indicated R3 had severe cognitive impairment and required extensive assist with bed mobility, transferring and eating. In addition, the MDS indicated R3 was on a mechanical altered diet and had no signs or symptoms of a swallowing disorder. R3's care plan dated 6/15/15, indicated R3 had an alteration in nutrition and directed staff to assure R3 was clearing his mouth between bites and to monitor and report signs and symptoms of choking such as coughing, eye tearing and wet voice. R3's medical record revealed R3 was seen in the emergency room (ER) on 5/7/15, for a sick visit. The record further revealed R3 was diagnosed with pharyngitis and acute bronchitis. A chest x-ray had been obtained during this ER visit which suggested a right lobe infiltrate (term used to describe the appearance of an abnormal substance that has accumulated in the lungs). R3	F 309	be conducted by the DON or designee 3 times per week for 4 weeks with results to QA committee and direction for further audits. R4 will be evaluated by Physical Therapy for appropriate contracture devices. The care plan will be updated to show current status. Staff will be educated on July 22 and 23, 2015 regarding contractures and devices. All residents with contractures will be evaluated by therapy for appropriate devices. Audits will be conducted three times per week for 4 weeks with results to QA committee and direction for further audits. The DON/designee will be responsible.	

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	245535	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 309	Continued From page 28 was placed on antibiotics. On 6/22/15, at 7:42 a.m. R3 was observed seated in a tilt back wheelchair in the dining area. R3's wheelchair was tilted back approximately 45 degrees. NA-A was observed feeding R3 his pureed breakfast meal while R3 remained reclined at 45 degrees, not upright. - At 8:06 a.m. R3 had a couple of hiccups. - At 8:17 a.m. R3 started to cough. R3 forcefully coughed six times. R3 remained positioned at a 45 degree angle, with his head unsupported and tilted back. - At 8:20 a.m. R3 had another coughing episode where R3's cough started out with a gurgling, moist sound and then coughed five times forcefully. - At 8:22 a.m. NA-A stood up and adjusted R3's chair to a more upright position (approximately 30 degrees). On 6/24/15, at 5:32 p.m. R3 was observed seated in a tilt back wheelchair in the dining room. R3's wheelchair was tilted back approximately 30 degrees. NA-B was observed feeding R3 his pureed evening meal while R3 remained reclined at 30 degrees. - At 5:37 p.m. R3 coughed twice. NA-B asked R3 if he was "okay." - At 5:42 p.m. R3 coughed six times - a moist gurgling sounding cough. - At 5:44 p.m. NA-B attempted to adjust R3's wheelchair to a more upright position. NA-B was unable to adjust the chair. At this time, licensed practical nurse (LPN)-D approached R3 and adjusted the wheelchair to an erect position. - At 5:47 p.m. R3 coughed twice. - At 5:53 p.m. R3 coughed once.	F 309		

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F 309	Continued From page 29 On 6/24/15, at 6:18 p.m. NA-B stated no one had instructed her regarding proper positioning of residents when assisting them with eating. NA-B stated she had repositioned R3 to a more erect position once R3 had started to cough. NA-B stated on previous day R3 was reclined back while he was eating and R3 was coughing like crazy. On 6/25/15, at 1:00 p.m. occupational therapist (OT)-A confirmed any resident like R3 who has dysphagia should be sat up as erect as possible when eating to avoid the chance of aspiration. No policies on proper positioning during meal times and/or dysphagia care were provided. R4 had a right hand contracture and staff failed to apply a rolled washcloth into the palm of his hand in order to minimize skin discomfort related to the contracture. R4's undated Diseases Index Report indicated R4 had diagnoses that included diabetes with neurological manifestations, chronic kidney disease, anemia and peripheral neuropathy. R4's quarterly MDS dated 1/6/15, indicated R4 had severe cognitive impairment, was not ambulatory and was totally dependent on two staff for transfer, toilet use and personal hygiene. The MDS also indicated R4 had a functional limitation in range of motion with impairment of the upper extremity (shoulder, elbow, wrist, hand) on one side. R4's care plan dated 4/12/15, did not address R4's right hand contracture (a condition of fixed	F 309		

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F 309	Continued From page 30 high resistance to passive stretch of a muscle), however, the West Hall CNA 1 care sheet dated 5/20/15, directed staff to apply a rolled washcloth in his right hand. R4's Physician Orders & Progress Notes dated 5/15/15, included the following: -Cleanse right hand with NS [normal saline], dry, and place rolled up washcloth in palm of hand every shift. Update if worsens. On 6/22/15, at 9:07 a.m. R4 was observed to potential contracture's to both hands. A washcloth was not observed in R4's right hand. On 06/24/2015, at 4:34 p.m. R4 was observed seated in the activity area. Both of R4's hands appeared contracted, however, when asked, R4 was able to independently open his left hand which was noted to not have contracture's. R4 was not able to open his right hand. A rolled washcloth was not placed in R4's right hand. On 06/24/15, at 5:32 p.m. R4 was observed at supper. R4 did not have a washcloth placed in the right hand. On 06/24/15, at 8:07 p.m. R4 was observed during evening cares. A washcloth was not observed in R4's right hand. On 06/25/15, at 8:32 a.m. R4 was observed in bed. A washcloth was not observed in his right hand. On 6/26/15, at 10:01 a.m. licensed practical nurse (LPN)-B, MDS coordinator, confirmed R4 had a contracture of his right hand and also had limitations in range of motion to his right arm as	F 309		

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F 309	Continued From page 31 well. On 06/26/15, at 10:30 a.m. R4 was observed in bed without a rolled washcloth in his right hand. On 06/26/15, at 11:35 a.m. RN-B stated R4 used a rolled washcloth in his right hand because he had a contracture and his fingernails would dig into the palm of his hand. RN-B stated it was possible R4 may not have had the washcloth placed in his hand as R4 had recently had a room change and new staff that were unfamiliar to him were working with him. RN-B also stated she usually placed the washcloth after the noon meal and would be doing so that afternoon. RN-B further stated R4 did not receive ROM services and the rolled washcloth was the only intervention used for R4's right hand contracture. On 6/26/15, at 2:00 p.m. R4 was observed in bed without a rolled washcloth placed in his right hand. On 06/26/15, at 3:47 p.m. the administrator stated she would have expected R4 to have had the washcloth placed as directed by the physician's orders and care plan.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	F312 R39 was given a bath on June 26, 2015. The bath list was reviewed and revised as needed by the DON. A policy/procedure for bathing was See next page	8/5/15

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F 312	Continued From page 32 by: Based on observation, interview and document review, the facility failed to provide assistance with bathing for 1 of 3 residents (R39) reviewed for activities of daily living, and failed to provide incontinent care for 1 of 3 (R4) residents reviewed for activities of daily living. Findings include: R39's care plan dated 6/21/15, identified R39's diagnoses as diabetes, congested heart failure (decrease in heart function to pump blood), cataracts, cardiovascular disease, edema in legs, anemia and hypertension. R39's Admission/Readmission Care Plan for bathing dated 6/11/15, indicated R39 required staff assistance to set-up and assistance to get in/out of the tub. R39's Individual care plan dated 6/18/15, indicated R39 required the assist of one staff for bathing. R39's care plan dated 6/21/15, indicated R39 required staff assist with set-up for bathing. The nursing assistant (NA) care sheet / directive titled CNA 2 care sheet revealed R39 was to have a whirlpool tub bath on Fridays and R39 required the assist of one with bathing. R39's admission Minimum Data Set (MDS) date 6/21/15, lacked a cognitive assessment, however, indicated R39 required support and set up for bathing.	F 312	developed to include providing a bath to each resident within 24 hours of admission and weekly thereafter. Staff were educated July 22 and July 23, 2015. Auditing of the bathing schedule will be performed three times per week for 4 weeks and results reported to the QA committee for further direction with audits. The DON/designee will be responsible. R4 was re-assessed for incontinence status and the plan was reviewed for appropriate timing of assistance. He continues to need assistance of two staff every two hours for incontinence care. Staff will be educated on providing incontinent care as care planned on July 22 and July 23, 2105. Incontinence care policy was developed. Audits will occur for residents who are three times per week for 4 weeks with results reported to the QA committee for further direction with audits. DON is responsible	

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F 312	Continued From page 33 R39's Nursing Assistant Daily Care Record for June 2015, indicated bathing included shaving, applying lotion and shampoo. The documentation on this care record revealed from 6/11/15, through 6/24/15, R39 had not been assisted with a whirlpool bath or shower. On 6/22/15, at 1:09 p.m. R39 stated she had not had a tub bath or a shower since she had been admitted to the facility (11 days ago). On 6/23/15, at 8:45 a.m. R39 was observed in her wheelchair propelling herself out of her room. R39's hair was observed wet. R39 stated she had not had a shower/bath that morning so she had just wetted her hair down under the sink in her bathroom. On 6/24/15, at 4:38 p.m. R39 stated staff had brought some towels in for her to use and she had "bed bath." however, R39 stated she had not been offered a tub/shower since she had been admitted to the facility. R39's hair was observed in a bun at the nape of her neck and her hair was observed to be oily. On 6/25/15, at 9:38 a.m. R39 confirmed she had not been offered a tub bath/shower yet. R39 stated she had just been washing herself up in the sink. JPECC (Jourdain Perpich Extended Care Facility) Bath Schedule [undated] revealed R39 was scheduled to have a bath on Friday evenings. On 6/25/15, at 12:04 p.m. the director of nursing (DON) verified the residents received a bath once a week and more if requested. The DON stated	F 312		

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F 312	Continued From page 34 any new resident should be offered/provided a bath/shower within the first week of admission. The DON reviewed the R39's Nursing Assistant Daily Care Record and verified that according to the documentation it appeared R39 had not had been offered/provided assistance with a bath/shower since her admission (14 days). No policy related to resident grooming, bathing, and/or assistance with activities of daily living was provided. R4 did not receive bowel incontinence care as directed by the care plan. R4's undated Diseases Index Report indicated R4 had diagnoses that included blindness, diabetes, peripheral neuropathy, venous insufficiency and alcohol induced persisting amnesic disorder. R4's Bowel Assessment Form dated 4/3/15, identified R4 as incontinent of bowel and indicated he was unable to participate in a bowel management program due to dementia and combativeness. R4's annual Minimum Data Set (MDS) dated 4/7/15, indicated R4 had severe cognitive impairment, was totally dependent on two staff for transfers, toilet use and personal hygiene and required extensive assistance of two staff for bed mobility and dressing. The MDS also identified R4 was always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R4's Annual CAA (Care Area Assessment) Summary for Urinary Incontinence dated 4/12/15, indicated R4 was always incontinent and toileting	F 312		

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F 312	Continued From page 35 programs had failed due to noncompliance secondary to behaviors and diagnosis of dementia. The CAA further indicated R4 required extensive assistance of one staff to check and change incontinent product and provide perineal care. The CAA indicated R4 was at risk for skin integrity issues, offensive odor, loss of dignity and falls. R4's care plan dated 4/12/15, indicated R4 was incontinent of bowel and directed staff to provide extensive assistance of two staff check incontinent product every two hours and change as needed and to provide peri-rectal care after elimination. On 06/24/2015, at 2:44 p.m. R4 was observed at a Bingo activity. On 6/24/15, during continuous observation from 4:34 p.m. until 8:07 p.m. the following was observed: -At 4:34 p.m. R4 was seated in a geri chair in the activity area. -At 5:19 p.m. NA-H wheeled R4 into the dining room and placed him by a table. -At 5:32 p.m. NA-I was observed feeding R4 supper. -At 6:10 p.m. NA-I wheeled R4 from the dining room to the common area. -At 6:12 p.m. NA-I positioned R4 in the hallway next to common area and stated he would leave him up for a 1/2 hour and then lay him down. -At 7:46 p.m. NA-I wheeled R4 to his room. He stated it was his first night working at the facility so he was unfamiliar with R4's care needs, however, stated he believed R4 was to have cares provided every two hours. NA-I was unsure when R4 had gotten up for the day.	F 312		

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F 312	Continued From page 36 -At 8:07 p.m. NA-I was observed to perform evening cares for R4. NA-I and NA-B transferred R4 to bed with the use of a mechanical lift. R4 was observed to have been incontinent of bowel and bladder. R4's back, buttocks and bony prominence's were observed non-reddened with intact skin. NA-I and NA-B both stated they had not checked R4 for incontinence since the beginning of their shift at 2:00 p.m. and should have been done every two hours. On 06/26/15, at 3:47 p.m. the administrator confirmed R4 should have been checked for incontinence/changed every two hours as directed by the care plan. No policy on incontinence care was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents (R37, R15, R4) identified with active or at risk for pressure ulcers were assessed and / or monitored and / or provided services in order to	F 314	F314 R37 was discharged from the facility on July 2, 2015. R15 and R4 were re-assessed for appropriate repositioning schedules. Other residents who have pressure ulcers were re-assessed for individualized repositioning schedules. The pressure ulcer prevention and treatment program were reviewed and revised as needed. Education will be provided to staff on July 22 and 23, 2015. Repositioning audits will occur three times per week for 4 weeks with results reported to the QA committee for further direction with audits. DON is responsible	8/5/15

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F 314	Continued From page 37 promote healing or prevent the development of pressure ulcers. Findings include: R37 had an unstageable pressure ulcer (ulcer with full thickness tissue loss covered by dead tissue and/or eschar which is thick tan, brown, or black tissue in the wound bed) which had developed at the facility, increased in size and had not been monitored and measured according to facility policy. F37's Admission Face Sheet identified R37's diagnoses of stage V (very severely reduced kidney function) chronic kidney disease, renal dialysis status, diabetes, ulcer on part of the foot and a recent above the knee amputation. R37's admission Minimum Data Set (MDS) dated 6/16/15, revealed R37 had intact cognition, required limited assist with bed mobility, dressing, toileting and personal hygiene and extensive assist with transferring and locomotion on and off the unit. The MDS also indicated R37 was non-ambulatory, utilized a wheelchair and was identified as being at risk for the development of a pressure ulcer, with no unhealed pressure ulcers recognized. R37's Nurses' Admission Assessment dated 6/2/15, indicated R37 had a healed ulcer site on her coccyx.	F 314		

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F 314	Continued From page 38 R37's Turning and Repositioning (Tissue Tolerance) Observation form dated 6/9/15, indicated R37 should be repositioned every two hours. R37's Wound Assessment Flow Sheet assessment 6/9/15, indicated R37 had a wound identified on her coccyx which measured 0.7 centimeters (cm) in length and 0.6 cm in width and no depth. The wound assessment progress notes dated 6/9/15, indicated during cares a small opened area (0.7 cm by 0.6 cm) on R37's coccyx had been identified. No further weekly wound assessments were documented on this flow sheet for the weeks of 6/15/15, and 6/22/15. On 6/9/15, registered nurse (RN)-C sent a fax notification to the physician with notification that R37 had a small "pressure wound on her coccyx, length 0.7, width 0.6." R37's Medication Administration Record (MAR) indicated an order had been initiated on 6/11/15, for a dressing change every three days to R37's open area on her coccyx. The MAR indicated a dressing change had occurred on 6/10/15. R37's Braden Scale (tool used to assess a resident's level of risk for developing a pressure ulcer) dated 6/14/15, indicated R37 was at risk for developing a pressure ulcer. R37's Individual Resident Care Plan dated	F 314		

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F 314	Continued From page 39 6/18/15, indicated R37 had wounds on her coccyx, shin and foot. R37's care plan dated 6/20/15, indicated R37 was at risk for the development of a pressure ulcer and directed staff to assess, record and monitor wound healing weekly, measure length, width and depth where possible and to assess and document status of the wound perimeter, wound bed and healing process. On 6/25/15, at 8:27 a.m. licensed practical nurse (LPN)-D was observed to complete R37's coccyx (tail bone) dressing change. Upon request, LPN-D measured the wound and stated the coccyx wound measured 1.5 cm in length by 0.5 cm in width with a depth which was undetermined. These measurements revealed the wound had increased 0.8 cm in length. Visualization of R37's coccyx wound revealed darkened scar tissue around the wound with the wound bed to be filled with blackened eschar (scab). LPN-A stated he was not certified to stage the wound and once the "scab" came off the wound, the wound could actually be deep, "you just don't know." On 6/25/15, at 1:59 p.m. the director of nursing (DON), LPN-B, and the ward clerk (WC)-A were unable to provide R37's comprehensive data risk assessment tool. The DON confirmed it should have been completed by RN-C when the pressure ulcer was identified. On 6/26/15, at 10:49 a.m. the administrator confirmed it was her expectation that wounds were measured and monitored weekly and that	F 314		

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	245535	A. BUILDING _____ B. WING _____	06/26/2015

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JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 314	Continued From page 40 staff followed the individualized care plan. The administrator stated in RN-C's absence LPN-B was available to measure wounds. The Pressure Ulcer/Wound Management Checklist dated 3/2015, directed staff to complete the Weekly Wound Assessment Flow Sheet which included information on date of onset, type of wound, location, stage, assessment date and time, measurements, wound base and wound edge description, drainage, undermining/tunneling if present, odor and pain. In addition, a Comprehensive Data Risk Collection Tool should be completed. Procedure for Treatment of Pressure Ulcers policy [undated] directed staff to assess the pressure ulcer for location, size, tunneling, undermining, drainage, odor, wound base characteristics and pain. Tips for Prevention of Pressure Ulcers [undated] directed staff to conduct weekly skin checks. Policy for the prevention of pressure ulcers and R37's Care Area Assessment (CAA) for pressure ulcers were not provided. R15 was not repositioned according to his assessed needs. R15's quarterly MDS dated 4/9/15, indicated R15's diagnoses include dementia, seizures and general paresis (paralysis). The MDS indicated had impaired cognition, had no speech, was totally dependent on staff for all activities of daily living, did not walk and required the assistance of two staff for transfers and repositioning. R15's The Assessment Tool for Predicting	F 314		

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F 314	Continued From page 41 Pressure Sore Risks (Braden) dated 4/2/15, indicated R15 was at moderate risk for developing pressure ulcers. R15's care plan dated 4/11/15, indicated R15 had impaired physical mobility with potential for impaired skin integrity related to dementia. The plan directed staff to turn and reposition R15 every 2 hours and to provide the assistance of two staff and a mechanical lift for all transfers and repositioning. On 06/24/2015, at 12:45 p.m. R15 was observed seated in a wheelchair while being wheeled to the activity room. R15 remained seated in the wheelchair until 3:45 p.m. without receiving repositioning assistance. -At 3:45 p.m. NA-D and LPN-C were observed to transfer R15 from the wheelchair into bed via a mechanical lift. R15's skin was intact with areas of indentations from the incontinent brief. R15 was positioned in bed on his right side. -At 3:55 p.m. NA-D stated R15 had been sitting in the wheelchair for 3 hours without being repositioned. NA-D stated R15 was not repositioned because he was in Bingo having good time and they did not want to disturb him. NA-D stated R15 did not get to go to activities very much. -from 3:15 p.m. until 7:00 p.m. R15 was continuously observed in bed, lying on his right side without repositioning assistance (3 hours and 15 minutes). -At 7:00 p.m. NA-H verified R15 was not repositioned every two hours as directed. On 6/24/2015, at 7:17 p.m. the DON verified R15 was not repositioned timely as directed by the care plan.	F 314		

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F 314	Continued From page 42 R4 was at risk for pressure ulcers and did not receive repositioning assistance as directed by the care plan. R4's undated Diseases Index Report indicated R4 had diagnoses that included blindness, diabetes, peripheral neuropathy, venous insufficiency, and alcohol induced persisting amnestic disorder. R4's annual Minimum Data Set dated 4/7/15, indicated R4 had severe cognitive impairment, was totally dependent on two staff for transfers, toilet use and personal hygiene and required extensive assistance of two staff for bed mobility and dressing. The MDS also identified R4 was always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R4's Pressure Ulcer CAA dated 4/12/15, indicated the following: R4 had diagnoses of diabetes with polyneuropathy, anemia, history of noncompliance and history of skin breakdown. He had pressure relieving mattress in bed and chair. He was turned and positioned every two hours. Skin checks were completed weekly by the nurse. His Braden scale result was 11 which indicated high risk. Risk factors included skin integrity changes, infections, weight changes and discomfort. R4's Resident Care Plan dated 4/12/15, identified a focus of self care deficit and directed staff all cares were to be provided by staff with assistance of two. The care plan also identified a focus of decreased physical mobility and directed staff to reposition R4 every 2 hours with the use of bilateral upper side rails.	F 314		

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F 314	Continued From page 43 The nursing assistant (NA) care sheet titled West Hall CNA 1 dated as revised 5/20/15, directed staff R4 required assistance of two with bed mobility and to reposition every two hours with the use of side rails. R4's Braden Scale-For Predicting Pressure Sore Risk dated 4/2/15 identified a score of 11 which indicated high risk. R4's Turning and Repositioning (Tissue Tolerance Assessment) (a tool to determine the length of time skin can withstand pressure without change) dated 12/31/14, indicated R4 was to be turned and repositioned every 2 hours when lying and sitting. On 06/24/2015, at 2:44 p.m. R4 was observed at a Bingo activity. He was positioned on his back, fully reclined in geri chair. On 6/24/15, during continuous observation from 4:34 p.m. until 8:07 p.m. the following was observed: -At 4:34 p.m. R4 was seated reclined approximately 45 degrees onto his back, in a geri chair, next to a table in the activity area. -At 5:19 p.m. nursing assistant (NA)-H wheeled R4 into the dining room and placed him by a table. He remained reclined upon his back. -At 5:32 p.m. NA-I was observed feeding R4 supper. He remained reclined upon his back. -At 6:10 p.m. NA-I wheeled R4 from the dining room to the common area. He remained reclined upon his back. -At 6:12 p.m. NA-I positioned R4 in the hallway next to common area and stated he would leave him up for a 1/2 hour and then lay him down. R4 remained on his back in a reclined position.	F 314		

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F 314	Continued From page 44 -At 7:46 p.m. NA-I wheeled R4 to his room. He stated it was his first night working at the facility so he was unfamiliar with R4, however, stated he believed R4 was to be repositioned every two hours. NA-I was unsure when R4 got up that day. -At 8:07 p.m. NA-I was observed to perform evening cares for R4. NA-I and NA-B then transferred R4 to bed with the use of a mechanical lift. R4 was observed to have been incontinent of bowel and bladder. R4's back, buttocks and bony prominences were observed to non-reddened, with intact skin. NA-I and NA-B both stated they had not repositioned R4 since the beginning of their shift at 2:00 p.m. and this should have been done every two hours. On 06/26/15, at 3:47 p.m. the administrator confirmed R4 should have been repositioned and checked for incontinence/changed every two hours as directed by the care plan. The undated Tips for Prevention of Pressure Ulcers policy directed staff to reposition per care plan, follow the Bowel and Bladder plan of care and provide peri-care as needed.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	See next page	

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F 315	Continued From page 45 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide urinary incontinence services as directed by the care plan for 1 of 3 residents (R4) reviewed for urinary incontinence and assessed to be incontinent of urine. Findings include: R4's undated Diseases Index Report indicated R4 had diagnoses that included blindness, diabetes, peripheral neuropathy, venous insufficiency, and alcohol induced persisting amnesic disorder. R4's Bladder Assessment Form dated 4/3/15, identified R4 with functional urinary incontinence. R4's annual Minimum Data Set dated 4/7/15, indicated R4 had severe cognitive impairment, was totally dependent on two staff for transfers, toilet use and personal hygiene and required extensive assistance of two staff for bed mobility and dressing. The MDS also identified R4 was always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R4's Care Area Assessment (CAA) Summary for Urinary Incontinence dated 4/12/15, indicated R4 was always incontinent of bladder, toileting programs had failed due to noncompliance secondary to behaviors and dementia, required extensive assistance of one staff to check and change incontinent product and provide perineal	F 315	R4 was re-assessed for incontinence status and the plan was reviewed for appropriate timing of assistance. He continues to need assistance of two staff every two hours for incontinence care. Staff will be educated on providing incontinent care as care planned on July 22 and July 23, 2015. Incontinence care policy was developed. Audits will occur for residents who are incontinent three times per week for 4 weeks with results reported to the QA committee for further direction with audits. DON is responsible	8/5/15

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F 315	Continued From page 46 care. The CAA also indicated R4 was at risk for skin integrity issues, offensive odor, loss of dignity and falls. R4's Resident Care Plan dated 4/12/15, indicated R4 had an alteration in elimination and directed staff to provide all cares with two staff assist. The care plan also indicated R4 was incontinent of bladder and directed staff to check R4 every 2 hours, change as needed and provide peri-rectal care after elimination. On 06/24/2015, at 2:44 p.m. R4 was observed seated in a geri chair at a Bingo activity. On 6/24/15, during continuous observation from 4:34 p.m. until 8:07 p.m. the following was observed: -At 4:34 p.m. R4 was seated in the geri chair in the activity area. -At 5:19 p.m. nursing assistant (NA)-H was observed to wheel R4 into the dining room and placed him by a table. -At 5:32 p.m. NA-I was observed feeding R4 supper. -At 6:10 p.m. NA-I wheeled R4 from the dining room into the common area. -At 6:12 p.m. NA-I stated he would leave R4 up for another 1/2 hour and then lay him down. -At 7:46 p.m. NA-I wheeled R4 to his room. NA-I stated it was his first night working at the facility so he was unfamiliar with R4, however, stated he believed R4 was to be toileted every two hours. NA-I stated he was unsure when R4 got up that day. -At 8:07 p.m. NA-I was observed to perform evening cares for R4. NA-I and NA-B then transferred R4 to bed with the use of a mechanical lift. R4 was observed to have been	F 315		

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F 315	Continued From page 47 incontinent of bowel and bladder. R4's back, buttocks and bony prominence's were observed non-reddened with intact skin. NA-I and NA-B both stated they had not checked R4 for incontinence since the beginning of their shift at 2:00 p.m. and verified this should have been done every two hours. On 06/26/15, at 3:47 p.m. the administrator confirmed R4 should have been checked for incontinence / changed every two hours as directed by the care plan. No policy on incontinence care was provided.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative range of motion services as directed physician orders and / or the individualized care plan for 2 of 3 residents (R3, R15) reviewed for range of motion and restorative nursing services. Findings include: R3 was not provided range of motion (ROM)	F 318	F318 Physical Therapy will be reassessing all residents with ROM deficits to determine a ROM program for each. This includes R3 and R15. A restorative nursing program will be established to be provided needed ROM services and will include documentation of ROM services. Staff will be educated on providing and documenting ROM services on July 22 and 23, 2015. Audits will be conducted three times per week for 4 weeks with results reported to the QA committee for further direction with audits. DON is responsible	8/5/15

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F 318	Continued From page 48 services as ordered by the physician. R3's undated Admission Face Sheet indicated R3 was diagnosed with quadriplegia (paralysis of all four limbs), contracture (deformity resulted from a stiffness or constriction in joints, tendons, or ligaments which restricted normal movement) of joints and dysphagia (difficulty swallowing). R3's Physician Notes dated 8/28/14, by the physical therapist, ordered rehabilitation aide to continue active (resident able to move the joint) and passive (therapist or equipment moves the joint manually) exercises to all extremities 3-6 times a week. R3's Physician Orders and Progress Notes dated 3/1/15, directed staff to provide active and passive ROM to all limbs. R3's clinic visit dated 3/11/15, identified R3 as having congenital generalized flexion contracture's of lower limb joints and chronic contracture's of upper and lower limbs. R3's quarterly Minimum Data Set (MDS) dated 5/26/15, indicated R3 had severe cognitive impairment and required extensive assist with bed mobility, transferring on and off the unit, eating, dressing, toileting and personal hygiene. In addition, the assessment area regarding functional limitation in ROM was not addressed. R3's care plan dated 6/15/15, indicated R3 had a self-care deficit and directed staff to thread R3's arms through clothing and staff would complete dressing. However, the care plan lacked directive on conducting active and passive ROM exercises.	F 318		

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F 318	Continued From page 49 R3's nursing assistant care sheet titled: West Hall: CNA 2, [undated] lacked directive on conducting active and passive ROM exercises. On 6/25/15, at 8:21 a.m. R3 was observed seated in his tilt back wheelchair by the nursing station. R3's feet were observed in extreme plantar flexion (foot or toes flexed downward toward the sole of the foot). R3's hands bilaterally were contracted and stiffly bent inward. On 6/25/15, at 9:06 a.m. the director of nursing (DON) verified R3 should have received ROM services as ordered by the physician. The DON stated she thought the ROM services were provided by the nursing assistants (NA) however, the DON did not think the NA's had been documenting when ROM was completed. The DON stated she was unsure of when the restorative nursing services program for the facility had ended. On 6/25/15, at 9:20 a.m. physical therapy aide (PTA)-A confirmed R3 was not on the physical therapy department's schedule to see and provide services. On 6/25/15, at 9:55 a.m. NA-G stated she was unsure if the NA's were supposed to document when ROM was provided for the residents. On 6/25/15, at 10:20 a.m. NA-E stated they used to have a form that the NA's utilized to document when they had done ROM, however they did not have it any more. On 6/25/15, at 12:20 p.m. NA-A stated the NA's did not do ROM exercises, the therapy	F 318		

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F 318	Continued From page 50 department did that. On 6/25/15, at 1:00 p.m. occupational therapist (OT)-A reviewed R3's physical therapy's evaluation (dated 8/29/13) and completed a thorough active and passive ROM evaluation of R3's upper and lower extremities. Upon completion of OT-A's ROM evaluation, OT-A stated she was unable to confirm if R3 demonstrated a decline in range of motion ability as the 8/29/13, physical evaluation did not state if the evaluation results had been done passively or actively. R15 was not provided ROM services to the right hand as directed by the care plan and was not provided with a right hand splint according to the assessed needs. An occupational therapist note dated 3/6/15, indicated R15 had contractures to the right hand and indicated R15 was in need of "cylindrical" splint for protecting the palm and maintaining ROM. R15's quarterly MDS dated 4/9/15, indicated R15 was diagnosed with dementia, seizures and general paresis (paralysis). The MDS also indicated R15 was cognitively impaired, had no speech and was totally dependent on staff for all activities of daily living. The MDS identified R15 had an upper extremity impairment on one side and lower extremity impairment on both sides and indicated R15 required the assistance of two staff for transfers and repositioning. R15's care plan dated 4/11/15, indicated R15 had impaired physical mobility related to dementia, seizure disorder and paralysis. The care plan directed staff to complete ROM exercises to	F 318		

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F 318	Continued From page 51 R15's upper and lower extremities four times a week. However, R15's medical record lacked indicated that R15 had received the ROM services. On 6/24/15, at 7:25 p.m. the DON stated she was not sure who completed ROM exercises for R15. At the same time, the DON asked NA-H who completed R15's ROM exercises. NA-H stated the facility used to have a rehab department and they would complete all the ROM and exercise programs for the residents but since they stopped the rehab program there was no book in the facility to document that ROM had been completed. On 6/25/15, at 8:20 a.m. the DON confirmed the facility had not documented the provision of ROM exercises for R15 and verified R15's care plan was not followed. On 6/25/2015 at 12:46 p.m. NA-D stated she thought the therapy department worked with R15. NA-D stated completing ROM for R15 was not on the assignment sheet to direct us to do it, and there was no place to sign it off if we had done it. On 6/26/15 at 2:15 p.m. the physical therapist assistant from the contracted therapy services stated R15 had not received therapy treatments from that department. In addition R15's treatment administration record included a treatment dated 4/10/15, directing nursing staff to place rolled washcloth in R15's right hand daily and remove for skin check and hygiene. However, on 6/24/15, from 12:40 p.m. until 7:00 p.m. R15 was observed to not have any kind of a splint or wash cloth in his right hand.	F 318		

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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 318	Continued From page 52 On 6/24/15 at approximately 7:10 p.m. Licensed practical nurse (LPN)-C verified R15 was to have a rolled wash cloth in his right hand. LPN-C was observed to place a rolled wash cloth in R15's right hand. No policies on ROM services or restorative nursing program were provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident 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 fall interventions had been implemented to help minimize the risk of further falls and / or injury for 1 of 3 residents (R13) reviewed for falls. Findings include: R13's undated Admission Face Sheet identified her diagnoses as dementia, chronic kidney disease, anemia, diabetes, blindness in both eyes. R13's Fall Risk Evaluation dated 11/17/14,	F 323	F323 R13 will be reassessed for safety devices and the care plan updated as needed. A procedure for moving residents and their safety devices will be developed. A list will be maintained of all devices and who they are used for by the DON. The care plans will be reviewed and revised as necessary. All staff will be educated on ensuring each resident has the proper safety devices on July 22 and 23, 2015. Audits will be conducted three times per week for 4 weeks with results reported to the QA committee for further direction with audits. DON is responsible	8/5/15

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F 323	Continued From page 53 indicated R13 was at risk for falls. R13's quarterly Minimum Data Set (MDS) dated 4/25/15, revealed R13 had severe cognitive impairment and required extensive assist with bed mobility, transferring, locomotion on and off the unit, dressing, eating, toileting and personal hygiene. The NA care sheet titled South Hall: CNA 1, directed staff to place a mat on R13's floor as she was a fall risk. The care plan dated 6/15/15, identified a focus area for a potential for falls and directed staff to conduct hourly visual safety checks, assure R13 was in a hi-lo bed with a mat on the floor by the outside edge of the bed. On 6/24/15, at 12:30 p.m. R13 was observed seated in her wheelchair in the common area. -At 12:40 p.m. nursing assistant (NA)-B brought R13 to her room, transferred R13 to her bed, placed the bed in the low position and assured R13's call light was within reach. R13 was in a double occupancy room, with R13's bed located closest to the door. There was not a mat placed beside R13's bed, nor a mat visualized in R13's room. On 6/24/15, at 12:40 p.m. registered nurse (RN)-A entered R13's room and administered medications to R13's roommate. RN-A did not identify that R13 did not have a floor mat in place. On 6/24/15, at 2:04 p.m. NA-D was observed to enter R13's room and proceed to assist R13 up into her wheelchair and into the bathroom. NA-D then transported R13 out into the common area.	F 323		

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F 323	Continued From page 54 On 6/24/15, at 2:15 p.m. NA-D stated when she conducted safety checks on residents she checked to assure alarms were in place, the side rails were in the proper position and the resident was comfortable. NA-D confirmed safety checks also included assuring a fall mat was in place, if it was ordered. NA-D verified R13 had not had a fall mat placed beside the bed, nor was there a fall mat even in R13's room. NA-D stated R13 had been temporarily moved to a new room as R13's room was being repaired. NA-D stated she bet when they moved R13 to the new room, they didn't move the mat with her. R13's Treatment Sheet indicated R13 was to be checked every hour as R13 was a high risk for falls. The documentation on R13's Treatment Sheet indicated safety checks had been conducted every hour on 6/23/15, and 6/24/15. On 6/14/15, at 2:30 p.m. the director of nursing (DON) confirmed it was her expectation that staff follow the resident's care plan. The DON reviewed R13's care plan and confirmed a mat should have been placed beside R13's bed and stated the mat probably didn't get brought with R13 when they temporarily moved R13 into the different room. Falls and Fall Risk, Managing policy dated 4/24/13, specified interventions would be identified related to the resident's specific risks to prevent the resident from falling and to try to minimize complications from falling. Using the Care Plan policy [undated] indicated care plans were used to develop the resident's daily care routines and that the documentation	F 323		

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F 323	Continued From page 55 was consistent with the resident's care plan.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a prescribed and recommended diet in order to prevent significant weight loss for 1 of 3 residents (R4) reviewed for nutrition and had experienced significant weight loss. Findings include: R4's undated Diseases Index Report indicated R4 had diagnoses that included diabetes with neurological manifestations, chronic kidney disease, anemia, and esophageal reflux. R4's Nutrition Assessment dated 3/17/15, indicated R4 was 72 inches (") tall, weighed 161 pounds (lbs) as of 3/16/15, and identified R4's ideal body weight (IBW) range as 153-187 lbs. The assessment indicated R4's estimated	F 325	F325 R4's dietary requirements have been reviewed. The dietary menus have been rewritten by the registered dietitians at the hospital and care center. Diets have been revised and renamed to reflect current practice standards. Diets of each resident were reviewed and changed to reflect the new revised diets. Dietary staff were educated on the new diets/menus July 16, 2015. The new diets/menus were put into place on July 20, 2015. A nutrition-at- risk committee was initiated June 1, 2015 and will meet monthly. A new form was developed to track residents who are at risk nutritionally. Consultant Dietitian reviews all resident weights monthly and updates this form. HS snack cart checkoff list was developed and is included on the snack cart for recording snack intakes. Nursing home staff were educated on July 22 and 23, 2015. See next page	8/5/15

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F 325	Continued From page 56 nutritional needs based on current body weight to include 2190-2690 kilocalories (kcal) + 500 kcal to gain. The assessment also identified R4 was totally dependent with eating and required a diet prescription of regular, mechanical soft with ground meat and 1/2 sandwich at lunch and supper. Oral nutrition supplements were identified as NIP and 4 oz. Mighty Shakes twice daily. The assessment identified the problem, etiology, signs/symptoms (PES) statement to be "Compromised nutrition and or hydration status, risk factors, and/or complications indicate need for intervention." R4's Medical Nutrition Therapy Note dated 3/17/15 indicated continued small weight loss. 3/16/15, weight of 161 lbs was 1% decrease in 30 days / 5% decrease in 180 days. The note indicated R4 was 100% of IBW range of 153-187. Body mass index of 21.75 was healthy. R4's intake was 50-100% most meals and R4 consumed 4 oz Mighty Shakes twice a day 100%. The note indicated the dietitian had no new recommendations. R4's annual Minimum Data Set (MDS) dated 4/7/15, indicated R4 had severe cognitive impairment and was totally dependent on one staff person for eating. The MDS also indicated R4 did not have any natural teeth, was on a mechanical altered diet and had no signs or symptoms of a swallowing disorder. R4's Care Area Assessment (CAA) Summary for Nutritional Status dated 4/12/15, indicated R4 had diagnoses of hyperlipidemia, hypertension and diabetes. His diet was identified as consistent carbohydrates, ground meat with NIP program [nutrition intervention program] and 1/2 sandwich	F 325	A handout describing each diet was provided to nursing staff on July 16, 2015. Tray cards were developed to place on the resident trays to include diet, likes, dislikes, fluids and restrictions. Audits will be performed five times per week for 4 weeks with results to QA for further direction with audits. The dietary supervisor will be responsible with oversight from the Administrator.	

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F 325	Continued From page 57 in the evening. The summary indicated R4 had no swallowing or chewing problems and staff fed him meals in the dining room. Risk factors identified were weight changes, choking or chewing problems, hypo-hyperglycemia and skin breakdown. R4's Care Plan dated 4/12/15, identified alteration in nutrition related to history of inadequate intake with a goal of weight stability within a goal range of 155-170 pounds. Approaches identified included regular mechanical soft diet with ground meat and extensive assist of 1 staff to feed in commons area or dining room, NIP diet, 1/2 sandwich with meal, 4 oz. Mighty Shake twice a day, and weights, vital signs and labs as ordered. R4's Physician Orders & Progress Notes dated 5/15/15, included the following: · Diet: regular with extra calories at meals - dietary to send 1/2 sandwich every lunch and supper with regular meal. · Resident to eat in commons area or dining room for all meals · Ensure nursing assistants (NA's) call kitchen to order soup and sandwich or make a shake with ice cream and mighty shakes between meals. · Res [resident] to have ground meats · NIP diet for extra calories · 4 ounce (oz) Mighty Shake (fortified nutritional supplement) twice a day. Can also pour over ice-cream to make milkshake. Alert dietitian if he is refusing. The NA care sheet titled West Hall CNA 1 dated as revised 5/20/15, directed staff R4 required a regular mechanical soft diet with ground meats, unable to feed self, and assist of 1 to feed in commons area. The care sheet also indicated	F 325		

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F 325	Continued From page 58 R4 was to be weighed on Mondays, Wednesdays, and Fridays. The Nursing Assistant Daily Care Record dated April 2015, May 2015 and June 2015, were reviewed and revealed the following regarding meal intake: -April 50-100% intake - 9 meals marked 0, 7 meals blank. 60 of 60 snacks not documented. -May 50 -100% intake except - 1 meal marked 0, 16 meals blank, 4 of 60 snacks marked 0, 54 of 60 snacks blank. -June 50-100% intake except - 30 meals blank of 71 opportunities, 1 snack marked 40%, 10 snacks marked 0, 37 snacks blank of 47 opportunities. The Medication Administration Record dated 4/1/15, through 6/24/15, were reviewed and revealed the following regarding R4's intake of Mighty Shake 4 oz twice daily: April: R4 consumed 50-100% twice daily with one entry marked 0. May: R4 consumed 100% twice daily with one entry marked 50 and one entry marked 80 June: R4 consumed 100% twice daily with 7 entries marked 0 or refused and one blank entry. Review of R4's weights revealed the following: 11/17/14: weight of 178.9 lbs. 12/8/15: weight of 175 lbs. 3/9/15: weight of 165 lbs 4/30/15: weight of 157 lbs 6/11/15: weight of 155.6 lbs. 6/19/15: weight of 147.2 lbs. On 6/24/15, at 5:32 p.m. NA-I was observed feeding R4 supper. R4 was observed to have	F 325		

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F 325	Continued From page 59 three lower teeth and no upper teeth. Supper consisted of a burrito with scrambled eggs with ground meat inside a soft tortilla, a muffin, 8 oz of milk, coffee and watermelon. No sandwich was provided. NA-I fed R4 the contents of the burrito but not the tortilla. -At 6:08 p.m. R4 had finished eating. He consume approximately 1/2 of the burrito contents, 1/4 of the muffin, 1/2 cup of coffee, 0 milk and 0 watermelon. On 06/25/15, at 9:52 a.m. the registered dietitian (RD) stated the nutrition intervention program (NIP) referred to a policy of specific nutrition interventions used for those residents who were more high risk, nutritionally. The RD stated the interventions were part of a system to encourage the use of real food first such as whole milk, butter, extra gravy and other high calorie items to assist with weight gain. On 06/25/15, at 1:00 p.m. the RD confirmed R4 had experienced a 16% weight loss in past 180 days which was a significant weight loss. The RD stated the NIP interventions were not as successful at the facility as she did not get compliance from the dietary supervisor (DS). The RD also stated it had been an ongoing issue getting compliance with diets such as mechanical soft. the RD confirmed the burrito served to R4 would probably not be part of a mechanical soft diet. the RD further stated she would be assessing R4 and implementing increased interventions, as well as meeting with the DS to try to get involvement. On 6/26/15, at 10:35 a.m. the DS stated the kitchen did not offer any type of therapeutic diet. She stated everyone received the same diet and	F 325		

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F 325	Continued From page 60 the same portion size. The DS confirmed they should be following the special diets / order and she had been working with another company to develop menus that were easier for her staff to follow along with. On 06/26/15, at 3:47 p.m. the administrator stated R4 had been eating with assistance of one staff member and usually ate well, however, "when he is done, he is done." She stated at that time R4 refused additional food or drink. She also stated R4 did not need more to eat, rather more opportunities to eat. The administrator confirmed a therapeutic diet had not been provided for R4. A policy regarding weight loss and nutrition was requested but none was provided.	F 325		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334	All JPECC residents receive their Pneumococcal vaccinations and influenza vaccinations at the IHS clinic. The clinic is responsible for obtaining the consents and explaining the risks and benefits. JPECC will be responsible for obtaining documentation from the clinic on which vaccinations were administered and/or refused. This will then be documented in the JPECC resident record. All resident records will be audited to ensure immunization status is up to date. Staff will be educated on this policy on July 22 and 23, 2015.	8-5-15

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F 334	Continued From page 61 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334	The policy and procedure will be updated to reflect this procedure. An audit was performed when immunizations were put into the new computer system on July 10, 2015. Audit of new admissions will include immunization statuses. As part of our ongoing infection control program, an immunization status report will be made to the QA committee. DON/designee is responsible for maintaining the list and reporting at QA.	

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F 334	Continued From page 62 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and administer or document refusal or contraindications of administering the influenza immunization for 1 of 5 residents (R19) reviewed for immunizations. Findings include: R19's quarterly Minimum Data Set (MDS) dated 4/11/15, indicated she was admitted prior to the 2014/2015 influenza season. The Influenza Vaccination Informed Consent form indicated R19 last received the influenza vaccination on 9/12/13. On 6/23/15, at 11:26 a.m. the director of nursing (DON) confirmed R19's medical record lacked documentation of contraindication, refusal or the administration of the influenza vaccination for the 2014/2015, influenza season. The Influenza/Pandemic policy dated 6/11/14, indicated all current and newly admitted residents would be offered the influenza vaccine from October of each year, through the end of March the following year. A signed or verbal consent form would be completed prior to vaccine administration with a note in the chart to indicate	F 334		

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F 334	Continued From page 63 refusals. The policy also indicated any contraindications present would be documented in the chart.	F 334		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide mechanically altered food according to the assessed need for 1 of 4 residents (R4) reviewed for nutrition. Findings include: R4's undated Diseases Index Report indicated R4 had diagnoses that included diabetes with neurological manifestations, chronic kidney disease, anemia, and esophageal reflux. R4's Nutrition Assessment dated 3/17/15, indicated R4 was totally dependent on staff for eating and required a diet prescription of regular, mechanical soft with ground meat and 1/2 sandwich at lunch and supper. R4's annual Minimum Data Set (MDS) dated 4/7/15, indicated R4 had severe cognitive impairment and was totally dependent on one staff person for eating. The MDS also indicated R4 did not have any natural teeth, was on a mechanical altered diet and had no signs or symptoms of a swallowing disorder.	F 365	Therapeutic menus have been rewritten to address food and mechanical alterations related to resident needs. Menus are posted and are to be followed as posted. If a menu item must be changed, the substitution policy must be followed which includes updating the posted menu. Mechanical alteration as ordered by the medical provider will be followed. An alternative entrée and vegetable is in place for the noon and evening meals. A list of other available alternatives which are readily available has been developed and posted by the menu. NIP recipes were provided to dietary staff along with a list of residents who require NIP foods. Education on importance of therapeutic diets and use in disease treatment by hospital and consultant dietitians was provided to dietary staff on July 16, 2015. A	8/5/15

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F 365	Continued From page 64 R4's Care Area Assessment (CAA) Summary for Nutritional Status dated 4/12/15, indicated R4 had diagnoses of hyperlipidemia, hypertension and diabetes. His diet was identified as consistent carbohydrates, ground meat with NIP program [nutrition intervention program] and 1/2 sandwich in the evening. The summary indicated R4 had no swallowing or chewing problems and staff fed him meals in the dining room. Risk factors identified were weight changes, choking or chewing problems, hypo-hyperglycemia and skin breakdown. R4's Care Plan dated 4/12/15, identified alteration in nutrition and directed staff to provide R4 a regular mechanical soft diet with ground meat and extensive assist of 1 staff to feed and a NIP diet, 1/2 sandwich with meal, 4 oz. Mighty Shake twice a day, and weights, vital signs and labs as ordered. R4's Physician Orders & Progress Notes dated 5/15/15, included the following: · Diet: regular with extra calories at meals - dietary to send 1/2 sandwich every lunch and supper with regular meal. · Resident to eat in commons area or dining room for all meals · Ensure nursing assistants (NA's) call kitchen to order soup and sandwich or make a shake with ice cream and mighty shakes between meals. · Res [resident] to have ground meats · NIP diet for extra calories · 4 ounce (oz) Mighty Shake (fortified nutritional supplement) twice a day. Can also pour over ice-cream to make milkshake. Alert dietitian if he is refusing.	F 365	handout will be provided to nursing on new diets and NIP features. Nursing will be educated on changes July 22 and 23, 2015. New menus will start being used on July 20, 2015. Audit 5 x week x 4 weeks with results to QA for further direction with audits. Dietary supervisor is responsible with oversight by the Administrator.	

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	245535	A. BUILDING _____ B. WING _____	06/26/2015

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F 365	Continued From page 65 The NA care sheet titled West Hall CNA 1 dated as revised 5/20/15, directed staff R4 required a regular mechanical soft diet with ground meats, unable to feed self, and assist of 1 to feed in commons area. On 6/24/15, at 5:32 p.m. NA-I was observed feeding R4 supper. R4 was observed to have three lower teeth and no upper teeth. Supper consisted of a burrito with scrambled eggs with ground meat inside a soft tortilla, a muffin, 8 oz of milk, coffee and watermelon. No sandwich was provided. NA-I fed R4 the contents of the burrito but not the tortilla. -At 6:08 p.m. R4 had finished eating. He consume approximately 1/2 of the burrito contents, 1/4 of the muffin, 1/2 cup of coffee, 0 milk and 0 watermelon. On 06/25/15, at 1:00 p.m. the RD stated it had been an ongoing issue getting compliance with diets such as mechanical soft. The RD confirmed the burrito served to R4 would probably not be part of a mechanical soft diet. The RD further stated she would be assessing R4 and implementing increased interventions, as well as meeting with the DS to try to get involvement. On 6/26/15, at 10:35 a.m. the DS stated the kitchen did not offer any type of therapeutic diet. She stated everyone received the same diet and the same portion size. The DS confirmed they should be following the special diets / order and she had been working with another company to develop menus that were easier for her staff to follow along with. On 06/26/15, at 3:47 p.m. the administrator confirmed a therapeutic diet had not been	F 365		

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F 365	Continued From page 66 provided for R4. A policy regarding the provision of therapeutic diets was requested and not provided.	F 365		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide therapeutic meals and prescribed meal portions for 5 of 5 residents (R34, R7, R26 and R39) on a prescribed therapeutic diet. The facility also failed to provide alternative meals and also failed to post the accurate menus. This deficient practice had the potential to affect all of 34 residents who resided in the facility and received meals from the kitchen. Findings include: The facility's undated Resident Diet Report which indicated each residents' prescribed diet revealed the following: R34 was prescribed a renal (diabetic) diet. R7 was prescribed a consistent carbohydrate, no added salt diet. R26 was prescribed a consistent carbohydrate, cardiac, no added salt, renal diet. R39 was prescribed a modified diet to include consistent carbohydrates and low sodium foods.	F 367	Therapeutic menus have been rewritten to address food and mechanical alterations related to resident needs. Menus are posted and are to be followed as posted. If a menu item must be changed, the substitution policy must be followed which includes updating the posted menu. Mechanical alteration as ordered by the medical provider will be followed. An alternative entrée and vegetable is in place for the noon and evening meals. A list of other available alternatives which are readily available has been developed and posted by the menu. NIP recipes were provided to dietary staff along with a list of residents who require NIP foods. Education provided to dietary staff July 16. A handout will be provided to nursing on new diets and NIP features. Nursing will be educated on changes July 22 and 23. New menus will start being used on July 20th. Residents will be updated on the new menu See next page	8/5/15

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F 367	Continued From page 67 On 6/23/2015, at 10:50 a.m. the facility's menu posted in the main hallway indicated the residents would be served Rosemary Chicken, Augratin Potatoes, Seasoned Green Peas, Wheat Dinner Roll, Margarine Pat, Frosted Brownies, 2% Milk and Coffee for their noon meal. However, at 10:56 a.m. during the noon meal tray observation, cook (C-A) was observed to serve noodles with tongs and served all the residents two helpings of noodles, one scoop of Chicken Ala King and one scoop of peas. The posted menu did not include an alternative meal or substitute. At the time of this observation, the dietary supervisor (DS) stated all the residents were served the same entrée but if they asked for something different they could get it. The DS stated the facility did not offer a substitute or any alternative but residents could ask for soup and a sandwich at any time and they would serve it to them. C-A stated there was one resident who did not like peas and they did serve her carrots warmed up in the microwave. The DS stated all residents received the exact same food and portion sizes. On 6/24/15, at 5:15 p.m. the facility's menu posted in the main hallway indicated the residents would be served Tri-Meat Salad Plate, Potato Salad, Wheat Dinner Roll, Margarine Pat, and Fresh Watermelon Cubes, 2% Milk and Coffee. However at 5:30 p.m. all residents were observed to be served two Egg Burritos and a Muffin. On 6/25/15, at 10:09 a.m. C-A stated when she served meals, she used only one serving spoon or scoop per food item. She stated when she served noodles she was told to give four ounces	F 367	changes via written communications and at the July Resident Council. Audits completed five times per week for 4 weeks for ordered diet served and ordered portion sizes. QA will review and provide for further direction with audits. Dietary supervisor is responsible with oversight from the Administrator.	

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F 367	Continued From page 68 of noodles to everyone, one scoop of sauce and one scoop of vegetables and the vegetables were supposed to be four ounces. On 6/25/25, at 10:30 a.m. the posted, current menu was reviewed with the DS. The DS stated on 6/23/15, when the resident's menu indicated they would be served Rosemary Chicken and Au Gratin Potatoes there were no chicken breasts available so the dietary staff prepared noodles and chicken ala king instead. The DS then stated the 6/24/15, menu indicated the residents would be served Stir Fry Pork, Fluffy Rice, Oriental Mix Vegetables, however she said they served Beef Steak, Mushroom Gravy, Mashed Potatoes, and Brussel Sprouts. The DS said the menu was not changed to indicate what was really going to be served. She verified the residents would not know what they were going to have for a meal until it was served. The DS stated they could ask for something different if they did not like what was served to them but that did not happen very often. On 6/25/15, at approximately 10:45 a.m. menus were reviewed with the DS that included several special diets such as, No Added Salt, Consistent Carbohydrate, Finger Food, Mechanical Soft, Dysphagia 2, Small Portion, 1200 Kcal,1800 Kcal and Renal Diet. The DS stated the special diets and menu exchanges had been developed for residents to meet their nutritional needs. However, because they [residents] changed their menu so much it was confusing to the dietary staff on what to serve or how much food each resident should receive. The DS stated they did not always have in stock what they were to be serving. The DS stated all residents received the same food and the same amount because it was so confusing for the dietary staff to follow all the	F 367		

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F 367	Continued From page 69 special menus. She added, they need to develop an easier system so the cook knows exactly what and how much of everything to serve to each resident. On 6/26/15, at 10:30 a.m. the DS was again interviewed and confirmed the facility was not providing any type of therapeutic diet. The DS stated the cooks should have been following the prescribed diet and she had been working with another food service company to develop menus and a system that was easier for her staff to follow along with. On 6/24/15, at 2:00 p.m. the administrator stated the facility had identified problems with the dietary department and had an upcoming meeting scheduled with dietary supervisor and the registered dietician to address some of the above concerns. The facility Nutrition and Dietetic Service Policy and Procedure dated 4/14/15, for Menu Substitutions noted the Purpose: To establish a procedure for identifying what constitutes a menu change and define a method of documentation of those required menu changes. Procedure B. indicated a change in the menu requires that the substituted item be replaced with a food item of similar nutritional and caloric value. The facility Nutrition and Dietetic Service Police and Procedure dated 4/14/15, for Patient Menus noted: When changes are necessary, the Dietician will approve all menu changes. Notations of the change will be recorded on the patient menu and staff will be notified of the change.	F 367		

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F 371	Continued From page 70	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure foods were stored under sanitary conditions and at the proper temperatures, failed to ensure the food was served at the proper temperature and staff failed to maintain proper hand hygiene when distributing meal trays which had the potential to effect all 35 residents who received their food from the kitchen. Findings include: On 6/23/15, at 10:56 a.m. during the noon meal tray observation the tray line began at 10:56 a.m. Cook (C)-A was observed to serve noodles, chicken ala king sauce and peas. The dietary supervisor (DS) stated at that time that all residents received the same entrée but if they asked for something different they could get it. During the serving of the tray line, C-A stated there was one resident who did not like peas and they would serve her carrots. Another dietary staff handed the cook a container of carrots and C-A	F 371	Therapeutic menus have been rewritten to address food and mechanical alterations related to resident needs. Menus are posted and are to be followed as posted. If a menu item must be changed, the substitution policy must be followed which includes updating the posted menu. Mechanical alteration as ordered by the medical provider will be followed. An alternative entrée and vegetable is in place for the noon and evening meals. A list of other available alternatives which are readily available has been developed and posted by the menu. NIP recipes were provided to dietary staff along with a list of residents who require NIP foods. FOOD TEMPERATURES: Food temperature policy and procedure reviewed and revised as needed. HAND SANITIZING: Tray passing policy and procedure reviewed and revised as necessary. Handwashing policy for dietary staff reviewed and revised as necessary.	8/5/15

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F 371	Continued From page 71 placed them on the resident's plate. The cook was asked what the temperature of the carrots were and C-A stated the temperature of the carrots were not taken because they knew they were hot because they had just been removed from the microwave. -At approximately, 11:05 a.m. the DS stated the temperature of the carrot should have been taken and recorded. On 6/23/15, at 11:09 a.m. activity aide (AA)-B was observed to assist with serving the noon meal trays to resident's in the activity dining room and in their rooms. AA-B was observed to have disposable gloves on. AA-B pushed the serving cart down the hallway, sat a tray on the table in the activity dining room in front of a resident, assisted the resident with a clothing protector, removed the lid, took a piece of bread out of the protective package, held the bread in the gloved hands and buttered the bread for the resident. -At approximately 11:14 a.m. AA-B pushed the cart with the same gloved hands, sat a tray down in front of another resident sitting in the rotunda area. With the same gloves on AA-B removed a piece of bread from the protective package and buttered a piece of bread for that resident. AA-B did not utilize any hand sanitizer or change gloves. AA-B pushed the meal cart to the North hallway, carried a meal tray inside of a resident's room and removed the bread from the protective package. AA-B then asked the resident if they wanted peanut butter and when the resident said yes, AA-B picked up the bread with the same gloved hands and spread peanut butter on the bread. -At 11:17 a.m. the interim activity director was informed of AA-B's lack of hand hygiene and the interim AD instructed the staff to remove the	F 371	DATING ITEMS: Policy and procedure for dating open food items in refrigerator and freezer will be reviewed and revised as necessary with audits to occur 5 x week x 4 weeks. THERMOMETERS: Activity refrigerator and freezers have thermometers placed in them. Temperatures will be recorded daily and audited weekly for compliance x 4 weeks by activity coordinator. Common area refrigerators and freezers have had thermometers placed in them and temperatures are recorded daily by nursing staff. This will be audited weekly x 4 by DON/designee. Education provided to dietary staff July 16, 2015. A handout will be provided to nursing on new diets. Nursing will be educated July 22 and 23, 2015. New menus will start being used on July 20th. Audits completed 5 x week x 4 weeks for ordered diet served and ordered portion sizes. Audits for hand sanitizing while passing trays for dietary staff will be 5 x week x 4 weeks. QA will review and provide for further direction with all audits.	

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F 371	Continued From page 72 gloves and wash hands before delivering another meal tray. On 6/25/15, at 10:30 a.m. the freezer in the main kitchen was observed to have an opened bag of carrots and an opened bag of hash browns that lacked a date when they were opened. Dietary aide-A verified they were undated. On 6/25/15 at 12:05 p.m. the refrigerator in the activity kitchen was observed to have many items stored in the shelves and doors that were not labeled with the date they were opened. The interim activity director stated at that time the refrigerator contained resident food that was used during activities. Some of the items identified included lunch meat, miracle whip, tartar sauce, taco seasoning, catsup, mustard, barbeque sauce and ranch dressing. The refrigerator also had an accumulation of dried food and dried liquid stains throughout the refrigerator section and the freezer. The interim AD verified there were many open containers in the refrigerator and none of them were labeled with a date on which they were open and there was no way to identify when they were opened. On 6/25/15, at 12:55 p.m. the two under counter refrigerators in the commons area were observed to be lacking thermometers in order to ensure the residents snack items, milk and juice was kept at the proper temperature. The refrigerator on the left had a huge amount of ice build up in the freezer and had a large black garbage bag inside the freezer. The administrator removed the bag, stated it was ice cubes and dumped the contents into a sink and threw the bag in the garbage. The entire bottom of the refrigerator was covered with light yellow liquid that was determined to be pickle	F 371	Dietary supervisor is responsible with Administrator oversight.	

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F 371	Continued From page 73 juice. The other refrigerator had spilled food dried on the racks and pieces of dried items on the bottom of the refrigerator. On 6/25/15, at approximately 1:05 p.m. the administrator stated nursing staff working the night shift was supposed to be cleaning the refrigerators and then verified the above refrigerators had not been recently cleaned. On 6/25/15, at 12:30 p.m. the dietary supervisor stated all food was to be dated right away when it was opened and staff had been instructed to always wash their hands before touching resident's food. The handwashing/hand hygiene policy dated 2010, indicated: Hand wash their hands for at least fifteen seconds using antimicrobial on non-antimicrobial soap and water under the following conditions: Before and after eating or handling food. Before and after assisting residents with meals.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	Misplaced policy and procedures and resident logs were found for last three months and given to the surveyors during survey. Log of employee illnesses will be created and kept current by the Infection Control designee. The resident infection control log will be revised to include room numbers and will be maintained on a daily basis. A map of the facility will be used to track trends on a daily	8/5/15

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F 441	Continued From page 74 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control program which included investigation, prevention, control, surveillance and reporting of disease and infection. This had the potential to affect all 35 residents who resided in the facility. Findings include: On 6/23/15, at 11:20 a.m. the director of nursing (DON) confirmed licensed practical nurse	F 441	basis. All new employees are given a handout on when to call off for work related to illnesses. The infection control policy dated 6/11/14 was reviewed and revised. JPECC infection control program includes ongoing monitoring per State and Federal Guidelines which include investigation, prevention, control and reporting of disease and infection. The DON and other staff as designated would directly supervise the facility's infection control program. The infection control designee is responsible for completing periodic surveillance and all staff will be kept informed of current infection control policies, procedures and concerns. A second APIC manual was ordered to replace the one stolen/misplaced. Weekly audits of infection control logs will be completed x 4 weeks and results reported to the QA committee. Ongoing audits will be determined by the QA committee. Infection control is a standing agenda item for the QA committee. DON/designee is responsible.	

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F 441	Continued From page 75 (LPN)-A was the infection control nurse for the facility. The DON stated infection control concerns were talked about Monday through Friday at the facility's stand up meetings. However, infection control concerns were not captured on the weekends. On 6/23/15, at 2:40 p.m. the DON provided the Infection Control Log for the months of April, May and June 2015. Each month had a separate log which included columns for information regarding resident name, room number, dates of treatment, date of onset, date of admission, admit/acquired, type/site of infection and symptoms, culture, x-ray, result of x-ray or culture and antibiotic. The room number column was left blank on all three (April, May and June) infection control logs. The DON stated she was unaware of the process LPN-A utilized to map infections to assist in the identification of cross contamination and ongoing surveillance. The DON stated she had "no idea" if LPN-A had someone else monitor for infection control concerns in her absence. On 6/23/15, at 3:20 p.m. the DON verified the facility did have an infection control policy and procedure book, however some of the policies had been updated and those had not been placed in the infection control book yet. On 6/24/15, at 5:14 p.m. the DON confirmed she was unable to provide the infection control logs for the past six months as LPN-A had given her notice and she would "need to start from scratch" with regards to the facility's infection control program. The DON verified she did not have facility infection control logs for the past six months.	F 441		

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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 441	Continued From page 76 On 6/24/15, at 6:43 p.m. the DON verified she was unaware of what training had been provided for new employees regarding infection control. The Infection Control policy dated 6/11/14, indicated the facility's infection control program included an ongoing monitoring process per State and Federal guidelines which included investigation, prevention, control and reporting of disease and infection. In addition, the policy specified the DON and other staff as designated would directly supervise the facility's infection control program. The infection control coordinator was responsible for completing periodic surveillance and all staff would be kept informed of current infection control policies, procedures, and concerns through orientation.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	Actions plans have been developed for each of the identified concerns listed in the deficiencies. Future deficient practice issues will have specific action plans developed to be acted on and reported back on at the next QA meeting with revisions to the action plans will be made as needed by the QA committee. Staff education on QA process will occur July 22 and 23, 2015. The agenda for QA will be audited monthly to ensure inclusion of deficient practices.	8/5/15

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	245535	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(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 520	Continued From page 77 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure quality assurance action plans had been developed for identified quality concerns related to nutrition and rehabilitative services. This had the potential to affect all 35 residents residing in the facility. Findings include: During the survey on 6/22/15, 6/23/15, 6/24/15, 6/25/15, and 6/26/15, the facility did not have any nursing rehabilitation services or restorative nursing services and nutritional services had multiple concerns see F364, F312 and F318. On 6/26/15 at 3:41 p.m. the quality assessment and assurance (QAA) program was reviewed with the administrator. The administrator stated the QAA committee met monthly and their meeting was structured around a standing agenda. The administrator confirmed that the QA committee had identified the facility did not have restorative nursing or rehabilitative service in place and had contracted an agency to provide services, however had not made a comprehensive QA plan to implement to ensure all residents who required those services received restorative nursing services. Additionally, the administrator stated she had been aware that the nutritional services	F 520	Next QA meeting will be August 5, 2015. Administrator/designee will be responsible.	

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F 520	Continued From page 78 had not been serving the appropriate diets and that there had been significant weight loss by some of the residents and the meals had not been served according to the posted menu's, however, a QA action plan had not been developed to address the identified deficiencies related to nutritional or restorative services.	F 520		

JOURDAIN/PERPICH EXTENDED CARE CENTER
24586 Hospital Drive – P O Box 399, Red Lake, MN. 56671
TELEPHONE: (218) 679-3400
FAX: (218) 679-3434

Fax RESPONSE NEEDED

TO: Lyla Burkman FROM: Mary Bell Zellner

FAX #: 218-308-2122 Pages (including cover): 80

Phone #: Date: 7-22-15

RE: cc:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

7/23/2015

Addendum to Plan of Correction

Changes to POC as follows:

All audit results will be reviewed at the Quality Assurance Committee on August 5, 2015 and recommendations for further audits and frequency and type will be determined by this committee for ongoing compliance.

All education has taken place on July 22 and 23, 2015. The training materials are placed on the electronic education system, EduCare. All staff who failed to attend will be required to complete the training on the EduCare system. The nursing department meetings were held on July 22, 2015 and those who failed to attend had packets put together with an acknowledgement form to be returned to the DON and it was also placed on the EduCare system.

F272

R39 and R2 will have full MDS's scheduled and completed by 8/5/15. All assessments used for completing MDS's are being audited for completion daily by the DON.

F282

Wounds are measured and monitored weekly by the wound nurse. In the case of the wound nurse being absent, the charge nurse and/or DON will be responsible to complete the weekly wound measurements and monitoring. Documentation will be reviewed weekly by the DON to ensure compliance.

F309

Observational audits will be completed daily on various shifts for devices used for contractures.

Observational audits will be completed daily on various meals to ensure residents using reclining chairs are placed at the appropriate angle for dining.

F312

Observational audits and record review will be used daily to ensure residents are receiving baths/showers as scheduled and that weights are obtained at least weekly or as ordered.

F314

R37 has discharged. All residents will have skin checks completed weekly with baths. Wounds are measured and monitored weekly by the wound nurse. In the case of the wound nurse being absent, the charge nurse and/or DON will be responsible to complete the weekly wound measurements and monitoring. Documentation will be reviewed weekly by the DON to ensure compliance.

Observational toileting/repositioning audits will be completed daily on various shifts and will include R4 and R15 in the observations.

F315

Observational toileting/repositioning audits will be completed daily on various shifts.

F318

Therapy is reviewing all residents for ROM. ROM will be added to the Point of Care documentation record. Observational audits will be conducted daily and on various shifts. Documentation audits will be competed weekly by the DON.

F323

Observational audits of safety devices will be performed daily on various shifts.

F325

Observation audits will be performed daily on various meals alternating.

F365

Observation audits will be performed daily on various meals alternating.

F371

Food temps will be taken and recorded for each meal daily and observational and documentation audits will be conducted daily for each meal.

F441

An initial documentation audit will be conducted of all resident infections starting with June 2015 and will be continued forward. The logs will be monitored daily by an RN to determine if patterns exist. A monthly audit will be done of the logs and reported to the QA committee monthly.

Signature Norma Brendle Date 7-23-15

Norma Brendle, Administrator

RECEIVED

JUL 28 2015

COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

Received
7/28/15
Approved
7/29/15
SB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Jourdain/ Perpich Extended Care Center 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 55101-5145, or	K 000	POC ok TB 8-3-15 RECEIVED JUL 23 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna J Brendle | TITLE: Asst. Administrator | (X6) DATE: 7-22-15

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 By e-mail to: Marian.Whitney@state.mn.us and 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. The Jourdain/ Perpich Extended Care Center is a 1-story building without a basement. The building was constructed in 1989 and is of Type II(000) construction. An assisted living apartment building, constructed in 2006 is separated from the building with a 2-hour fire barrier to the west and a hospital building, built prior to the extended care building is separated with a 2-hour fire barrier is to the east. The building is divided into 3 smoke compartments with 1-hour fire rated barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection, smoke detection in all common areas and automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and has	K 000		

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K 000	Continued From page 2 automatic fire detection in all areas required by the Minnesota State Fire Code 2007 edition. The facility was surveyed as one building. The facility has a capacity of 47 beds. At the time of the survey the census was 43 residents. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 11:00 AM to 3:00 PM on 06/23/2015, it was revealed during the review of the facility's fire and smoke damper	K 067	The fire/smoke damper system will be maintained. Service has been scheduled and will be done every four years thereafter. The tribal sanitarian is responsible to schedule the service meeting the NFPA 90 section 3-4.7 requirement.	8/5/15

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K 067	Continued From page 3 test/inspection documentation and was confirmed by interview with the Facility Administrator (NB), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Facility Administrator (NB).	K 067		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include:	K 154	The policy and procedure to be used in the event that the automatic fire sprinkler system has to be placed out of service for four hours in 24 hours was reviewed and revised to include all pertinent information. Tribal sanitarian is responsible to keep policy current.	7/16/15

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K 154	Continued From page 4 On facility tour between 11:00 AM to 3:00 PM on 06/23/2015, during a records review and an interview with the Facility Administrator (NB), the facility did not have an acceptable fire sprinkler system out of service policy to include the triggering criteria, and contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Facility Administrator (NB).	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 155	The policy and procedure to be used in the event that the fire alarm system is out of service for four hours in 24 hours was reviewed and revised to include the triggering criteria, and contact information in the event of the fire alarm system being out of service and the need for a fire watch to be initiated. Tribal sanitarian is responsible for keeping the policy current.	7/16/15

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K 155	Continued From page 5 Findings include: On facility tour between 11:00 AM to 3:00 PM on 06/23/2015, during a records review and an interview with the Facility Administrator (NB), the facility did not have an acceptable fire Alarm system out of service policy to include the triggering criteria, and contact information in the event of the fire alarm being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Facility Administrator (NB).	K 155		