

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2019

Ms.. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, MN 56464

Re: Reinspection Results - Complaint Number H5563012C

Dear Ms.. Ahlf:

On April 9, 2019 a surveyor from the Minnesota Department of Health, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on February 26, 2019. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted March 18, 2019

Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, MN 56464

RE: Project Number H5563012C

Dear Administrator:

On February 26, 2019, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 26, 2019 extended survey the Minnesota Department of Health completed an investigation of complaint number H5563012C.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 26, 2019, the situation of immediate jeopardy to potential health and safety cited at F-684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 17, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 17, 2019, 42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 17, 2019, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 26, 2019. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If

you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Green Pine Acres Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 26, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an "E" 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

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 Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 26, 2019 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health & 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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

Feel free to contact me if you have questions.

Sincerely,

6

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	VB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́сом	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	VINE ACRES NURSIN	G HOME		4	27 MAIN STREET NORTHEAST		
				N	IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 0	00			
	On 2/25/19, and 2/ was completed at y investigation was all was found NOT to b requirements of 42 requirements for Lo Complaint H556307 substantiated and re Jeopardy (IJ) at F68 thoroughly investigat to the saturation an surgical wound for physician orders to the resident had ex result of saturated w resulted in macerat and required addition An extended survey Minnesota Department's accept enrolled in ePOC, y at the bottom of the	26/19, an abbreviated survey our facility. A complaint so conducted. Your facility be in compliance with CFR Part 483, Subpart B and ong Term Care Facilities. I2C was found to be esulted in an Immediate 34 due to the facility's failure to ate contributing factors related d subsequent decline of a 1 of 1 resident (R1) who had keep the surgical site dry and perienced complications as a wound dressings which ed skin, wound dehiscence, onal surgical intervention. / was conducted by the hent of Health on 2/26/19. f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will					
F 684	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 6	84			3/26/19
	-						
	ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 03/28/2019

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.

PRINTED: 03/28/2019

	-	AND HUMAN SERVICES			FORM OMB NO.	APPROVEI 0938-039		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		245563	B. WING _			C 02/26/2019		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		•		
GREEN	PINE ACRES NURSIN	GHOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 684	Continued From pa	age 1	F 68	84				
	CFR(s): 483.25	0						
	applies to all treatm facility residents. B assessment of a re- that residents recei- accordance with pr practice, the compr care plan, and the This REQUIREMED by: Based on interview facility failed to thou factors related to the decline of a surgica (R1) who had phys surgical site dry and complications result dressings which re- wound dehiscence surgical intervention investigate causations surgical wound decomplications	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced w and document review, the roughly investigate contributing ne saturation and subsequent al wound for 1 of 1 resident ician orders to keep the d the resident experienced Iting from saturated wound sulted in macerated skin, and required additional n. This failure to thoroughly we factors related to the cline, and subsequent failure to erventions, resulted in an		Preparation, submission and implementation of this Plan of does not constitute an admiss agreement with the facts and set forth in the statement of do The facility has appealed the of and licensing violations stated Plan of Correction is prepared executed as a means to conti improve the quality of care, to all applicable state and federa requirements and constitutes allegation of compliance	ion of or conclusions eficiencies. deficiencies herein. This and/or nuously comply with l regulatory the facility's			
	when the facility red medical provider th dehisced as a resu wound dressings, a thoroughly investig develop policies an protection of surgic identified on 2/25/1 of nursing (DON) a	pardy (IJ) began on 2/8/19, ceived notification from a at R1's surgical wound had It of maceration from saturated and the facility failed to ate, and failed to modify or d procedures for the cal wounds. The IJ was 9. The administrator, director nd licensed social worker d of the IJ at 6:38 p.m. on		It is the policy of Green Pine A provide quality of care to all ou including those with wounds. The policy and procedure hav updated to include bathing sta will be obtained by the provide admission on residents with w have non-removable dressing splints, staples and/or sutures orders to keep the wound/dres Cast covers have been obtain nursing staff (RNs and LPNs)	e been itus. Orders or on ounds that s, casts, , and with ssing dry. ed and			

Facility ID: 00678

If continuation sheet Page 2 of 26

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
		245563	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/2	20/2019
	PINE ACRES NURSIN	G HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (2)			
F 684	Continued From pa	ae 2	F 68	4		
	 2/25/19. The IJ was noncompliance rem severity of G, isolat Findings include: R1's Admission Re- indicated R1 was a with diagnoses white aftercare following a vascular disease, d condition with diabed deficiency, hyperter vascular dementian disturbance, arterior extremities with gan of other right toes. R1's admission Min assessment dated admitted from the h cognitive impairment behaviors. The MD extensive assist of mobility, transfers, toileting, dressing a limited assistance of assistance of one p which had occurred also indicated R1 u wheelchair. The MI foot infection, a sur surgical wound care 	s removed on 2/26/19, but hained at the lower scope and red scope with actual harm. cord form printed 2/25/19, dmitted to the facility 1/25/19, ch included: orthopedic surgical amputation, peripheral liabetes due to underlying etic polyneuropathy, nutritional nsive chronic kidney disease, without behavioral osclerosis of native arteries of ngrene, and acquired absence himum Data Set (MDS) 2/7/19, indicated R1 was nospital, had moderate nt and demonstrated no S also indicated R1 required: one to two staff for bed locomotion on and off the unit, and bathing; and required of one staff for hygiene, and berson to walk in the corridor, d only once or twice. The MDS tilized a walker and DS also indicated R1 had a gical wound and received e with the application of foot		educated on the use of them as w demonstrated competency in the them, according to manufacturer's guidelines from 3/6/19-3/15/19. Cast covers will be used to cover on extremities that require moistu barrier where the physician has in the resident may shower. If a resid a wound order which indicates it is kept dry on another area of the bo a bed bath will be done, with the w that is to be kept dry avoided. If a resident requires open or clos wounds, dressings, wraps, braces or casts to be kept dry, the NAR w bathe resident until a cast cover h applied by a competent licensed r The licensed nurse will apply the of which time the NAR may then bat resident. Once the bathing is com licensed nurse is to remove the ca and assess for any wetness by bo looking and feeling. Any dampnes wetness noted will be reported to provider immediately, for further instructions. The Wound Care Nurse will assur care plans, orders, and document up-to-date and notify provider if co This is to be done on weekly wour rounds, ongoing. Nurse will docur concerns found and report to Dire Nursing and/or provider, if warran	use of wounds re dicated dent has to be dy then yound ed s, splints, vill not as been yourse. cover at he the plete the ast cover th s or the the the the solution is oncerns. nd care nent any ctor of ted.	
	surgical wound care dressings, and phy (PT and OT) were p MDS also dated 2/7 information as the a indicated R1 did no				ted. ee will are plan , if ssure	

Facility ID: 00678

If continuation sheet Page 3 of 26

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED	
		245563	B. WING			C 26/2019	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	•	20/2013	
GREEN	PINE ACRES NURSIN	NG HOME		427 MAIN STREET NORTHEAS MENAHGA, MN 56464	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR			F CORRECTION TION SHOULD BE THE APPROPRIATE CY)	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 3	F 68	4			
	 wheelchair. R1's p due to an amputation R1's Cognitive Loss Assessment (CAA) was aware of his s goal of cognitive in return home. R1's Activities of D Potential CAA date admitted from the following the surgion 3rd digits on the riginalizated R1 was read non-ambulatory, and with ADLs. In additive working with PT (p (occupational theration of the right foot 2nd place. According to consisted of cleans: In addition intervered monitor pain, monitor pain, monitor pain, monitor pain, monitor R1's Prescure Ulconsisted of cleans: In addition intervered monitor pain, monitor pain, monitor pain, monitor R1's Psychosocial 	rimary medical condition was ion. as/Dementia Care Area) dated 2/7/19, indicated R1 short term memory deficit with a nprovement as he desired to Paily Living (ADL)/Rehabilitation ed 2/7/19, indicated R1 was hospital for short term stay cal amputation of the 2nd and ght foot. The CAA also non weight bearing, nd required physical assistance tion, the CAA indicated R1 was obysical therapy) and OT apy) and indicated the goal was ADL abilities and avoid er/Injury CAA dated 2/7/19, admitted following amputation d and 3rd digits with stitches in o the CAA, wound treatment sing and dressing as needed. ntions included staff were to itor and manage diabetes, as weekly, weekly skin checks x priate foot and nail care, and Well-Being CAA dated 2/7/19, working hard toward his		 The procedure for trans changed January 28, 20 orders are to be doubled (2) nurses or a nurse ar added to the policy and February 26, 2019 was to number orders if ther orders on a page that an Nursing and TMA staff with the policy and procedure was completed Februar Date of compliance whe complete was March 15 that is currently on a leas training/competency test a shift at the facility. The QA committee was of correction on March 2 QA committee will conti compliance/training auction months. The Administrator and D responsible for oversigh of this plan 	219 in that all -checked by two and TMA. Also procedure on for the nurse/TMA e are multiple re difficult to read. were educated on e update. Training y 26, 2019. en all training was 5, 2019. Any staff twe will receive sting prior to taking updated on plan 22, 2019 and The nue to monitor lits monthly for 6		

If continuation sheet Page 4 of 26

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLET 245563 B. WING 02/26/2	SURVEY .ETED
	6/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GREEN PINE ACRES NURSING HOME 427 MAIN STREET NORTHEAST MENAHGA, MN 56464	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)CO	(X5) COMPLETION DATE
F 684 Continued From page 4 required physical assist of two staff for transfers and toileting, had a history of falls prior to admission and one fall occurrence while at the facility with no injury. The CAA also indicated R1 required reminders of non-weight bearing status. An Interagency Referral Form dated 1/25/19, indicated R1 had been hospitalized with a principal problem of gangrene of right foot, had undergone cystoscopy for foreign body removal from bladder, and had a right transmetatarsal amputation. Discharge orders included but were not limited to: -Appointments with Podiatry 1 week and 2 weeks from discharge -Don't change dressing, keep clean dry and intact until clinic visit -Non weight bearing-right. Medical predictability-predict that weight bearing status will increase and will be reevaluated at next appointment in 2 weeks. - Will have follow-up in 1 week but sutures will not be removed for at least 2 weeks and he is non weight bearing until the sutures are removed. -Physical Therapy: evaluate and treat -Discharge potentiai: length of stay <30 days, then plan assisted living. In addition an After Visit Summary (AVS), also dated 1/25/19, included the following instructions for R1's care: -Weight bearing status: non weight bearing-right -Medical Predictability - Predict that weight bearing status will increase and will be reevaluated at next appointments in 2 weeks. Will have follow-up in 1 week but sutures will not be removed for at least 2 weeks and he is non weight bearing utilt the sutures are removed.	

If continuation sheet Page 5 of 26

		AND HUMAN SERVICES				FORM	APPROVED
			(X2) MUI	TIPI	UI PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	` '		B	COMPLETED	
						(C
		245563	B. WING			02/2	26/2019
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN PINE ACRES NURSING HOME					427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From pa	ige 5	F 6	84	4		
	Injury/Trauma: amj	•					
	-Wound Care Instru	uctions: Don't change					
		an dry and intact until clinic					
	podiatry orders.	und care instructions: per					
		Referral instructions: evaluate					
	and treat						
	-Discharge Potential: Length of stay < 30 days.						
	Then plan assisted	living.					
	Although both documents include physician						
	discharge wound ca	are orders with directions to					
		essing intact, R1's facility Skin					
		1/25/19, identified an incision nich was 12 centimeters (cm)					
		s however the wound would					
		le had the dressing remained					
	intact.						
	R1's Medication Ad	ministration Records (MAR)					
		and 2/1-2/28/19, included the					
	following orders:						
		nitoring to right foot					
		putation site in the morning The order start date was					
	, , ,	ocumented as completed on					
	1/30/19, 2/6/18 and	l 2/13/19.					
		nitoring to right foot open					
	order start date was	day every Wednesday. The s 2/13/19 and was					
	documented as con						
	-Do not change dre	ssings. Elevate leg and keep					
		I times every shift for right foot.					
	discontinued 2/8/19	e was 2/1/19. The order was).					
		ministration Record (TAR)					
	dated 1/1 -1/31/19 a following orders:	and 2/1-2/28/19, included the					

If continuation sheet Page 6 of 26

PRINTED: 03/28/2019

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		C	
		245563	B. WING		02/26/2019		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN I	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 6	F 68	34			
	-Check right foot su signs/symptoms of as needed two time was 1/25/19. -Infection monitorin day. The order sta -Do not put plastic extremity when sho to wound. The ord -Dressing change to betadine, non-adhe bandage one time start date was 2/9/7 -Strict non weight to three times a day for date was 2/9/19. The podiatrist's Su 2/1/19, indicated F post transmetatars to peripheral artery changes to the dist indicated instructio hospital were to ke skilled nursing facil "Unfortunately, his therefore, they wer whether there was	urgical site for any infection. Cleanse and dress es a day. The order start date and note to right foot two times a rt date was 1/25/19. bandage over right lower owering will cause maceration er start date was 2/9/19. to right lower extremity, apply erent gauze, 4 x 4 gauze, ace a day for diagnosis. The order 19. bearing to right lower extremity or diagnosis. The order start rgical Follow report dated an amputation secondarily due disease with gangrenous al forefoot. The report ns after discharge from the ep dressings on while at the					
	overall diminished extremity and peda however, indicated the transmetatarsa capillary refill time of report included, "In although there was necrosis which was	I exam had revealed R1 had sensation to the lower I pulses were not palpable dorsal not plantar aspect of I amputation site did have a of less then 3 seconds. The cision site was well coapted a central portion of mild s dry and stable. There was utures were intact without					

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		NG	· · /	MPLETED		
		245562	B. WING			С		
		245563	B. WING			2/26/2019		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE			
GREEN I	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE		
F 684	Continued From pa	age 7	F 6	84				
		postoperative edema near						
		e was also an ulcerative lesion						
		ct at the central portion of the						
		appeared superficial in						
		ndicated R1 would have a ent in one week for suture						
		led: "Keep leg elevated, do not						
		vet. Keep Bunny boot on at all						
	times. Continue or	al antibiotics previous						
		rimary care team. Informed the						
		bes develop further necrosis or amputation site does develop						
		cence we will go forth with						
		ssed by the vascular team next						
		uctions were provided for						
	skilled nursing facil	lity to not change dressings."						
	P1's podiatry Surai	ical Follow up dated 2/8/19,						
		nt had attended the						
		is sister and included: "Patient						
		g in a skilled nursing facility.						
		e visit there is significant						
		d with the patient's operative						
		Iressings were saturated. After his sister, it does appear that						
	5	howering by the nursing staff at						
		They are attempting to wrap						
		with plastic to prevent water						
		essings. Unfortunately, we do						
	•	his dressings have been s macerated and wound						
		early evident to the amputation						
		laps had coaptation						
	secondarily due to	macerated tissue. Erythema						
		and laterally to the amputation						
		s to be no cellulitis or						
		king, however we will obtain nfections. Discussing with [R1]						
	101 10 10 10 10 10 1					1		

Facility ID: 00678

If continuation sheet Page 8 of 26

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII	TIPLE CONSTRUCTION		TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		ING		MPLETED	
						С	
		245563	B. WING		02/26/2019		
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COI			
GREEN	PINE ACRES NURSIN	G HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 8	F 6	84			
	the dressings were completely macera hyperkeratotic tissu indicated R1's right touch and, "Pedal p Central area of neo and laterally to the site there was woul with no acute signs was noted laterally. erythema from this drainage was noted	"The physical exam indicated removed and the heel was ted with desquamated ie. The surgical follow up note lower extremity was colder to pulses were difficult to Doppler. crosis was present. Medially transmetatarsal amputation ind dehiscence noted laterally of infections, no coaptation . Medially there is increase in area however, no purulent d with mechanical compression					
	PAD (peripheral art extremity. Capillar the amputation site seconds and slugg included: "I informed do have some cond appearance of his a	bableconcern for worsening ery disease) of his right lower y refill time dorsal lateral flat of was delayed between 3 and 5 ish in nature." The plan ed the patient and his sister I cern about worsening amputation site which is likely sons including but not limited					
	to patient's periphe recent saturation of and complete nonce extremity. I informe below-knee amputa wound dehiscence Going forth we can management poter	ral arterial disease, diabetes, f his postoperative dressings compliance of ambulating on ed him there is a higher risk of ation. I informed him of the as the flap has not adherent. continue with wound care ntial use of a wound VAC, more utation versus below-knee					
	amputation given the clinically, I do not be heal. We will await for the time being re dressing changes we dry sterile gauze, s	The appearance of his foot elieve this amputation site will t vascular's recommendation, hursing staff will perform daily with the use of Betadine and trict non-weight bearing to the try, do not get operative site					

If continuation sheet Page 9 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING			C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST //ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	wet. Patient will fol discuss further optivi instructions for the transmetatarsal am "Dressings need to Betadine, non-adhe bandages. Patient bearing to the right the operative site w today's office visit w his gauze and dress water after his rece attempt to apply a p lower extremity and to some sort of leak to become macerat wound dehiscence Follow-up with vaso likely needs revaso below-knee amputa extremity." R1's care plan print right foot surgical w provide weekly wou However, the care p interventions related site/extremity such surgical limb as we appropriate bathing getting wet when ba Review of R1's prog following: -1/25/19, R1 admitta amputation of right related to diabetes	low up with me next week to ons going forward." The right lower extremity uputation site included: be changed every day, apply erent gauze, 4 x 4 gauze, Ace is to be strictly non-weight lower extremity. Do not get vet, patient presented during with macerated tissue due to sings being saturated with and shower. Please do not olastic bandage around his d shower as this typically leads kage causing noted dressings ted and wet which will lead to which he currently has. cular next week, Wednesday ularization per vascular versus ation to the right lower ted on 2/25/19, identified the yound and directed the staff to and monitoring and treatments. plan failed to include the d to the care of the surgical as to maintain dryness of the II as how to provide g, and protect dressing from	F6	\$84			

If continuation sheet Page 10 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING			C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST /IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	on the right foot unt additional PN dated admitted for a short heal surgical site, re home. Incision clea with no signs of infe -1/30/19, weekly we surgical amputation incision measured A 20 cm x 45 cm dr site on bottom of fo scab on top of the f scab on the top of t the aforementioned small amount of set blood and serum) d odor, skin was a he indicated skin intact with dark red areas within. both #3 and dried res scabs, ski cleansing and cove and as needed. The improving. An addit indicated pedal pulse edema noted. -2/1/19, R1 had a p orders to no change elevated with bunny to "follow up with por removal". -2/8/18, pedal pulse edema present. Rig indicated at 12:19 p podiatry appointme -2/8/19, the note ino facility at 5:30 p.m.	ould be non-weight bearing il cleared by the physician. An 1/25/19, indicated R1 was stay of about three weeks to ecover strength and return n and dry on top of right foot ection noted. ound monitoring: right foot of toes. 1. The surgical 120 cm with intact sutures. 2. ied blister from amputation ot. 3. A 10 cm x 10 cm dried oot. 4. A 20 cm x 16 cm dried he foot. The observation of indicated wound #1 had a rosanguineous (contains both rainage on the dressing, no althy pink color. Wound #2 with no drainage skin soft and a couple of lighter areas #4 wounds were noted as n dry. Treatment consisted of ring the wounds twice a day e wounds were identified as ional PN dated 1/30/19, ses were present with no odiatry appointment. New e R1's dressings, keep leg boot on at all times, and R1 odiatrist next week for suture es present bilaterally with no pht foot dressing intact. A note om, R1 left the facility for a	F	\$84			

If continuation sheet Page 11 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING	i		C 02/26/2019	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	now incision line is cm long with open a line. Skin on the ed color. Incision clear covered with a non dressing followed b -2/11/19, late entry included: "Dressing with betadine applie followed by 4x4 gau was to be strictly no lower extremity. Do patient presented d macerated tissue to saturated with wate do not attempt to ap his lower extremity leads to some sort dressing to become lead to wound dehis Follow up with vaso revascularization pe knee amputation to On 2/25/19, at 11:14 therapist (OTR) sta the facility and was received skilled PT stated R1 had come amputation and had the right side. The 0 some cognitive test him to have minimu deficits. In addition, weak, had enduran been working with F cares/independence	red at 2/8/19, appointment and open. Incision measures 12 area 1 cm along entire incision ge of the incision is dusky in hised, painted with betadine, adherent, wrapped with kling y an Ace wrap. from appointment 2/8/19, needs to be changed daily ed, non adherent gauze uze and an Ace bandage. R1 on-wight bearing to the right not get the operative site wet, uring today's visit with o his gauze and dressing being r after recent shower. Please oply plastic bandage around and shower as this typically of leakage causing noted e macerated and wet which will scence which he currently has. cular next week as likely needs er vascular versus a below the the right lower extremity." 4 a.m. the occupational ted she was contracted with familiar with R1, who had and OT services. The OTR e in with a metatarsal d been non weight bearing on DTR stated she had done ing with R1 and had assessed im to moderate cognitive she stated R1 had been very ce issues, and that she had	F	584			

Facility ID: 00678

If continuation sheet Page 12 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST /IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	The OTR stated wh he'd had the impress his heel and the OT stressed with him h also stated R1 had transfer so they had for transfers. The C whether R1 had be leg when nursing ph he had it in his mind heel. The OTR reite R1 he was strict no after awhile he kind R1's cognitive defic Further, the OTR st surgical wound and used the shower. On 2/25/19, at 11:2 (TMA)-A confirmed amputation of the ri weight bearing. TM to a slide board with TMA-A stated R1 h had no resistance to behaviors. TMA-A walked while in the had remained wrap treatments to the for taken a shower and his room which he h week. TMA-A stated staff had wrapped h "Saran wrap." TMA had assisted R1 with Saran Wrap around supposed to chang TMA-A stated when	age 12 hen R1 had been admitted, ssion he could put weight on IR stated everyday they'd he could not do that. The OTR a tough time standing to d started using a sliding board OTR stated she could not verify en putting weight on his right rovided care however, stated d he could bear weight on his erated staff had stressed with in-weight bearing and stated to fremembered it, but thought cits were a factor in that. tated she had not seen R1's twas not aware whether R1 2 a.m. trained medication aide R1 had been admitted with an ight forefoot and had been non MA-A stated R1 had graduated h assist of 2 for transfers. ad been compliant with cares, o cares and exhibited no indicated R1 had never facility, and stated R1's foot oped and she had not done any bot. TMA-A verified R1 had d indicated he had a shower in had used one to two times per ed when R1 had showered his right lower extremity in A-A stated the last time she th a shower, she had applied d the foot as they were not e the dressing. However, n she had assisted R1 with a ing to the right foot had never	F	584			

If continuation sheet Page 13 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF F	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	any drainage on the looked or felt wet. On 2/25/19, at 11:2' (PT) indicated she we stated PT had work PT verified R1 had the right side and in stand/pivot transfer transfers due to his PT indicated they h awareness. PT sta so she couldn't ima indicated she didn't or get up on own. F seen R1's wound at if it was wet or if the dressing. PT stated when up and in bed On 2/25/19, at 11:3 were allowed to do involved a sterile we indicated she had n treatments for R1 a updated to not char alone by the time st capacity. TMA-B in the dressing for dra never noted any dra thought R1 had a st on Monday, Wedne the shower in his ro she had given R1 a right lower extremity the top of the bag w	 o denied having ever noted a dressing and stated it never 7 a.m. the physical therapist was familiar with R1 and red with him, 5 days per week. been non weight bearing on naticated they worked with R1's s and also sliding board non weight bearing status. ad also worked on safety ted R1 needed help to get up gine him walking and feel he was able to ambulate PT indicated she he never nd stated she had never noted are had been drainage on the d R1 had worn a bunny boot I for the relief of pressure. 1 a.m. TMA-B stated TMA's wound care but not if it pund treatment. TMA-B lever done any wound s his orders had been nge the dressing and leave it ne worked with him in a TMA dicated they would visualize inage and stated she had ainage. TMA-B stated she hower three times per week esday and Friday and bathed in oom. TMA-B indicated when shower, she had wrapped his y with a garbage bag, wrapped <i>i</i>th plastic wrap and taped it. 	F	584			
	the top of the bag w TMA-B indicated R						

If continuation sheet Page 14 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	G HOME			127 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	checking the banda if R1's dressing had been evident as it h mid calf with an Ace a wound got wet sh RN to get order from dressing and would stated R1 did not w reminders to mainta TMA-B stated R1 w back of his heel with happened less as h board. TMA-B state could not use slide example and indica once a shift or coup On 2/25/19, at 11:44 coordinator (HUC) s provided personal of helped transfer R1 also entered physic had orders to be no stated R1 had put h assisted him with tr reminded him not to had exhibited no be to cares. HUC indic R1 to the shower ar but had heard about one of his podiatry appoint had been noted to b podiatry appointment not sure how/if the o	The dressing, they had been ge twice daily. TMA-B stated I gotten wet, it would have ad been wrapped from foot to a bandage. TMA-B indicated if e would have contacted the n physician to change the not have left it wet. TMA-B alk, but needed some ain non weight bearing. Fould sometimes try to use the n transfers, but indicated this e started to use the slide ed it happened more when he board; using the toilet for ted this happened maybe le of days. 6 a.m. the health unit stated she sometimes also cares for residents and had once. The HUC stated she ian orders so she knew R1 n weight bearing. The HUC is weight down when she had ansferring but they had o do so. HUC indicated R1 thaviors and was not resistive cated she had never assisted nd had not seen his wound, t R1's dressing being wet after appointments. HUC stated he change the dressing after his tment and then the dressing oe wet after his second nts. The HUC stated she was dressing had gotten wet and	F	\$84			
	stated she thought	dressing had gotten wet and R1 had utilized a slide board time. The HUC stated she					

Facility ID: 00678

If continuation sheet Page 15 of 26

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED	
						С	
		245563	B. WING			2/26/2019	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
GREEN I	PINE ACRES NURSIN	IG HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 15	F 68	4			
		had ever been provided a bed s showers had ever been					
	stated she primarili care unit (TCU) and stated R1 had a litt reminders such as right foot during transition never assisted with in the room while F stated for the most needed reminders upon admission the change with telfa, 4 RN-C indicated R1 sutures. R1 had se and they had recein appointment to no had not done so. F prompt in compute dry intact, ace wrand daily. RN-C stated appointment and w wound was open. received new order dressing and wrap saw a vascular sur to hospital. RN-C s approximately thre showered in room. wrapped the wound	88 AM registered nurse (RN)-C y worked on the transitional d was familiar with R1. RN-C le dementia and needed with not bearing weight on his insfers. RN-C stated she had n R1's transfers but had been R1 had been transferred. RN-C part he did not bear weight but not to do so. RN-C stated ey had done a daily dressing 4x4 and ace wrap for R1. 's incision had been intact with een the podiatrist after 1 week ved orders after that change the dressing so they RN-C indicated they had a r to assess the dressing, clean o on which she had assessed R1 then had another podiatry then he came back and the She indicated they had rs for betadine, non-adherent it. After this, RN-C stated R1 geon and was then transferred stated R1 had showers e times per week and RN-C stated the aids had d with plastic bag to prevent it					
	showered in room. wrapped the wound from getting wet. If have let her know i could change it. R notified R1's dress	RN-C stated the aids had					

If continuation sheet Page 16 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING	i			C 26/2019
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	not know how the d RN-C indicated R1' afternoon and he has RN-C stated she has had lunch and had common area. RN- R1's dressing and it had been no indicat assessment. RN-C appointment alone. think the dressing of her knowledge and entire area. She sta had been wrapped Ace bandage. RN- the dressing in the On 2/25/19, at 1:23 was interviewed by had met R1 at his 2 and had observed h very noticeably" how not appear visibly w dressing was remov be gaping open wittl line. FM-A stated th shower prior to his her the staff had wr plastic during the sl wound dressing was appointment and as below the knee am returned to the facil had spoken to the s physician was extre dressing having bee informed her the ph	ge 16 noon. RN-C stated she does ressing could have gotten wet. s appointment had been in the ad left the facility at 12:15 p.m. ad tested R1's blood sugar, he then been seated in the -C indicated she had felt of t had not been wet and there tion the wound required further c indicated R1 had went to the RN-C stated she doesn't could have been wet without indicated she had felt the ated R1's right lower extremity from foot to mid calf with an C stated she always looked at morning and at noon. p.m. family member (FM)-A telephone. FM-A stated she t/8/19, podiatry appointment his wound dressing "was wet, wever, the Ace bandage did wet. FM-A said when the wet ved, R1's wound was noted to n areas of black in the incision he staff had given R1 a appointment and R1 had told apped the right foot with hower. FM-A stated R1's s wet when he arrived at the s a result ended up having a putation. FM-A said when R1 ity from the appointment, she staff and informed them R1's emely upset about R1's wound en wet. FM-A said staff had hysician had already contacted a concerns. FM-A stated R1's	F	684			

If continuation sheet Page 17 of 26

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	1 ` <i>´</i>	NG	· · ·	MPLETED
		245563	B. WING		02	C 2/ 26/2019
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	•	
GREEN	PINE ACRES NURSIN	G HOME		427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	ige 17 shape from day one, was not	F 68	84		
	healing, and getting stated she was awa providing R1 show the 2/1/19 appointm	g it wet "did not help." FM-A are the facility had been ers every 2-3 days however, at nent, the physician had I for the wound dressing to not				
	confirmed she had was a resident at th non-weight bearing for transfers and hi wrapped with an Ad what type of dressi wrap. NA-A stated showers and had w saran type plastic/w when washed. Foll- wrap would be rem assisted R1 with a 2/8/19, appointmen shower, R1 had stu nothing for him to r NA-A stated she had the saran wrap and gotten wet, she wo nurse. NA-A stated dressing ever gettin	p.m. nursing assistant (NA)-A provided cares to R1 while he he facility. NA-A stated R1 was required assist of two staffs right foot to mid-calf was ce wrap but was unsure as to ngs was beneath the Ace she had assisted R1 with vrapped the right extremity with vrap and kept the foot elevated owing the shower, the saran oved. NA-A stated she shower the morning of the that and stated during the tand stated during the tand stated during the tand stated during the tand wrapped the foot well with I if she had noticed if it had uld have reported it to the d she did not recall the wound ng wet and and believed she I the change in the coloring of ad gotten wet.				
	orders were review the discharge orde dressing, keep clea visit". HUC verified from entry into the	p.m. R1's hospital discharge ed with HUC. HUC verified rs included "Don't change an, dry and intact until clinic I the order had been omitted facility computer system and t got missed. HUC stated the				

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
GREEN	PINE ACRES NURSIN	G HOME			427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	unit manager had eright surgical site for and cleanse and dr R1 had a podiatry at they received order that order was adder returned to podiatris had received orders over R1's right lowe will cause macerati an order for dressin adherent gauze 4 x HUC verified there computer system to to 2/9/19. On 2/25/19, at 2:36 manager (CM) state foot care was the fap resented to his ap wound dressings sa dehisced (incision I CM stated the skin macerated which co previous hours of th macerated at any ti The CM stated the and putting a bag of keep it dry which m effective. The CM sa indicated it was unk wound had been sa On 2/25/19, at 3:19 health unit coordinator orders into the elect however, the orders reviewed and activation	entered the order to check the or signs/symptoms of infection ress as needed. HUC verified appointment on 2/1/19 and s to not change dressing so ed. HUC also verified R1 st on 2/8/19 after which they s to not place plastic bandage er extremity when showering on to occur and also received ng change with betadine, non 4 gauze and ace bandage. was no order in the facility b keep R1's dressing dry prior 6 p.m. the podiatry clinic ed the concern related to R1's act that on 2/8/19, R1 pointment with the right foot aturated and his wound had ine ruptured/separated). The on the right foot was ould have occurred within the ne appointment or could have me during the previous week. facility had been showering R1 ver the foot in order to try ay or may not have been stated the physician's notes known as to how long the	F	584			

If continuation sheet Page 19 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
		245563	B. WING	i			C 26/2019
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	admission orders w confirmed the admi foot dressing intact stated it had been r order to cleanse an as needed, RN-A si order and not physi surgical wound was Saran wrap and pro be appropriate. RN of a written protoco or how to wrap a wa and indicated it wou verified there was water wasn't seepin wrapped in plastic v unsure of how R1's indicated she had s and had been surp RN-A stated if she f probably wouldn't h the sutures were ou plan did not addres R1's surgical wound provided care as di podiatrist/surgeon. On 2/25/19, at 5:48 (DON) reviewed R1 confirmed the 1/25/ the right foot wound been missed. DON surgical wound on a bathing/showering v confirmed the faciliti standard process fo wrap to cover surgi aforementioned teo	vere reviewed. RN-A who ssion order to leave R1's right had not been processed and missed. When asked about the d dress the right foot wound tated this order was a nursing cian ordered. RN-A stated if a s on a limb they could put on otect the area so bathing would I-A stated she was not aware I on how to keep a wound dry ound for bathing/showering uld be common sense. RN-A probably not a way to ensure ing into a dressing for a wound wrap. RN-A stated she was dressing got wet and seen the wound prior to 2/1/19 rised at how well it looked. hadn't missed the order she ave had R1 shower until after ut. RN-A verified R1's care s the care and treatment of d and confirmed R1 was not	F	584			

If continuation sheet Page 20 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245563	B. WING	i		(02/2	26/2019
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	dressing wrapped in and stated that goe if R1's dressing cou 2/8/19 appointment showering, the ace dressings remained have occurred. DOI maintain the dressin been transcribed up have expected staff were his preference have notified the MI bath . DON stated the by the podiatrist after were discussed at the however, determined not gotten wet at the investigation or pro- identified or implement had been other occh had determined a se a resident and other recommended and could potentially ob upon admission. On 2/26/19, at 9:02 was conducted with who had cared for F appointment. The m had been given to t wet however, when appointment, he way wheelchair with his and dressings were nurse stated there we discoloration noted wrap was multi tone	nge 20 n this way would remain dry s for everything. When asked ald have been wet prior to the t due to seepage during wrap dried, however d wet, DON agreed this could N stated even if order to ng clean, dry and intact had pon admission, she still would f to offer R1 a shower if that e and if concerns arose would D rather than offering a bed the concerns communicated er the 2/8/19 appointment the facility stand up meeting ed they felt the dressing had e facility, therefore, no further cess improvements had been hented. The DON stated there casions where a unit manager shower was not appropriate for er bathing interventions were verified going forward, they tain a physician bathing order ended strict instructions he facility to not get the wound R1 presented to the 2/8/19 as seated in a tilt in space leg elevated and his Ace wrap e wet like a sponge. The clinic was no wound drainage or on the wet dressings. The Ace e and was also wet to the tated FM-A had accompanied		584			

If continuation sheet Page 21 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	R1 to the appointme facility had been ap foot and giving him she could not speal facility, rather only to touched at the appod due to the wet dress R1 would now need amputation. The nut complicating health issues, however, the related skin macera R1's wound dehised further surgical inter On 2/26/19, 10:34 a responsible for staff testing. RN-B states training or completes protection of wound RN-B confirmed sh call from R1's podia R1's wound/dressin indicated she had s reported concerns a been discussed at the However, they had not become wet wh further investigation been identified or in On 2/26/19, at 11:4 administrator, DON When asked about with directives to lead times, they stated " interpretation and the during times such a	ent and informed her the polying plastic over the right showers. The nurse stated k as to what happened at the to what she had seen and pointment and unfortunately, sings and wound dehiscence, d to have a partial leg trse confirmed R1 had other factors such as vascular e saturated dressings and ation directly contributed to ence and subsequent need for rvention. a.m. RN-B stated she was f education and competency ed the facility did not provide e competency testing for the ds/dressings during bathing. e had received a telephone atrist related to concerns of ng becoming saturated. RN-B spoken with staff regarding the and verified the concerns had the stand up meeting. determined the dressing had nile at the facility therefore, no n or process improvement had nplemented. 3 a.m. an interview with the l, and RN-B was conducted. the 2/1/19 physician orders, ave the bunny boot on at all	F	584			

If continuation sheet Page 22 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245563	B. WING				C 26/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME			27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	regarding the wet d wound, she had as was wet when he h the staff had stated policy and procedur showers and the pr during showering w the facility did not h which addressed th The facility's Medica procedure signed 5 of orders must be n record of each resid written and maintain The section Record Treatment Orders, order, specify the tr duration of the treat The facility's Baseli procured signed 4/6 plan of care to mee developed for each hours of admission Unit Manager was to care plan and enter information for the I was to continue to I with final completio plan as indicated in Plan policy. The po interdisciplinary tea physician's order w treatments, and we plan. The baseline a minimum, the foll	The second status of the ked the staff if the dressing ad left for the appointment and the dressing was dry. When a re related to the provision of rotection of an affected limb vas requested, the DON stated ave policies and procedures nat. ation Orders policy and 5/2/17, indicated a current list maintained in the clinical dent and orders must be ned in chronological order. ding Orders #6 titled indicated when recording reatment, frequency and the the resident's needs shall be resident within twenty-four ." The policy indicated the RN to open the comprehensive r the required baseline baseline care plan. Information be entered into the care plan no f the comprehensive Care licy further indicated the mould review the attending hich included routine re to complete a nursing care care plan was to consist of, at	F	\$84			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245563	B. WING _			C 26/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	
	PINE ACRES NURSIN	C HOME		427 MAIN STREET NORTHEAST		
GREEN	TINE ACKES NORSIN	GHOME		MENAHGA, MN 56464		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	The facility's Care F and procedure date facility's care planni coordination with the representative, dev comprehensive care identified the highes resident may be ex- indicated the compre- based on a thoroug but was not limited resident's care planni identified problem a The facility's Policy Assessment and Pr 10/10/18, indicated skin assessment an	endation, if applicable Plans-Comprehensive policy ed 11/28/16, indicated the ing/interdisciplinary team, in e resident, his/her family or eloped and maintained a e plan for each resident which st level of functioning the pected to attain. The policy rehensive care plan was h assessment which included to the MDS, and each was designed to incorporate areas. and Procedure on Skin reventative Skin Care dated each resident wound have a nd treatment plan for the n integrity and wound	F 68			
	was removed on 2/ could be determine review, the facility h acceptable remova -bathing orders wou residents admitted removable dressing sutures and/or stap wound dry. -If a resident had a	bardy that began on 2/8/19, 26/219, at 4:02 p.m. when it d by interview and document ad implemented an I plan: uld be obtained for all with wounds that have non gs, casts, splints, wraps, les or with orders to keep wound indicated to be kept uld be provided with the wound				

If continuation sheet Page 24 of 26

PRINTED: 03/28/2019

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/28/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
245563			B. WING			02/26/2019	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN PINE ACRES NURSING HOME					27 MAIN STREET NORTHEAST IENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	\$84			

If continuation sheet Page 25 of 26

		AND HUMAN SERVICES				FORM	03/28/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED		
245563			B. WING			C 02/26/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CI				
GREEN PINE ACRES NURSING HOME				427 MAIN STREET N MENAHGA, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	educated via text m be received that the Staff will be remind	ige 25 transcription. Staff will be bessage and a confirmation will ay have received the message. ed via the home page to any orders that are unclear.	F 6	34				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 18, 2019

Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, MN 56464

Re: State Nursing Home Licensing Orders - Complaint Number H5563012C

Dear Administrator:

A complaint investigation was completed on February 26, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically 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

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

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

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File
Minnesc	ta Department of He	ealth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00678	B. WING		C 02/26/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GREEN	PINE ACRES NURSIN	GHOME	STREET NO A, MN 5646		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been			
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
Ainpaceta	was conducted to d licensure. The follo issued. Please indi correction that you and identify the date	FS: 26/19, an abbreviated survey letermine compliance for state owing correction orders are icate in your electronic plan of have reviewed these orders, e when they will be completed.		*****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute section 144A.10, this correction order	
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

Electronically Signed

STATE FORM

6899

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	_ETED
		00678	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	GHOME	A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	The following comp substantiated: H5563012C: Correct The facility is enroll signature is not req page of state form. is required, it is req acknowledge receip Minnesota Departm the State Licensing federal software. Ta assigned to Minner Nursing Homes. The assigned tag n column entitled "ID statute/rule number the state statute/rul in the "Summary St column and replace the correction order the findings which statute after the stat as evidenced by." findings are the Sug and the Time Perio PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	ection order issued at 0830 ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility pt of the electronic documents. hent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left Prefix Tag." The state r and the corresponding text of e out of compliance is listed tatement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met Following the surveyors ggested Method of Correction d For Correction. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.		been issued pursuant to a sureinspection, it is found that to or deficiencies cited herein and corrected, a fine for each viol corrected shall be assessed accordance with a schedule of promulgated by rule of the M Department of Health. Determination of whether a w been corrected requires com all requirements of the rule pit tag number and MN Rule nur indicated below. When a rule several items, failure to compliance the items will be considered I compliance. Lack of complia re-inspection with any item of rule will result in the assessme even if the item that was violat the initial inspection was corrected you may request a hearing of assessments that may result non-compliance with these of provided that a written request the Department within 15 day of a notice of assessment for non-compliance. INITIAL COMMENTS:	he deficiency re not ation not in of fines innesota iolation has pliance with rovided at the mber e contains oly with any of ack of unce upon f multi-part nent of a fine ated during ected. n any from rders st is made to <i>y</i> s of receipt	
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				

	ota Department of He NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION (X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		00678	B. WING		C 02/26/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GREEN	PINE ACRES NURSIN	G HOME	STREET NO		
		MENAHG	A, MN 5646		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830		3/26/19
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.			
	by: Based on interview facility failed to thor factors related to the decline of a surgica (R1) who had physis surgical site dry and complications resul dressings which res wound dehiscence surgical intervention investigate causativ surgical wound dec	ent is not met as evidenced and document review, the roughly investigate contributing le saturation and subsequent al wound for 1 of 1 resident ician orders to keep the d the resident experienced ting from saturated wound sulted in macerated skin, and required additional n. This failure to thoroughly ve factors related to the line, and subsequent failure to erventions, resulted in an y situation for R1		Corrected	
	when the facility red medical provider th dehisced as a result	bardy (IJ) began on 2/8/19, ceived notification from a at R1's surgical wound had It of maceration from saturated and the facility failed to			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00678	B. WING	B. WING		26/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	N STREET NOF GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	thoroughly investiga and procedures for wounds. The IJ was administrator, direct licensed social work IJ at 6:38 p.m. on 2 on 2/26/19, but non lower scope and se with actual harm. Findings include: R1's Admission Rea indicated R1 was a with diagnoses white aftercare following se vascular disease, d condition with diabe deficiency, hyperter vascular dementia se	ate, modify or develop policies the protection of surgical s identified on 2/25/19. The tor of nursing (DON) and ker (LSW) were notified of the 2/25/19. The IJ was removed compliance remained at the everity of G, isolated scope cord form printed 2/25/19, dmitted to the facility 1/25/19, ch included: orthopedic surgical amputation, periphera liabetes due to underlying etic polyneuropathy, nutritional nsive chronic kidney disease,	1			
	assessment dated admitted from the h cognitive impairment behaviors. The MD extensive assist of mobility, transfers, toileting, dressing a limited assistance of assistance of one p which had occurred also indicated R1 u wheelchair. The MD foot infection, a sur	himum Data Set (MDS) 2/7/19, indicated R1 was hospital, had moderate int and demonstrated no S also indicated R1 required: one to two staff for bed locomotion on and off the unit, and bathing; and required of one staff for hygiene, and berson to walk in the corridor, d only once or twice. The MDS tilized a walker and DS also indicated R1 had a gical wound and received e with the application of foot				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00678	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	IG HOME	N STREET NO GA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	 (PT and OT) were MDS also dated 2/ information as the indicated R1 did no reference period ar wheelchair. R1's pr due to an amputati R1's Cognitive Los Assessment (CAA) was aware of his si goal of cognitive im return home. R1's Activities of Da Potential CAA date admitted from the f following the surgio 3rd digits on the rig indicated R1 was n non-ambulatory, ar with ADLs. In additi working with PT (pl (occupational thera for R1 to improve A complications. R1's Pressure Ulce indicated R1 was a of the right foot 2nd place. According to consisted of cleans In addition interven monitor pain, moni- diabetic foot check 	provided. R1's 5 day Medicare 7/19, idenfied the same admission MDS, however, at ambulate during the nd utilized a walker and a rimary medical condition was on. s/Dementia Care Area dated 2/7/19, indicated R1 hort term memory deficit with a provement as he desired to ally Living (ADL)/Rehabilitation d 2/7/19, indicated R1 was nospital for short term stay cal amputation of the 2nd and pht foot. The CAA also				
prosota D		Well-Being CAA dated 2/7/19, /orking hard toward his				

STATE FORM

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00070	B. WING	B WING		С	
		00678	D. WING		02/2	26/2019	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S				
GREEN	PINE ACRES NURSIN	GHOME	N STREET NO BA, MN 56464	-			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLET DATE	
				DEFICIENC	:Y)		
2 830	Continued From pa	ige 5	2 830				
	discharge goal of re	eturning home.					
		ed 2/7/19, indicated R1 was to the right foot therefore					
		ssist of two staff for transfers					
		history of falls prior to					
		fall occurrence while at the					
		y. The CAA also indicated R1 of non-weight bearing status.					
		or non weight bearing status.					
		erral Form dated 1/25/19,					
		een hospitalized with a					
		f gangrene of right foot, had opy for foreign body removal					
		nad a right transmetatarsal					
		rge orders included but were					
	not limited to:						
	-Appointments with from discharge	Podiatry 1 week and 2 weeks					
		sing, keep clean dry and intact					
	until clinic visit						
	-Non weight bearing						
		t that weight bearing status ill be reevaluated at next					
	appointment in 2 w						
	- Will have follow-u	p in 1 week but sutures will not	t l				
		east 2 weeks and he is non					
	-Physical Therapy:	I the sutures are removed.					
		al: length of stay <30 days,					
	then plan assisted						
	In addition an After	⁻ Visit Summary (AVS, also					
		uded the following intructions					
	for R1's care:	-					
		atus: non weight bearing-right					
		lity - Predict that weight ncrease and will be					
		appointments in 2 weeks.					
		in 1 week but sutures will not					

If continuation sheet 6 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00678	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOI GA, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 6	2 830			
	weight bearing until -Appointment with F Injury/Trauma: am -Wound Care Intruck keep clean dry and Additional wound care orders. -Physical Therapy F and treat -Discharge Potentia Then plan assisted Although both docu discharge wound care leave the wound dr Check form dated f to R1's right foot we long with 18 stitche	ctions: Don't change dressing intact until clinic visit. are instructions: per podiatry Referral instructions: evaluate al: Length of stay < 30 days.				
	dated 1/1 -1/31/19, following orders: -Weekly wound mo transmetatarsal am every Wednesday. 1/30/19 and was do 1/30/19, 2/6/18 and					
	incision one time a order start date was documented as cor -Do not change dre bunny boot on at al	npleted on 2/13/19. ssings. Elevate leg and keep I times every shift for right foot e was 2/1/19. The order was				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00678	B. WING		C 02/26/2019	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
REEN F	PINE ACRES NURSIN	G HOME	I STREET NOF 6A, MN 56464	-		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	following orders: -Check right foot su signs/symptoms of as needed two time was 1/25/19. -Infection monitorin day. The order stat -Do not put plastic b extremity when sho to wound. The order -Dressing change to betadine, non-adher bandage one time a start date was 2/9/1 -Strict non weight b three times a day for date was 2/9/19.	infection. Cleanse and dress as a day. The order start date g note to right foot two times a rt date was 1/25/19. Dandage over right lower overing will cause maceration er start date was 2/9/19. To right lower extremity, apply rent gauze, 4 x 4 gauze, ace a day for diagnosis. The order 19. earing to right lower extremity or diagnosis. The order start				
	2/1/19, indicated R post transmetatarsa to peripheral artery changes to the dista indicated instruction hospital were to kee skilled nursing facili "Unfortunately, his of therefore, they were whether there was drainage from this a indicated a physica overall diminished s extremity and peda however, indicated the transmetatarsal	dressings are different, e changed but I am unaware strikethrough noted or any area." Further documentation I exam had revealed R1 had sensation to the lower I pulses were not palpable dorsal not plantar aspect of amputation site did have a of less then 3 seconds. The				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00678	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	GHOME	N STREET NOI GA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 8	2 830			
	loosening, normal p incision site. There to the plantar aspec flap as well, which a nature." The plan ir follow up appointme removal and includ get operative site w times. Continue ora dispensed by the p patient that if he do the transmetatarsal some wound dehise having him reasses week. Written instru- skilled nursing facil	atures were intact without postoperative edema near a was also an ulcerative lesion ct at the central portion of the appeared superficial in ndicated R1 would have a ent in one week for suture ed: "Keep leg elevated, do not vet. Keep Bunny boot on at all al antibiotics previous rimary care team. Informed the es develop further necrosis or I amputation site does develop cence we will go forth with ssed by the vascular team next uctions were provided for ity to not change dressings."				
	indicated the patier appointment with h is currently residing During today's offic malodor associated extremity and his d discussing this with patient has been sh the nursing facility. his lower extremity seeping into the dre not know how long saturated. Skin was dehiscence was cle					
	secondarily due to is present medially site. There appear lymphangitic streak labs to assess for in	aps had coaptation macerated tissue. Erythema and laterally to the amputation s to be no cellulitis or ting, however we will obtain nfections. Discussing with [R1] e has been ambulating on the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ (E SURVEY PLETED
		00678	B. WING		02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	NSTREET NOI GA, MN 56464			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 9	2 830			
	operative extremity." The physical exam indicated the dressings were removed and the heel was completely macerated with desquamated					
	hyperkeratotic tissue. The surgical follow up note indicated R1's right lower extremity was colder to					
	touch and, "Pedal pulses were difficult to Doppler. Central area of necrosis was present. Medially and laterally to the transmetatarsal amputation					
	site there was wour	nd dehiscence noted laterally of infections, no coaptation				
	was noted laterally.	Medially there is increase in				
		area however, no purulent with mechanical compression	1			
	of the amputation s	ite. No soft tissue				
		bableconcern for worsening ery disease) of his right lower				
		y refill time dorsal lateral flat of was delayed between 3 and 5				
	seconds and sluggi	ish in nature." The plan				
		ed the patient and his sister I cern about worsening				
	appearance of his a	amputation site which is likely				
		sons including but not limited ral arterial disease, diabetes,				
		his postoperative dressings				
	and complete nonc	ompliance of ambulating on				
		ed him there is a higher risk of ation. I informed him of the				
		as the flap has not adherent.				
		continue with wound care				
		tial use of a wound VAC, more	•			
		tation versus below-knee				
		ne appearance of his foot elieve this amputation site will				
		vascular's recommendation,				
		ursing staff will perform daily				
	dressing changes v	vith the use of Betadine and				
		trict non-weightbearing to the				
		y, do not get operative site				
	epartment of Health	low up with me next week to				

If continuation sheet 10 of 26

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00678	B. WING		02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	GHOME	N STREET NOI GA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
2 000	 2 830 Continued From page 10 discuss further options going forward." The instructions for the right lower extremity transmetatarsal amputation site included: "Dressings need to be changed every day, apply Betadine, non-adherent gauze, 4 x 4 gauze, Ace bandages. Patient is to be strictly non-weightbearing to the right lower extremity. 		2 830			
	Do not get the oper presented during to macerated tissue d being saturated with shower. Please do bandage around his as this typically lead causing noted dres and wet which will I which he currently I next week, Wednes revascularization per	rative site wet, patient oday's office visit with ue to his gauze and dressings h water after his recent not attempt to apply a plastic s lower extremity and shower ds to some sort of leakage sings to become macerated ead to wound dehiscence has. Follow-up with vascular				
	R1's care plan printed on 2/25/19, identified the right foot surgical wound and directed the staff to provide weekly wound monitoring and treatments. However, the care plan failed to include the interventions related to the care of the surgical site/extremity such as to maintain dryness of the surgical limb as well as how to provide appropriate bathing, and protect dressing from getting wet when bathing.					
	following: -1/25/19, R1 admitt amputation of right related to diabetes	gress notes (PN) revealed the ted post transmetatarsal foot secondary to gangrene and frost bite. To receive				
	management. R1 w	IV therapy for wound yould be non-weight bearing til cleared by the physician. Ar	1			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING			C 26/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	N STREET NOR GA, MN 56464	RTHEAST		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 11	2 830			
	admitted for a short heal surgical site, re home. Incision clea with no signs of infe -1/30/19, weekly we surgical amputation incision measured A 20cm x 45cm drie on bottom of foot. 3 on top of the foot. 4 on the top of the foot aforementioned ind amount of serosang and serum) drainag skin was a healthy j indicated skin intact with dark red areas within. both #3 and dried res scabs, ski cleansing and cove and as needed. The improving. A second pedal pulses were p -2/1/19, R1 had a p orders to no change elevated with bunny to follow up with poor removal. -2/8/18, pedal pulse edema present. Rig 12:19 p.m. PN indic podiatry appointme -2/8/19, R1 returned -2/9/19, at 10:31 a.r foot, sutures removinow incision line is	bund monitoring: right foot of toes. 1. The surgical 120 cm with intact sutures. 2. ed blister from amputation site 3. A 10cm x 10cm dried scab b. A 20cm x 16cm dried scab ot. The observation of the licated wound #1 had a small guineous (contains both blood ge on the dressing, no odor, pink color. Wound #2 t with no drainage skin soft and a couple of lighter areas #4 wounds were noted as in dry. Treatment consisted of rring the wounds twice a day e wounds were identified as d PN dated 1/30/19, indicated present with no edema noted. odiatry appointment. New e R1's dressings, keep leg y boot on at all times, and R1 diatrist next week for suture es present bilaterally with no ght foot dressing intact. A cated R1 left the facility for a				

Minnesota Department of Health STATE FORM

6899

1W5R11

If continuation sheet 12 of 26

innesota Department of H ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C		
	00678	B. WING		02/	26/2019		
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
REEN PINE ACRES NURSIN	IG HOMF	N STREET NOF GA, MN 56464	RTHEAST				
REFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A			TION SHOULD BE	(X5) COMPLET DATE
2 830 Continued From pa	age 12	2 830					
betadine, covered with kling dressing -2/11/19, late entry included: "Dressing with betadine appli followed by 4x4 ga was to be strictly n lower extremity. Do patient presented of macerated tissue to saturated with wate do not attempt to a his lower extremity leads to some sort dressing to becom lead to wound deh Follow up with vas revascularization p knee amputation to On 2/25/19, at 11: therapist (OTR) sta the facility and was received skilled PT stated R1 had com amputation and ha the right side. The some cognitive tes him to have minim deficits. In addition weak, had endurar been working with cares/independend OTR also confirme The OTR stated w he'd had the impre his heel and the O stressed with him	with a non adherent, wrapped followed by an Ace wrap. from appointment 2/8/19, g needs to be changed daily ed, non adherent gauze uze and an Ace bandage. R1 on-wight bearing to the right o not get the operative site wet, during today's visit with o his gauze and dressing being er after recent shower. Please upply plastic bandage around and shower as this typically of leakage causing noted e macerated and wet which wil iscence which he currently has cular next week as likely needs or the right lower extremity." I4 a.m. the occupational ated she was contracted with a familiar with R1, who had and OT services. The OTR be in with a metatarsal d been non weight bearing on OTR stated she had done ting with R1 and had assessed um to moderate cognitive , she stated R1 had been very nee issues, and that she had						

Minnesota Department of Health STATE FORM

TATEMEN	<u>ita Department of He</u> IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			B. WING		С	
		00678	D. WING		02/2	26/2019
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
BREEN I	PINE ACRES NURSIN	GHOME	N STREET NO 3A, MN 56464	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 13	2 830			
	whether R1 had be leg when nursing p he had it in his minu- heel. The OTR reite R1 he was strict no after awhile he kind R1's cognitive defie Further, the OTR si- surgical wound and used the shower. On 2/25/19, at 11:2 (TMA)-A confirmed amputation of the ri- weight bearing. TM to a slide board with TMA-A stated R1 h had no resistance to behaviors. TMA-A walked while in the had remained wrap treatments to the fo- taken a shower and his room which he li- week. TMA-A state staff had wrapped H "Saran wrap." TMA- had assisted R1 wi Saran Wrap around supposed to chang TMA-A stated wher shower, his dressin gotten wet. She als any drainage on the looked or felt wet.	DTR stated she could not verify en putting weight on his right rovided care however, stated d he could bear weight on his erated staff had stressed with n-weight bearing and stated I of remembered it, but though cits were a factor in that. tated she had not seen R1's I was not aware whether R1 2 a.m. trained medication aide R1 had been admitted with ar ight forefoot and had been non IA-A stated R1 had graduated n assist of 2 for transfers. ad been compliant with cares, o cares and exhibited no indicated R1 had never facility, and stated R1's foot ped and she had not done any bot. TMA-A verified R1 had d indicated he had a shower in had used one to two times per ed when R1 had showered his right lower extremity in A-A stated the last time she th a shower, she had applied d the foot as they were not e the dressing. However, n she had assisted R1 with a ig to the right foot had never o denied having ever noted e dressing and stated it never	t ,			
	(PT) indicated she	7 a.m. the physical therapist was familiar with R1 and ed with him, 5 days per week.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00678	B. WING		C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOF SA, MN 56464	RTHEAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 14	2 830			
	PT verified R1 had been non weight bearing on the right side and indicated they worked with R1's					
		s and also sliding board				
	transfers due to his	non weight bearing status.				
		ad also worked on safety				
		awareness. PT stated R1 needed help to get up so she couldn't imagine him walking and				
		feel he was able to ambulate				
		PT indicated she he never				
		nd stated she had never noted				
		ere had been drainage on the				
		d R1 had worn a bunny boot				
	when up and in bed	d for the relief of pressure.				
	On 2/25/19, at 11:3	1 a.m. TMA-B stated TMA's				
		wound care but not if it				
		ound treatment. TMA-B				
		never done any wound				
		as his orders had been				
	•	nge the dressing and leave it he worked with him in a TMA				
		ndicated they would visualize				
		ainage and stated she had				
		ainage. TMA-B stated she				
		hower three times per week				
		esday and Friday and bathed ir	1			
		oom. TMA-B indicated when a shower, she had wrapped his				
	U	y with a garbage bag, wrapped his				
		with plastic wrap and taped it.				
		R1's dressing never got wet, to				
	her knowledge. TN	IA-B indicated prior to the				
		he dressing, they had been				
		age twice daily. TMA-B stated				
		d gotten wet, it would have ad been wrapped from foot to				
		e bandage. TMA-B indicated i	F			
		e would have contacted the				
		m physician to change the				
		I not have left it wet. TMA-B				

D PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMF	PLETED	
	00678	B. WING			C 26/2019
AME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
REEN PINE ACRES NURSIN	G HOMF	I STREET NO	-		
	MENAHO	A, MN 56464			
REFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 830 Continued From pa	ge 15	2 830			
reminders to mainta TMA-B stated R1 w back of his heel with happened less as h board. TMA-B state could not use slide example and indica once a shift or coup On 2/25/19, at 11:44 coordinator (HUC) i provided personal of helped transfer R1 of entered physician o been non weight be put his weight down with transferring but do so. HUC indicat behaviors and was indicated she had no shower and had not she had heard about after one of his pod stated he had an or dressing after his fin then the dressing has his second podiatry she was not sure how wet and stated she board for transfers I was not sure if R1 h bath or if his showe hold. On 2/25/19, at 11:50	alk, but needed some ain non weight bearing. yould sometimes try to use the h transfers, but indicated this he started to use the slide ed it happened more when he board; using the toilet for ted this happened maybe ble of days. 6 a.m. the health unit indicated she sometimes also cares for residents and had once. HUC stated she also orders so she knew R1 had earing. HUC indicated R1 had on when she had assisted him t they had reminded him not to red R1 had exhibited no not resistive to cares. HUC never assisted R1 to the t seen his wound. HUC stated ut R1's dressing being wet iatry appointments. HUC der to not change the rst podiatry appointment and ad been noted to be wet after appointments. HUC stated pow/if the dressing had gotten thought R1 had utilized a slide by that time. HUC stated she had ever been provided a bed rs had ever been placed on 8 AM registered nurse (RN)-C				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00678	B. WING			26/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	N STREET NOR 6A, MN 56464	THEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE AC CROSS-REFERENCED TO		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 16	2 830			
	never assisted with in the room while R stated for the most needed reminders r upon admission the change with telfa, 4 RN-C indicated R1' sutures. R1 had se and they had receiv appointment to no c had not done so. R prompt in computer dry intact, ace wrap daily. RN-C stated appointment and w wound was open. S received new order dressing and wrap saw a vascular surg to hospital. RN-C s approximately three showered in room. wrapped the wound from getting wet. R have let her know it could change it. RI notified R1's dressi had been at the fac podiatry appointme had been dry as of not know how the d RN-C indicated R1' afternoon and he ha common area. RN	nsfers. RN-C stated she had R1's transfers but had been 1 had been transferred. RN-C part he did not bear weight but not to do so. RN-C stated ey had done a daily dressing x4 and ace wrap for R1. s incision had been intact with een the podiatrist after 1 week ved orders after that change the dressing so they RN-C indicated they had a to assess the dressing, clean o on which she had assessed R1 then had another podiatry hen he came back and the She indicated they had s for betadine, non-adherent it. After this, RN-C stated R1 geon and was then transferred stated R1 had showers e times per week and RN-C stated the aids had d with plastic bag to prevent it RN-C indicated the aids would f the dressing was wet so she N-C stated she was never ng was wet. RN-C stated she ility the day R1 had his nt and indicated R1's dressing noon. RN-C stated she does ressing could have gotten wet s appointment had been in the ad left the facility at 12:15 p.m. ad tested R1's blood sugar, he then been seated in the -C indicated she had felt of t had not been wet and there	t			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	<u></u> .		
		00678	B. WING			C 26/2019
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	PINE ACRES NURSIN	GHOME	N STREET NOI GA, MN 56464	-		
	SUMMARY STA			PROVIDER'S PLAN OF ((XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	think the dressing of her knowledge and entire area. She st had been wrapped Ace bandage. RN- the dressing in the On 2/25/19, at 1:23 was interviewed by had met R1 at his 2 and had observed f very noticeably" how not appear visibly w dressing was remo be gaping open with line. FM-A stated th shower prior to his her the staff had wr plastic during the sh wound dressing wa appointment and as below the knee am returned to the facil had spoken to the s physician was extre dressing having be informed her the ph the facility about his foot was in horrible healing, and getting stated she was awa showers every 2-3 appointment, the ph	RN-C stated she doesn't could have been wet without indicated she had felt the ated R1's right lower extremity from foot to mid calf with an C stated she always looked a morning and at noon. p.m. family member (FM)-A telephone. FM-A stated she 2/8/19, podiatry appointment his wound dressing "was wet, wever, the Ace bandage did vet. FM-A said when the wet ved, R1's wound was noted to h areas of black in the incision he staff had given R1 a appointment and R1 had told rapped the right foot with hower. FM-A stated R1's as wet when he arrived at the s a result ended up having a putation. FM-A said when R8 lity from the appointment, she staff and informed them R1's enely upset about R1's wound en wet. FM-A said had hysician had already contacted s concerns. FM-A stated R1's shape from day one, was not g it wet "did not help." FM-A are of the facilty providing R1 days however, at the 2/1/19 hysician had specifically und dressing to not get wet.				

If continuation sheet 18 of 26

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00678	B. WING		C 02/26/201	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOF GA, MN 56464			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 18	2 830			
	Continued From page 18 for transfers and his right foot to mid-calf was wrapped with an Ace wrap but was unsure as to what type of dressings was beneath the Ace wrap. NA-A stated she had assisted R1 with showers and had wrapped the right extremity with saran type plastic/wrap and kept the foot elevated when washed. Following the shower, the saran wrap would be removed. NA-A stated she assisted R1 with a shower the morning of the 2/8/19, appointment and stated during the shower, R1 had stuck his foot out as there was nothing for him to rest it on while showering. NA-A stated she had wrapped the foot well with the saran wrap and if she had noticed if it had gotten wet, she would have reported it to the nurse. NA-A stated she did not recall the wound dressing ever getting wet and and believed she would have noticed the change in the coloring of the Ace wrap, if it had gotten wet.					
	the discharge order dressing, keep clea visit". HUC verified	ed with HUC. HUC verified rs included "Don't change an, dry and intact until clinic the order had been omitted facility computer system and				
	unit manager had e right surgical site fo and cleanse and dr	t got missed. HUC stated the entered the order to check the or signs/symptoms of infection ess as needed. HUC verified appointment on 2/1/19 and				
	they received order that order was adde	ed. HUC also verified R1 st on 2/8/19 after which they				
	had received orders over R1's right lowe will cause macerati	s to not place plastic bandage er extremity when showering on to occur and also received				
	adherent gauze 4x4	ng change with betadine, non 4 gauze and ace bandage. was no order in the facility				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		SURVEY PLETED
			A. BUILDING:			~
		00678	B. WING			C 26/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	STREET NO A, MN 56464	-		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET
2 830	Continued From pa	ige 19	2 830			
	computer system to keep R1's dressing dry prior to 2/9/19.					
	On 2/25/19, at 2:36 p.m. the podiatry clinic manager (CM) stated the concern related to R1's foot care was the fact that on 2/8/19, R1 presented to his appointment with the right foot wound dressings saturated and his wound had dehisced (incision line ruptured/separated). The CM stated the skin on the right foot was macerated which could have occurred within the previous hours of the appointment or could have macerated at any time during the previous week. The CM stated the facility had been showering R ² and putting a bag over the foot in order to try keep it dry which may or may not have been effective. The CM stated the physician's notes indicated it was unknown as to how long the wound had been saturated.					
	health unit coordina orders into the elect however, the orders reviewed and activat interagency referral admission orders w confirmed the admi foot dressing intact stated it had been r order to cleanse an as needed, RN-A st order and not physi surgical wound was Saran wrap and pro be appropriate. RN of a written protoco	p.m. RN-A confirmed the ator (HUC) inputted physician stronic medical record s remained there until a nurse ated the order. R1's AVS and I form which contained the vere reviewed. RN-A who ission order to leave R1's right had not been processed and missed. When asked about the of dress the right foot wound tated this order was a nursing ician ordered. RN-A stated if a s on a limb they could put on btect the area so bathing would N-A stated she was not aware I on how to keep a wound dry ound for bathing/chowering				
	or how to wrap a wo	ound for bathing/showering uld be common sense. RN-A probably not a way to ensure				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		00678	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOI BA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
	Continued From pa	ge 20	2 830			
	water wasn't seeping into a dressing for a wound wrapped in plastic wrap. RN-A stated she was unsure of how R1's dressing got wet and indicated she had seen the wound prior to 2/1/19 and had been surprised at how well it looked. RN-A stated if she hadn't missed the order she probably wouldn't have had R1 shower until after the sutures were out. RN-A verified R1's care plan did not address the care and treatment of R1's surgical wound and confirmed R1 was not provided care as directed by the podiatrist/surgeon. On 2/25/19, at 5:48 p.m. the director of nursing (DON) reviewed R1's admission orders and					
	confirmed the 1/25/ right foot wound dre missed. DON indica surgical wound on a bathing/showering confirmed the facilit standard process for wrap to cover surgi aforementioned teo DON verified she c dressing wrapped i	(19, physican order to keep the essing dry and intact, was ated if had a resident a an extremity she felt was appropriate. DON ty did not have a protocol or br the use of Saran/plastic cal dressings and any of the chniques would be appropriate. ould not guarantee 100% a n this way would remain dry				
	if R1's dressing cou 2/8/19 appointment showering, the ace dressings remained have occurred. DO maintain the dressi been transcribed up have expected staf were his preference have notified the M	s for everything. When asked ald have been wet prior to the due to seepage during wrap dried, however d wet, DON agreed this could N stated even if order to ng clean, dry and intact had bon admission, she still would f to offer R1 a shower if that e and if concerns arose would D rather than offering a bed				
	by the podiatrist aft	he concerns communicated er the 2/8/19 appointment the facility stand up meeting				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00678	B. WING		02/26/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOF GA, MN 56464	RTHEAST		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 21	2 830			
	however, determined they felt the dressing had not gotten wet at the facility, therefore, no further investigation or process improvements had been identified or implemented. DON indicated there had been other occasions where a unit manager had determined a shower was not appropriate for a resident and other bathing interventions were recommended and verified going forward, they could potentially obtain a physican bathing order upon admission.					
	was conducted with who had cared for I appointment. The r had been given to t wet, however, wher appointment, he way wheelchair with his and dressings were no wound drainage wet dressings. The also wet to the touch accompanied R1 to informed her the fa over the right foot a nurse stated she co happened at the fac had seen and touch unfortunately, due t wound dehiscence, partial leg amputati had other complica vascular issues, ho dressings and relat contributed to R1's	a.m. a telephone interview in the podiatry clinic's nurse R1 during the 2/8/19, nurse stated strict instructions the facility to not get the wound in R1 presented to the 2/8/19, as seated in a tilt in space leg elevated and his Ace wrap e wet like a sponge. There was or discoloration noted on the Ace wrap was multi tone and ch. The nurse stated FM-A had of the appointment and cility had been applying plastic and giving him showers. The build not speak as to what cility, rather only to what she hed at the appointment and to the wet dressings and b, R1 would now need to have a on. The nurse confirmed R1 ting health factors such as owever, the saturated and skin maceration directly wound dehiscence and or further surgical intervention.				
	On 2/26/19, 10:34 a	a.m. RN-B indicated she was f education and competency				

If continuation sheet 22 of 26

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING			C 26/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	GHOME	N STREET NOF SA, MN 56464	RTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 22	2 830			
	training or complete protection of wound	ated the facility did not provide competency testing for the ls/dressings during bathing.				
	from R1's podiatrist	had received a telephone call related to concerns of R1's coming saturated. RN-B				
		poken with staff regarding the and verified the concerns had				
	stated they had dete become wet while a	he stand up meeting. RN-B ermined the dressing had not at the facility, therefore, no or process improvement had				
	On 2/26/19, at 11:4 administrator, DON When asked about and the directive to times, they stated "a interpretation and th during times such a stated once RN-B v regarding the wet d wound, she had ask was wet when he has the staff indicated th policy and procedur showers and the pro- during showering w	3 a.m. an interview with the , and RN-B was conducted. the 2/1/19, physician orders leave the bunny boot on at all all times" was for ne boot could be taken off is when showering. They was notified by the physician ressings and status of the ked the staff if the dressing ad left for the appointment and ne dressing was dry. When a re related to the provision of otection of an affected limb as requested, the DON stated ave policies and procedures	1			
	5/2/17, and proced orders must be mai of each resident an maintained in chron Orders #6 titled Tre	ation Orders policy signed ure indicated a current list of ntained in the clinical record d orders must be written and iological order. The Recording eatment Orders indicated er, specify the treatment,				

If continuation sheet 23 of 26

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION D PLAN OF CORRECTION D PLAN OF CORRECTION		A. BUILDING:		COM	E SURVEY PLETED
	00678	B. WING		C 02/26/2019	
				02/	20/2019
	427 MAII				
PINE ACRES NURSIN	G HOME MENAHO	GA, MN 56464			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 23	2 830			
of care to meet the resident's needs shall be developed for each resident within twenty-four hours of admission. The RN Unit Manager was to open the comprehensive care plan and enter the required baseline information for the baseline care plan. Information was to continue to be					
-physician orders -dietary orders -therapy services -social services					
and procedure date facility's care planni coordination with th representative, dev comprehensive car identified the highes resident may be ex comprehensive car thorough assessme limited to the MDS. was designed to	ed 11/28/16, indicated the ing/interdisciplinary team, in e resident, his/her family or eloped and maintained a e plan for each resident which st level of functioning the pected to attain. The e plan was based on a ent which included but was not Each resident's care plan				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The facility's Baseli procured signed 4/6 of care to meet the developed for each hours of admission open the comprehe required baseline in care plan. Informati entered into the car the comprehensive Ca interdisciplinary tea physician's order w treatments and con The baseline care p minimum, the follow -initial goals based -physician orders -dietary orders -therapy services -social services -pASARR recomme The facility's Care F and procedure date facility's care planni coordination with the representative, dev comprehensive car identified the higher resident may be ex comprehensive car thorough assessme limited to the MDS. was designed to incorporate identified	INE ACRES NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 The facility's Baseline Care Plans policy and procured signed 4/6/17, indicated a baseline plan of care to meet the resident's needs shall be developed for each resident within twenty-four hours of admission. The RN Unit Manager was to open the comprehensive care plan and enter the required baseline information for the baseline care plan. Information was to continue to be entered into the care plan as indicated in the Comprehensive Care Plan policy. The interdisciplinary team would review the attending physician's order which included routine treatments and complete a nursing care plan. The baseline care plan would to consist of, at a minimum, the following: -initial goals based on admission orders -physician orders -bhysician orders -bhysician exervices -social services -social services -paSARR recommendation, if applicable The facility's Care Plans-Comprehensive policy and procedure dated 11/28/16, indicated the facility's care plan for each resident which identified the highest level of functioning the resident may be expected to attain. The comprehensive care plan was based on a thorough assessment which included but was not limited to the MDS. Each resident's care plan the facility's Policy and Procedure on Skin	INEACRES NURSING HOME 427 MAIN_STREET NOMENAL ACCENT NOMENAL ACCE	INE ACRES NURSING HOME 427 MAIN STREET NORTHEAST MENAHGA, MN 56464 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) Continued From page 23 2 830 Image: Comparison of the comprehensive care plan and enter the required baseline information for the baseline care plan. Information was to continue to be entered into the care plan and enter the required baseline information was to continue to be entered into the care plan as indicated in the Comprehensive Care plan policy. The interdisciplinary team would review the attending physician's order which included routine treatments and complete a nursing care plan. The baseline care plan holicy. The interdisciplinary team would to consist of, at a minimum, the following: -initial goals based on admission orders -physician orders -dietary orders -dietary orders -dietary orders -dietary order explaned the, final care plan. The facility's Care Plans-Comprehensive policy and procedure dated 11/28/16, indicated the facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representative, developed and maintained a comprehensive care plan mays based on a thorough assessment which included but was not limited to the MDS. Each resident's care plan was designed to incorporate identified problem areas The facility's Care Ploicy and Procedure on Skin He facility's Care Plans-Comprehensive care plan was designed to incorporate identified problem areas	INE ACRES NURSING HOME 227 MAIN STREET NORTHEAST MENANGA, MN 58464 SUMMARY STATEMENT OF DEFICIENCICES REGULATORY OR USCIDENTIFYING INFORMATION) ID PREFIX REGULATORY OR USCIDENTIFYING INFORMATION) Continued From page 23 2 830 ID PREFIX REGULATORY OR USCIDENTIFYING INFORMATION) ID PREFIX REGULATORY OR USCIDENTIFYING INFORMATION) Continued From page 23 2 830 ID PREFIX REGULATORY OR USCIDENTIFYING INFORMATION OF Care to meet the resident's needs shall be developed for each resident within twenty-four hours of admission. The RN Unit Manager was to comprehensive Care Plan and enter the required baseline information was to continue to be entered into the care plan and incompletion of the comprehensive Care Plan policy. The interdisciplinary team would review the attending physician's order which included torutine treatments and complete anursing care plan. The baseline Care plan would to consist of, at a minimum, the following: -initial goals based on admission orders -optical services -PASAR recommendation, if applicable ID REGULATORY AND

If continuation sheet 24 of 26

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00678		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER.	A. BUILDING: B. WING		C 02/26/2019	
		00678				
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	GHOME	N STREET NO GA, MN 56464	-		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN			
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From page 24		2 830			
	Assessment and Preventative Skin Care dated 10/10/18, indicated each resident wound have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. The immediate jeopardy that began on 2/8/19, was removed on 2/26/219, at 4:02 p.m. when the facility had implemented an acceptable removal plan: -bathing orders would be obtained for all residents admitted with wounds that have non removable dressings, casts, splints, wraps, sutures and/or staples or with orders to keep wound dry. -Cast covers were ordered and to be applied and removed by a licensed nurse after the nurse had completed a competency assessment related to the placement of the covers. -If a res had a wound indicated to be kept dry, a					
	is to remain dry, av -If a resident requir NA will not bathe th nurse applied the c Following the show	provided with the wound that oided. ed the use of a cast cover, the e resident until the licensed over to the affected limb. er, the NA would notify the e cover and assess the area				
	for wetness by look dampness notes we provider immediate wound care nurse v orders, and docume	ing and feeling. Any ould be reported to the ly for further instructions. The would assure the care plans, entation was up to date and				
	Procedure on Skin Skin Care, and Ret Admission check lis new procedure.	ssion policy, Policy and Assessment and Preventative urn from Hospital and sts to reflect the established				
nnesota D		loffing of cast covers as well of the covered site for				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00678		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING			C 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GREEN F	PINE ACRES NURSIN	IG HOME	STREET NOF A, MN 56464	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPL IE APPROPRIATE DATI	
2 830	Continued From page 25		2 830			
	nurse and would be care planned on applicable residents. The DON will complete weekly chart audits on care plan completion and orders for bathing, if applicable, for six months to assure competency then will continue monthly. The wound care nurse would continue weekly chart audits with wound care day to assure care plan and ETAR accuracy. -Procedure was changed on 1/28/19, after a QA meeting to double check all orders entered into the computer. New procedure was effective 2/26/19, to numerate orders if there are multiple orders on a page that are difficult to read and will be numbered by the nurse or the HUC during transcription. Staff will be educated via text message and a confirmation will be received that they have received the message. Staff will be reminded via the home page to remember to clarify any orders that are unclear.					
	The director of nurs review and revise a procedures regardi wounds. The DON training for all appr and procedures. Th assurance commit surgical wounds ar compliance.	THOD FOR CORRECTION: sing (DON) or designee could as necessary the policies and ing the care of surgical or designee could provide opriate staff on these policies ne quality assessment and tee could do random audits of nd physician orders to ensure				
	(21) days.	R CORRECTION: Twenty one				

If continuation sheet 26 of 26