CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JTGN Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER (L1) 245323 2.STATE VENDOR OR MEDICAID NO. (L2) 677088600 5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2017 6. DATE OF SURVEY 11/08/ 8. ACCREDITATION STATUS:	NERSHIP	(L4) 209 BIRCHN (L5) WALKER, N 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	EHABILITATI WOOD AVENU MN PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray	RY 09 ESRD 10 NF 11 ICF/IID	(L6) 56484 02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC	4. TYPE OF ACTION:2 (L8) 1. Initial	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	40 (L18) 40 (L17)			ram	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOW	'n				15. FACILITY MEETS		_
18 SNF 18/19 SNF 40 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:	
Vienna Andresen, HFE - NE II 12/13/2018 (L19)							
Vienna Andresen, HFI	E - NE II	1	12/13/2018	(L19)	Joanne Simon, Enfor	rcement Specialist 01/04/2019 (L	20)
				_ ` ′	Joanne Simon, Enfor	(L:	20)
	ART II - TO BE	E COMPLETED 20. COM		EGIONAI	21. 1. Statement of Finar	CATE AGENCY ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	20)
P. 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa	ART II - TO BE Y rticipate	E COMPLETED 20. COM RIG	BY HCFA RI	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro	CATE AGENCY ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	20)
P. 19. DETERMINATION OF ELIGIBILIT	ART II - TO BE Y rticipate (L21)	E COMPLETED 20. COMPLETED IENT 2	BY HCFA RI APLIANCE WITH GHTS ACT:	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	CATE AGENCY Incial Solvency (HCFA-2572) Incial Solvency (HCFA-1513) (L30)	20)
P. 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	ART II - TO BE Y rticipate (L21) 23. LTC AGREEM	E COMPLETED 20. COMPLETED IENT 2	BY HCFA RI MPLIANCE WITH GHTS ACT: 4. LTC AGREEM	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety of L30 OFAIL to Meet Agreement	20)
P. 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986	Y rticipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI	E COMPLETED 20. COMPLETED 20. TOMPLETED 20. TOMP	BY HCFA RI APLIANCE WITH GHTS ACT: 4. LTC AGREEM ENDING DAT	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety of L30 OFAIL to Meet Agreement	
P. 19. DETERMINATION OF ELIGIBILIT X 1. Facility is Eligible to Pa 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24) 25. LTC EXTENSION DATE:	Y rticipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	E COMPLETED 20. COMPLETED 20. TOMPLETED 20. TOMP	BY HCFA RI APLIANCE WITH GHTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	(L30) INVOLUNTARY O5-Fail to Meet Health/Safety ent OTHER O7-Provider Status Change	20)
P. 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24) 25. LTC EXTENSION DATE: (L27)	Y rticipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	20. COMPLETED 20. COMPLETED 20. TOMPLETED 20. COMPLETED 20. CO	BY HCFA RI APLIANCE WITH GHTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) INVOLUNTARY O5-Fail to Meet Health/Safety ent OTHER O7-Provider Status Change	
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 27, 2018

Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

RE: Project Number S5323029 and H5323021

Dear Administrator:

On November 8, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the November 8, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5323021 that was found to be unsubstantiated.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

• State Monitoring effective December 2, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) 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 January 27, 2019.
- 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 January 27, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 27, 2019.

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.

If you have not achieved substantial compliance by January 27, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Walker Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 27, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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 May 8, 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

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.

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have 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

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

1	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245323	B. WING			11/	08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		209 E	ET ADDRESS, CITY, STATE, ZIP CODE BIRCHWOOD AVENUE WEST PO BOX 7 .KER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕO	000			
F 000	Emergency Prepar conducted on Nove recertification surve	liance with CMS Appendix Z redness Requirements, was ember 5, 6, 7, 8, 2018, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	000			
	survey was comple Minnesota Departn your facility was in of 42 CFR Part 483	5, 7, and 8 2018, a standard eted at your facility by the nent of Health to determine if compliance with requirements 3, Subpart B, and Long Term Care Facilities.					
	allegation of complenrolled in the election (ePOC), a signature	ion will serve as your facility's iance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form.					
	revisit of your facility validate that substa	acceptable ePOC an on-site ty may be conducted to antial compliance with the en attained in accordance with					
F 578 SS=D	complaint investigathe time of the star An investigation of completed and fou	complaint H#5323021 was nd not to be substantiated. scntnue Trmnt;FormIte Adv Dir	F 5	578			
LABORATORY		right to request, refuse, and/or	NATURE		TITLE		(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11	/08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 578	to participate in exp formulate an advantal state of the provision of me services deemed minappropriate. §483.10(g)(12) The requirements specified subpart I (Advance (i) These requirements inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable State (iii) Facilities are perentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission a information or article has executed an admay give advance of individual's residential with State Law. (v) The facility is not provide this information or she is able to reconstruction of the surgical provide this information or she is able to reconstruction.	ent, to participate in or refuse perimental research, and to perimental resident to receive dical treatment or medical redically unnecessary or redically unnecessary or refuse fied in 42 CFR part 489, Directives). The perimental research in a comply with the fied in 42 CFR part 489, Directives). The perimental research in a comply with the perimental research in a comply with the perimental research in a comply with the implemental research in the perimental research in	F 57	8		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIE	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	This REQUIREM by: R22's admission dated 10/25/18, id intact. R22's current Ordidentify a CPR or chart had a full conchart. R22's Provider Of Treatment (POLS Section A for card (CPR) patient has section, directed a resuscitation/DNF Section B indicate medical treatment cardiac monitor, receive comfort-for was signed by resuscitation D was signed by resuscitation by tube, and oral antibiotic On 11/05/18, at 3 stated she could down but wants to On 11/06/18, at 1 nurse (LPN)-B status by checkin medical chart. It is pretty much knowned and the status by checkin medical chart. It is pretty much knowned for no CPR. It is status by checkin medical chart. It is pretty much knowned for no CPR.	ENT is not met as evidenced Minimium Data Set (MDS) dentified R22 was cognitively der Summary Report did not DNR status. R22's medical ode sticker on the binder of the rders for Life-Sustaining of dated 10/22/18, included: diopulmonary resuscitation is no pulse and is not breathing staff to "Do Not Attempt" R allow for a natural death. ded selective treatment, to include t, antibiotics, intravenous fluids, no intubation, all patients will ocused treatments. Section C sidents although not dated in E indicated no artificial use intravenous, intramuscular		578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
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F 578	stated she would of the medical red - At 1:41 p.m. reg would check the I sticker on the out - At 1:48 p.m. RN something in their DNR/DNI - looked determine. RN-C how they flag the not go by the sticklook at the POLS - At 2:31 p.m. NA NA care sheet the confirmed that concare sheets. On 10/8/18, at 12 director of nursing should be aware resident's name, indicated that she POLST did not must be resident's wis	check the sticker on the outside cord. istered nurse (RN)-B stated she POLST, electronic record or the side of the chartC stated there should be room that says if they are d in 3 rooms not able to stated I should find out myself rooms. RN-C stated she would kers on the chart rather would	F 5	578			
	facility failed to er emergency care	w and document review, the nsure advanced directives for and treatment were accurately eas of the medical chart to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED			
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
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F 578	correctly in an emeresidents (R9, R, F directives. Findings include: R4's admission Min 7/05/18, identified R4's current Order identify a CPR or Emedication administatus. R4's medic binder of the chart. R4's Provider Order Treatment (POLST for cardiopulmonal has no pulse and idirected staff to "D DNR allow for a na indicated selective treatment, antibioti	shes would be implemented ergent situation for 3 of 3 R) reviewed for advanced nimum Data Set (MDS) dated R4 was cognitively intact. Summary Report did not DNR status. R4's electronic stration form indicated full code al chart had full code sticker on ers for Life-Sustaining T) undated, included: -Section Ary resuscitation (CPR) patient is not breathing" section, o Not Attempt" resuscitation/atural death. Section B treatment, to include medical cs, intravenous fluids, cardiac	F 57				
	comfort-focused trivial period of artific POLST had been see POLST lacked a policy of the policy of	2:04 p.m. a nursing note e conference was held. R4 and resent. The note indicated to status. 5 p.m., during an interview R4 ure if she should be a full code I would like my family to be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 578	,		F 5	78		
	identified, C4's PC Chess, medical do record lacked doc	0 p.m. R4's record review DLST had been signed by David potor on 11/7/18. The clinical umentation indicating the facility POLST choice of DNR with R4				
	confirmed R4's cli	director of nursing (DON) nical record and POLST ing information related to code				
	(DON) stated Dr. (director (MD) loca confirmed the POI for signature and I The DON confirmed medical physician	30 a.m. the director of nursing Chess is the facilities medical ted in Connecticut. The DON LST had been faxed to the MD returned to the facility via fax. ed R4, her family, and primary had not been consulted prior to ST signed by the MD.				
F 655 SS=D	4/28/18, indicated resident charts up the attending phys orders for all advareviews and update	n	F 6	55		
	Planning §483.21(a) Baselii §483.21(a)(1) The	ensive Person-Centered Care ne Care Plans facility must develop and line care plan for each resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED				
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 655	that includes the ineffective and persor that meet profession. The baseline care (i) Be developed wadmission. (ii) Include the minnecessary to propeincluding, but not li (A) Initial goals bas (B) Physician orde (C) Dietary orders. (D) Therapy service (E) Social services (F) PASARR reconsection (F) PASARR reconsection (II) Is developed wadmission. (III) Meets the required (b) of this section (III) Meets the required (b) of this section (III) The initial goals (III) A summary of the baseline car limited to: (III) A summary of the dietary instructions (IIII) Any services a administered by the on behalf of the factive (IV) Any updated in of the comprehensive care (IV) Any updated in of the care (IV) Any upd	istructions needed to provide on-centered care of the resident onal standards of quality care. plan mustithin 48 hours of a resident's imum healthcare information orly care for a resident mited to-sed on admission orders. In mendation, if applicable. facility may develop a re plan in place of the baseline mprehensive care plantithin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of the facility must provide the representative with a summary e plan that includes but is not and treatments to be a facility and personnel acting	F 65	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED				
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484			
(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 API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 655	Regimen Review 11/08/18 07:38 AM Admit:10-19-18 DX: encephalopath pacemaker, parkin fx skull and facial by MDS: 10/19/18 BIN CAA: (PSYCH/Pair CARE PLAN: ADL self care need balance Disease Process: FDate Initiated: 10/2 BATHING/SHOWE assistance by 1 state bathing/showering Date Initiated: 10/2 Revision on: 11/05/CNA LPN RN BED MOBILIT and offload independents	as, Psychotropic Meds, and Med as, and is and as a solution of the solution of	F 65	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING			11/0	08/2018
NAME OF	PROVIDER OR SUPPLIEF	2		ST	REET ADDRESS, CITY, STATE, ZIP CODE		00.20.0
\A/A /E				20	9 BIRCHWOOD AVENUE WEST PO BOX 7	00	
WALKE	REHABILITATION	& HEALTHCARE CENTER		W	ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	DRESSING: assistance by 1 st Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN EATING: Ass and allows Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN ORAL CARE Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN TOILET USE toileting Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN TOILET USE toileting Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN TRANSFER: 1 Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN TRANSFER: 1 Date Initiated: 10/3 Revision on: 11/05 CNA LPN RN Encourage the assistance The resident is an risk/wanderer r/t Here	The resident requires aff to dress 25/2018 5/2018 5/2018 sist with eating as he tolerates 25/2018 7/2018 FROUTINE 25/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018 5/2018	F6	055			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 655	awareness Date Initiated: 11/0 Assess for fall risk. Date Initiated: 11/0 LPN RN Distract reside pleasant diversions activities, food, cor Resident prefers: Date Initiated: 11/0 ACTA CNA LPN RN SW WANDER AL Date Initiated: 11/0 The resident is higl Deconditioning, Ga confusion, Parkinso Anticipate and mee Date Initiated: 10/2 CNA LPN RN Be sure The r reach and encoura for assistance as n prompt response to assistance. Date Initiated: 10/1 CNA LPN RN RN RN RN RN	5/2018 5/2018 ent from wandering by offering s, structured oversation, television, book. 5/2018 ERT: right ankle 5/2018 n risk for falls r/t hit/balance problems, on's Disease et The resident's needs. 8/2018 resident's call light is within ge the resident to use it eeded. The resident needs of all requests for 9/2018 esident/family/caregivers about and what to do if a	F 6	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 655	LPN RN Ensure that T appropriate footwe when ambulating of Date Initiated: 10/2 Revision on: 10/28 ACTA CNA LPN RN Follow facility Date Initiated: 10/1 ACTA CNA LPN RN Pt evaluate a Date Initiated: 10/1 LPN RN RN RN RN RN Review inform to determine cause possible root cause causes if possible.	The resident is wearing par shoes or gripper socks or mobilizing in w/c. 28/2018 /20	F 65	5			
	falls since admission attempts to ambulate falls. Note poor pobed and mats. Standequate footwear	6/18 falls Resident has had 7 on date of 10/19/18. Resident ate per self, loses balance and sitioning in bed. Will trial low ff to ensure that he has and performing checks assessment completed and					

	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655	MD Orders: just st changed to DNR and Behavior monitoring safety. The resident meds which are as of confusion, amner cognitive impairmed increases risk of fat ANTIDEPRESSAN observed) Monitor behavior/mood/coghallucinations/delust thoughts, withdrawd continence, no voic impaction, diarrheat balance probs, more muscle cramps, fall insomnia; appetite dry eyes Staff Interventions: Falls: 6 falls since at Observations: 11/08 low to floor, mat near the safety of th	arted Hospice 11/7/18, POLST and signed by wife g:Monitor the resident for sit is taking ANTI-ANXIETY sociated with an increased risk sia, loss of balance, and ant that looks like dementia and sills, broken hips and legs. TS (0 indicates no side effects for side effects: change in unition; sions; social isolation, suicidal al; decline in ADL ability, sing; constipation, fecal significant changes, rigid muscles, wement problems, tremors, ls; dizziness/vertigo; fatigue, loss, wt loss, n/v, dry mouth, admission, no injury 8/18 08:24 AM restless bed	F6	55	DEFICIENCY)			
	should have been of been completed, it admission. Shari I	nd a baseline care plan, there one done. It must not have should have been done upon DON I was not able to locate it. macy review completed yet.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245323	B. WING_		11/0	08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BC WALKER, MN 56484	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 655	Dependence on rei	D, fusion of spine, ESRD, nal dialysis, anemia, HTN. sessed	F 6	55		
	nurse, admissions plans, it should be it in here, it should look in a box that het you know. Develop/Implement CFR(s): 483.21(b)(§483.21(b) Compre §483.21(b)(1) The implement a compresident rights set f §483.10(c)(3), that objectives and time medical, nursing, a needs that are identification assessment. The codescribe the following it is should be a second to the interval of t	7/18 11:29 AM Beth MDS does the 24-48 hour care in his paper chart. I don't see be in the paper chart. I will as misc papers, if I find it I will at Comprehensive Care Plan 1) chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable frames to meet a resident's ind mental and psychosocial tified in the comprehensive omprehensive care plan must ing -	F 6	56		
	assessment. The c describe the followi (i) The services tha	omprehensive care plan must				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
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F 656	required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS, rationale in the resident's represent (A) The resident's represent (A) The resident's regular discharge. Fawhether the resident community was assolicated as appropriate requirements set for section. This REQUIREMENT by: Based on observative review the facility fainterventions on the 1 of 1 residents (R1 behavior/emotion, comanagement)	and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights uding the right to refuse 83.10(c)(6). I services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document and the desire to return to the sessed and any referrals to be sessed and any referral to the sessed and	F6	556			
	Findings include:						
	R16's 14 day minim	num data set (MDS) dated					

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		245323	B. WING _		11	/08/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	10/18/18, indicated impaired, demons symptoms and recomost activities of concluded demential disturbance, chrorodisease (COPD) and infection. The MD not pain, was not receded (PRN) pain antipsychotic, antimedications. Care area assessificated cognitive incontinence, falls ulcer. Pain Evaluation con R16 had occasion Analgesic pain measurements of the summary indicate analgesics, rest, reseated in one place. Recreation service indicated that R16 games, beading, to cards, cribbage, vin Assessment indicated thought pain and impaired cognimpaired thought patents.	d R16 was severely cognitively trated no mood or behavior quired limited assistance with laily living (ADL's). Diagnoses without behavioral nic obstructive pulmonary and recent urinary tract S also indicated that R16 had receiving any scheduled or as an medications or any anxiety or antidepressant ments triggered on 10/18/18, loss/dementia, urinary, nutritional status and pressure ompleted on 10/4/18, indicated al pain in low back and legs. Indication was effective. In overment and not staying e. Se assessment dated 10/5/18, interests included crossword elevision game shows, bingo, siting the birds and 1:1's, small and the site of the second content	F 65	6		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11	/08/2018
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F 656	reorient and super also directed to moneeded any change specifically change memory, recall and expressing self, dif level of consciousr made to care plan anti-anxiety med us. Physician orders us included aspirin 32 sulfamethoxazole/to tablet twice daily (Emg daily PRN for conditional medication 10/16/18 aceta hours PRN for pair on 10/18/18 loraze for anxiety on 10/23/18 loraze for anxiety on 10/26/18 Lexalon 10/30/18 loraze agitation (in addition on 11/6/18 rispering disorder (antipsychology con 10/18/18, at 3 having increased of 17th). Pacing floor oxygen, crying outlorazepam or pain something for pain	vise as needed. Staff were positor/document/report as es in cognitive function, es in: decision making ability, digeneral awareness, difficulty ificulty understanding others, ness, mental status. Additions on 11/7/18 includes se & pain pon admission 10/4/18, 5 milligrams (mg) daily; crimethoprim (antibiotic) 1 milligrams (mg) daily for 2 days; guaifensin 600 milligrams (mg) daily for depression depam 1 mg BID for anxiety pro 5 mg daily for depression depam 1 mg every 6 hours PRN on to 1 mg BID) done 0.25 mg BID for mood notic medication)	F 65	6		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	- On 10/18/18 at 4 loreazepam 1 mg every 6 hrs PRN - On 10/20/18 responded to 500mg 3000mg; lorazepa agitation - On 10/29/18, no yelling out severe knife stabbing" look region between shwith staff intervent amount 7 frequence of urine on floor with 11 reassure, rediin Phone call to daugterm (5-10) minute PRN Tylenol #3 ef again at 3:45 ineff st bedtime. PRN order received for for PRN lorazepar Urinalysis on 10/2 tablets every 4 horough to 11/5/18, no time with anxiety re: pla PM, difficulty deseinterventions. Cry Reassuring dog is effectiveness in Plutilized daily in add 5mg every AM stareferral for in-house Review of Medical indicated the follow - 5 does of PRN locations.	p.m orders received for BID PRN pain & Tylenol #3 1 conse at 4:25 p.m change 2 tablets every 6 hrs PRN - max am 1 mg evey 6 hrs PRN time noted.: restless, agitated, complaints of pain. "feels like rated mid-upper back/spinal roulder blades. Increase yelling ion, increase incontinence by soiling bed & leaving puddles ille having brief on. Cold pack, rect, distraction all ineffective. In the system of the system	F6	356			

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	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 656	- 6 doses of PRN in October 2018 - 13 doses of Tyle October 2018; 14 No pain monitorir of pain medication On 11/5/18, at 11 significant pain in blades At 11:56 a.m. R down in bed from stating Oh God At 2:23 p.m. R16 find her dog - plea outside. On 11/07/18, at 2 be assist by staff staff person state end of the bed ba - At 2:51p.m. R16 of bed trying to put of bed trying to put of bed on left side - At 8:06 a.m. a c placed on overbe - At 8:23 a.m. bre and R16 was ask - At 8:46 a.m. lice entered room with of back pain and LPN-B administer from breakfast, a - At 9:07 a.m. R16	acetaminophen 650 mg given and #3 were administered in doses in November 2018 ag prior to or after administration in were found. 505 a.m. R16 stated she has her back between her shoulder a sitting position, grimacing and a sitting position, grimacing and a sitting position, grimacing and a see look in the bathroom and see look in the bathroom and the interfect. 5 was observed sitting on edge at on socks "oh god, oh god." g continuous observation from the amount of a.m. R16 was observed lying and and the interfect. The provided Hamber of the proposition of the wall overed breakfast tray was display the wall overed breakfast tray was display the wall overed breakfast tray remained covered ing where was her puppy. The proposition of the wall overed breakfast tray remained covered ing where was her puppy. The medications of the wall of the wall overed breakfast tray remained covered ing where was her puppy. The medications of the wall of the wall of the wall overed breakfast tray remained covered ing where was her puppy. The medications of the wall of the wall overed breakfast tray remained covered ing where was her puppy. The medications of the wall of the	F6	656		

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	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 70 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	not eaten any brea - At 9:24 a.m. R16 No staff assistance 8:06 a.m At 11:09 a.m. R1 was an 8 out of 1-stops me from bei enjoy things At 12:10 p.m. R1 rubbing her head, Progress Notes re - PN dated 10/5/18 calling out for her dog is dead on the redirection as her Residnt voiced that can see her dog on to consistently eff - PN dated 10/17/1 wandering out in h Staff redirected se evening PN dated 10/19/1 agitated, came out where my dog was dog was at daught dog run down the several times. Rewent back to room her reassurance the come back in PN dated 10/20/1 crying this afternoot to daughter who we - PN dated 10/21/1	akfast. had eaten a piece of bacon. e with meal since delivery at 6 told surveyor that back pain 10 scale. R16 stated the pain ng able to move about and 6 was observed lying in bed, no TV or music was playing. viewed as follows: 3, at 12:41 p.m. has been dog and has stated her white e road being eaten by a crow, dog is with her daughter. It staff is lying to her and she in the road. Attempts to redirect	F 65				

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F 656	- PN dated 10/22/1 visabily upset, cryir redirect. Resident she would "blow he administered. Res of distress, 15 minu had been on 1:1 sin with resident she wher wrists" and "bu Daughter called an room PN dated 12:31 a ready to return to fabored PN dated 10/25/1 agitated and lookin television turned or given PN dated 10/25/1 anxious this AM lood dog was with dauglying to her PN dated 10/29/1 regarding dog. Diff Attempted to call d. PN dated 11/1/18 dog thinks he is mi crying and repeater feels like someone and pain radiates a ribs. Tylenol #3 ad. PN dated 11/3/18 and yelling out at 6 anxiety regarding dalong with AM lorar redirection effective escalated early after AM. Crying regard.	8, at 8:37 p.m. resident is no that dog is missing. Tried to verbalized is she had a gun er brains out." Lorazepam ident continued to exhibit signs ute checks instilled but resident nce 7:10 p.m. While staff was erbalized she was going to "slit st her head into the wall." d wanted sent to emergency .m. indicated resident was acility - no longer suicidal just 8, at 5:11 a.m. resident g for dog. Redirected, n. Ineffective. Lorezapam 8, at 3:44 p.m. resident oking for dog. Writer voiced hter, resident voiced they were 8, at 12:19 p.m. anxious in AM ficulty to reassure or distract. aughter x2 - no answer. , at 11:36 p.m. anxious about ssing. Redirected. Resident dly saying "ow." States she is stabbing her in the back around the front towards the	F 65	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING		_	11/08/201	8
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED			ETION
F 656	on 10/8/18, at 12:3 stated that R16 like does not have them likes socializing in a not get up for morn - At 12:41 p.m. liced & LPN-B stated R1 she is comfortable R16's daughter brir weaning off the visi after she sees her ostuffed animal or do When a new mediowe have faxed the local physician comtomorrow. Non phatried before we give evaluation has been the survey) but is 3 issues are back paid disease - we are located to be transferred Ativan we documer - 12:48 p.m. nursing R16 cries at least of	arrange of the start of weeks out. Some of R16's in and other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of weeks out. Some of R16's in and other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of weeks out. Some of R16's in and other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of weather is doing. We have not tried a complete the start of weeks out. Some of R16's in and other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of weeks out. Some of R16's in and other is doing. It what she is doing. It what she is doing of the start of the start of other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of the start of other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of the start of other is Alzheimer's oking into a possible unit for dto. When we give PRN of the start of the s	F6		:IENCY)		
	staff report R16 is of will accuse daughter facility would allow daughter says that stuffed animal and not sware of non-howith R16 and has nexcept to take her be	ed social worker (LSW) stated constantly looking for her dog, er of taking the dog. The the dog to live here but R16's is not an option. We tried a R16 just got angry. LSW is comological interventions to use ot had any contact with R16 pack to her room. No LSW we found in R16's chart since					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED		
		245323	B. WING				11/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO) WALKER, MN 56484			700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	admission on 10/4/ - At 12:54 p.m. dire she expected staff non-pharmaco;ogic administering medi determine why risp morning as there windicate communication confirmed that persure not developed behavioral/emotion management. Cardio-Pulmonary I CFR(s): 483.24(a)(§483.24(a)(3) Persupport, including a such emergency care emergency medicar related physician or advance directives.	18. ctor of nursing (DON) stated to be trying all approaches before cations. DON was unable to erdone was ordered this ere not progress notes to ation with physician. DON concentered interventions of for R16 related to all, dementia care or pain (CPR) (SPR), to a resident requiring are prior to the arrival of all personnel and subject to orders and the resident's	F 6					
		lasm of brain, neuralgia and epsy, GERD, degenerative system,						
	MDS: quarterly MD	OS 8/8/18 BIMS 6						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11	/08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	
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F 678	CAA: (PSYCH/Pair	ration in elimination. provide with each episode, check on minutes.	F 67	8		
	MD Orders: see so Vitals:	canned document				
	Staff Interventions: contact with family. antidepressant use	offer faviorite activities, chart mood behavior and				
	water temp 125 11/07/18 01:09 PM 11/06/18 01:09 PM soaked wet w/c cus 01:30 PM peri care hand hygiene. No Interviews: 11/06/18 07:19 PM decided DNR in Au 11/06/18 07:51 PM	shari is this an advance I want the one from the chart,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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)	HOULD BE	(X5) COMPLETION DATE	
	Shari got the chart was in the back to 8/9/06. The copy wasked for copy of countries the front of the chart 11/08/18 07:51 AM temps checked? The temps checked? The temps checked? What should the temps checked? The temps ch	and the code status directive be filed. This was dated when asked was dated 11/6/18, ode status directive that was in rt, copied was recieved. How often are the water vice a week emp be? 115 temp myrna's room 115.9 118.9 my thermometer calibrated, 2 degrees. I will have to go to be ecrease in ROM/Mobility 1)-(3) facility must ensure that a sethe facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range	F 678				
	receives appropriat assistance to main the maximum prac reduction in mobilit	eident with limited mobility se services, equipment, and tain or improve mobility with ticable independence unless a sy is demonstrably unavoidable.					

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F 688	by: Based on observareview, the facility facility facility facility facility facility for splints to prevent the extremity contractuous observed with contractual harm for R1 contractures in upper Findings include: R10's quarterly Mir 9/12/18, indicated I impairment and dia Parkinson's diseas depression. The Macton total assistance of transfers and all act and had bilateral furmation of the upper R10's Activities of It Assessment (CAA) required assistance extensive to total contracture R10 was unable to the had contracture R10 was at risk for motion (ROM) declipraces to arms, an for ROM declines. R10's Therapy and dated 6/5/18, regar orthotics/splints to exception of bathin range of motion (Pincilla R10).	tion, interview and document failed to provide the use of the development of upper lives for 1 of 1 residents (R10) ractures. This resulted in 0 due to worsening of identified per extremities. This resulted in 10 due to worsening of identified per extremities.	F6	88				

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	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 688	staff should be in-sapplication. In-service training 10 staff received tr PROM for R10. R10's Occupational Encounter note dated a cated nursing application of bilated educated staff on a sprolonged stretch benefits and import R10's Order Summindicated an order be worn at all times dressing and daily was started 6/15/1. R10's care plan dated decline in physical fracture, neurologic evidenced by poor reposition. The cate hand splints at all the off for cares, dress for 20 minutes per to potential for importal for important for im	record dated 5/28/18 indicated aining on use of braces and all Therapy Treatment ted 4/25/18, indicated staff present on proper eral elbow splints. Additionally, contracture management such ching of bilateral elbows, tance of applying splints. The properties of the exception of bathing, stating all orthotics/splints to swith the exception of bathing, PROM and stretching. Order 8. The properties of the exception of bathing, PROM and stretching. Order 8. The properties of the exception of bathing, PROM and inability to replan directed staff to apply imes to reverse contractures and bathing. May have off shift to allow skin to heal due aired skin integrity.	F 68	8			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 688	has worked here siknown R10 to wear On 11/08/18, at 7:0 in wheelchair with a contractured. R10 across chest. - At 7:10 a.m. NA-PROM when R10 I - At 8:10 a.m. adm room. Observed be chest. - At 8:54 a.m. direct confirmed that R10 splints and she see elbow & hand splin items on spare bed began working at a seen R10 with splint R10 into bed, NA-A splints to R10. - At 11:04 a.m. lice stated that R10 will splint him - will yell - At 11:11 a.m. direct she spoke to Physical he would say the R worsened. Physical on-site. Review of progress dates R10 was not - 9/24, 9/25, 9/27, 9/21, 10/1, 10/6 - 10/9, 10/25 - 11/1, 11/2, 11/4, 1	nce 9/5/18 and has never any type of splints 6 a.m. R10 was observed up no elbow splints on. Right arm was holding arm upwards A stated she provides his ays down after breakfast. Inistrator wheeled R10 into his oth arms curled up towards tor of therapy services of was suppose to be wearing arched throughout room for ts. They were located under in room. (NA)-A stated she acility in April and has never its in place. After assisting a did not apply hand/elbow on sed practical nurse (LPN)-B is yell at you when you try to non-stop. Cotor of therapy services stated cal Therapist by telephone and that R10 was not tolerating and by seeing R10 in passing, and by seeing R10 in passing, and therapist was not available in notes indicated the following tolerating splints: 20/28 3 notes indicated the following tolerating splints: 20/28 3 notes indicated the following tolerating splints: 20/28	F 6	888			

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F 688	on 11/08/18, at 11: stated the nurses h tolerating or not tole DON verified that n "not tolerating" and been contacted by tolerating splints.	28 a.m. director of nursing ave signed off that either he is erating the use of splints. nost days were documented physical therapy should have now that R10 had not been	F 68	38				
	procedure to ensur- splinting device, en according to care p ensure skin is prote and splint fits prope removed for period circulation and if sp or physician for new documentation may	ated 3/8/18, included the there is an order for the sure the splint is being put on lan and physician order, tected around the splinted area terly, all sprints need to be s of rest to ensure proper lint does not fit refer to therapy order. The policy indicated or include: any sign of s in skin, refusal of application 1.	F 69	97				
	provided to resident consistent with profite the comprehensive and the residents' of this REQUIREMED by: Based on observative review the facility faces assess pain and idea.	anagement. Issure that pain management is the who require such services, fessional standards of practice, person-centered care plan, goals and preferences. No is not met as evidenced tion, interview and document ailed to comprehensively entify non-pharmacological of 1 residents (R16) who						

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F 697	voiced complaints Findings include: R16's 14 day mining 10/18/18, indicated impaired. Diagnose behavioral disturbation pulmonary disease tract infection. The had not pain, was needed (PRN) in the complete com	num data set (MDS) dated I R16 was severely cognitively es included dementia without ance, chronic obstructive (COPD) and recent urinary e MDS also indicated that R16 not receiving any scheduled or pain medications. Inents triggered on 10/18/18, loss/dementia, urinary nutritional status and pressure impleted on 10/4/18, indicated al pain in low back and legs. dication was effective. If use of as needed (PRN) inovement and not staying et.	F 69	,			
	tablet twice daily (Emg daily PRN for canditional pain me follows: - on 10/16/18 aceta hours PRN for pair - on 10/18/18 aceta	dications were added as aminophen 650mg every 4					

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F 697	Fax's sent to physe - On 10/18/18, at for something for PRN 650mg Tyler due to pain? - On 10/18/18 at 4 tablet every 6 hrse - On 10/20/18 res Tylenol to 500mg 3000mg - On 10/29/18, no yelling out severe knife stabbing" loor region between shwith staff interven amount 7 frequen of urine on floor with 1:1 reassure, rediphone call to daugterm (5-10) minute PRN Tylenol #3 eragain at 3:45 ineff st bedtime. PRN order received for for PRN lorazepal Urinalysis on 10/2 tablets every 4 horder received for for PRN lorazepal Urinalysis on 10/2 tablets every 4 horder received for for PRN lorazepal Urinalysis on 10/2 tablets every 4 horder received for for PRN lorazepal Urinalysis on 10/2 tablets every 4 horder 2018 - 13 doses of Tyle October 2018; 14	sician as follows: 3:30 p.m. R16 has been asking pain. Only thing she has is nol. Wondering if agitation is 4 p.mordered Tylenol #3 - 1 PRN ponse at 4:25 p.m change 2 tablets every 6 hrs PRN - max time noted.: restless, agitated, complaints of pain. "feels like cated mid-upper back/spinal noulder blades. Increase yelling tion, increase incontinence cy soiling bed & leaving puddles file having brief on. Cold pack, rect, distraction all ineffective. In ghter re: dog effective short tes Scheduled lorazeapam & fective. Lorazepam scheduled lorazeapam discontinued when scheduled. Requesting: OK m in addition to scheduled. 3 - increase Tylenol #3 to two urs. tion Administration Records wing: acetaminophen 650 mg given nol #3 were administered in doses in November 2018 g prior to or after administration	F 6	97			

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F 697	Continued From pa	nge 30	F 69	97				
	significant pain in h blades At 11:56 a.m. R16 self down in bed fro and stating Oh God On 11/7/18, at 2:51 on edge of bed trying god." On 11/8/18, at 8:46 (LPN)-B entered ro complained of backdog was At 9:07 a.m. R16 stating "Oh God, Conot eaten any breal - At 11:09 a.m. R16 was an 8 out of 1-1	p.m. R16 was observed sitting ng to put on socks "oh god, oh a.m. licensed practical nurse om with medications. R16 c pain and asked where her was observed crying and the God I want to die." R16 had						
	nurses (LPN)-A & L we assess her pain prescribed. - At 12:54 p.m. dire confirmed R16 had assessed for pain a	241 p.m. licensed practical LPN-B stated R16 cries daily, and give medications as actor of nursing (DON) not been comprehensively and a care plan had not been fy pharmacological and cal interventions.						
	A policy for pain ma was not provided. Dialysis CFR(s): 483.25(I)	anagement was requested and	F 69	98				

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F 698	§483.25(I) Dialysis The facility must er require dialysis rec with professional s comprehensive pe the residents' goals This REQUIREME by: Based on observa review, the facility f monitoring of dialys comprehensive car reviewed for dialys Findings include: The admission rec indicated diagnose limited to end stage dependent on rena Review of R21's ac (MDS) dated 9/12/ memory or cognitiv was independent w a wheelchair, had o (ESRD), and receiv Review of R21's ph for renal diet, renal and Friday of each restriction, and to r however there was R21's tunneled cat	nsure that residents who reive such services, consistent tandards of practice, the rson-centered care plan, and and preferences. NT is not met as evidenced tion, interview and document failed to ensure consistent sis access sites and develop a re plan for 1 of 1 resident (R21) is. ord dated 11/8/18 for R21 as that included, but were not be renal disease and was all dialysis. dmission Minimum Data Set 18, indicated R21 had no re impairment, the resident with transfer and mobility using end stage renal disease		8			
		s noted that R21 had a					

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F 698	Continued From p	•	F 69	86			
	tunneled catheter that had a double dressing. R21 sta checked the cathedialysis unit was redressing. R21's medication treatment adminis and there was no catheter was monitariated the following: -Do not draw blooded a catheter was monitariated the following: -Do not draw blooded a catheter was monitariated the following: -Do not draw blooded a catheter was monitariated to conscious and symptoms of level of conscious oral mucosa, chard-Monitor/document and symptoms of hemorrhage, bacted the conscious oral mucosa, chard-Monitor and country the resident has overload related to the conscious of the catheter was not conscious or and symptoms of the morrhage, bacted the conscious of the conscious of the resident has overload related to the conscious of the catheter was not conscious or and symptoms of the morrhage, bacted the conscious of the cons	on the right upper chest wall lumen and was covered with a ted that the facility never ster following dialysis, and the esponsible for changing the administration records and tration records were reviewed indication R21's tunneled itored. The plan dated 9/25/18, included a contact of the scheduled ents. The dialysis 3 times a week-and output. The port to doctor as needed. The port to doctor as needed. The port as needed for signs renal insufficiency, changes in the potential fluid deficit or fluid to diuretic use, hemodialysis, and will drink/take in a minimum each 24-hour period. The port in the records were reviewed indication in the scheduled ents. The plan dated 9/25/18, included in the scheduled ents. The plan dated 9/25/18, included ents. The					
	in the arm, it had r tunneled catheter(not identified R21 had a TC), and appropriate ed to the TC (like dialysis does					

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F 698	the dressing change checked following chances of exsang implement should infection or get dislidentified at which hemodialysis and happropriate diet res R21 was restricted the care plan had result would be delineated going to receive for R21 was going to response and distinguished which drugiven at 8:00 a.m. Wednesday, and FR21's nursing progress note indicated in the restriction, although progress note indicated in the restriction of the fluinterventions had restriction and different drinking water (har pops etc) The DON was integrated in the restriction of R21's admission, the risk over loaded were restricted to R21, and R21's to show correct diagrams.	ges, the catheter should be dialysis and daily to minimize duination, and interventions to catheter show signs of odged.) The care plan had not ESRD facility R21 received now to contact them, strictions including which foods from eating in a renal diet, and not identified how R21's fluid d as far as how much R21 was reach meal, and how much receive with each medication. The care plan had not ags would be dialyzed off when prior to dialysis on Monday, iriday.	F 69				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY IPLETED
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F 698	о оттанова т тотт ра	•	F 69	8		
		contact information, renal diet that should and should not be is.				
F 744 SS=D	Treatment/Service CFR(s): 483.40(b)(F 74	.4		
	diagnosed with den appropriate treatme maintain his or her mental, and psychology. This REQUIREMEN by: Based on observative review the facility facentered dementia	ent and services to attain or highest practicable physical,				
	Findings include:					
	10/18/18, indicated impaired, demonstr symptoms and required most activities of daincluded demential disturbance, chronical disturbance,	num data set (MDS) dated R16 was severely cognitively rated no mood or behavior uired limited assistance with aily living (ADL's). Diagnoses without behavioral c obstructive pulmonary ad recent urinary tract				
	included cognitive le	nents triggered on 10/18/18, oss/dementia, urinary nutritional status and pressure				
	indicated that R16 i	s assessment dated 10/5/18, nterests included crossword levision game shows, bingo,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING		_ 11	/08/2018		
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, ST. 209 BIRCHWOOD AVENUE WALKER, MN 56484	ATE, ZIP CODE	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE		
F 744	cards, cribbage, Nassessment indice group or in room R16's care plant of had impaired cog impaired thought Staff were directed order to determine communicate with regarding resident reorient and superalso directed to meeded any chan specifically changemenory, recall are expressing self, clevel of conscious activity of daily live provide cues and Additions made to anti-anxiety med On 11/5/18, at 2:2 surveyor to help for bathroom and our communicate with person who state barefoot at the emberson who sta	risiting the birds and 1:1's. rated R16 preferred 1:1's, small activities. ated 10/19/18, indicated R16 nitive function/dementia or processes related to dementia. d to ask yes/no questions in the resident's needs, in the resident/family/caregivers its capabilities and needs, cue, rivise as needed. Staff were nonitor/document/report as ges in cognitive function, les in: decision making ability, and general awareness, difficulty lifficulty understanding others, sness, mental status. In the ing section staff were directed to redirection with meals. In the case a pain and the redog - please look in the tiside. 23 p.m. R16 was asking and her dog - please look in the tiside.	F7	744				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING		11	/08/2018		
	PROVIDER OR SUPPLIE	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 744	On 11/08/18 from was observed lyside. R16 appealant 8:06 a.m. nurscovered tray of beat 8:23 a.m. R1 "where's my pupper At 8:33 a.m. R1 and no staff have At 8:44 a.m. R16 untouched and noffer encouragenerat 8:46 a.m. lice entered room with for her dog and L daughter had her from breakfast arbreakfast was the At 9:07 a.m. R16 was observed to want to die" At 9:24 a.m. R16 At 12:10 p.m. R rubbing head - not progress Notes reprogress Notes reprogre	in 7:05 a.m. until 8:22 a.m. R16 ing in bed facing the wall on left red asleep. sing assistant (NA)-A placed a reakfast on overbed table. 6 was sitting up in bed asking by?" 6 had not began to eat breakfast in not been in to encourage by streakfast remained or staff have been to room to ment to eat meal. It is ensed practical nurse (LPN)-B in medications. R16 was asking in PN-B indicated that R16's indog. LPN-B removed covers indicated R16 that her in the remained R16 that her in the room. So had not begun to eat meal and in the bed be crying "Oh God, Oh God I in the room in the room. Attempts to redirect in the room.	F 7	44				
	- PN dated 10/17 wandering out in Staff redirected s evening.	/18, at 11:29 p.m. resident hallway looking for her dog. everal times throughout the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/(08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	agitated, came out where my dog was dog was at daughted dog run down the his several times. Resident back to room. Her reassurance the come back in. PN dated 10/20/1 crying this afternood to daughter who with the reassurance the come back in. PN dated 10/21/1 agitated and asking she saw him go to redirected. PN dated 10/22/1 visabily upset, crying redirect. Resident she would "blow headministered. Resident she would blow headministered.	to the nurse station and asked. Writer told resident that her er's. Resident stated I saw my hallway. Writer tried to redirect sident became irritated and Left resident's door open for at she thinks her dog may 8, at 3:15 p.m. upset and n regarding dog. Call placed II bring dog in this afternoon. 8, at 4:40 a.m. resident g where her dog was. States the end of the hallway. 8, at 8:37 p.m. resident is ng that dog is missing. Tried to verbalized is she had a guner brains out." Lorazepam ident continued to exhibit signs at checks instilled but resident nece 7:10 p.m. While staff was erbalized she was going to "slit st her head into the wall." d wanted sent to emergency 1.m. indicated resident was acility - no longer suicidal just 8, at 5:11 a.m. resident g for dog. Redirected,	F7	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		, , ,	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 744	- PN dated 11/1/18 dog thinks he is m crying and repeate feels like someone and pain radiates ribs. Tylenol #3 ac - PN dated 11/3/18 and yelling out at 6 anxiety regarding effective short terrafternoon, in similar regarding dog and interventions with On 10/8/18, at 12: stated that R16 like does not have the likes socializing in not get up for mor - At 12:41 p.m. lice & LPN-B stated R she is comfortable R16's daughter briweaning off the visafter she sees her stuffed animal or ownerow. Non phried before we give evaluation has been the survey) but is sissues are back padisease - we are lefter to be transferr - 12:48 p.m. nursing traditional process.	R, at 11:36 p.m. anxious about issing. Redirected. Resident edly saying "ow." States she is stabbing her in the back around the front towards the dministered. R, at 6:59 p.m. resident crying is 30 p.m. from upper back and dog. Distraction and redirection in. Behaviors escalated early ar fashion as AM. Crying upper back. Repeated similar effectiveness noted. 37 p.m. activities director (AD) is adult coloring books but in her room. AD stated R16 is a small group but usually does ning activities. It is usually about her dog. It is because it upset R16 more dog. We have not tried a doll but not sure it would work. Cation is ordered it is because in physician with symptoms. The mes in every other Friday - due harmacological interventions are the medications. A psychiatric in requested (since the start of a weeks out. Some of R16's ain and other is Alzheimer's booking into a possible unit for	F 7	44			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11/	08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 744	dog. R16 will yell a - 12:49 p.m. license staff report R16 is owill accuse daughter facility would allow daughter says that stuffed animal and not aware of non-howith R16 and has nexcept to take her be progress notes were admission on 10/4/- At 12:54 p.m. dire she expected staff non-pharmacological administering medioperson centered into developed for R16 behavioral/emotion management.	and call you a liar. Indical you a liar. Indical worker (LSW) stated constantly looking for her dog, are of taking the dog. The the dog to live here but R16's is not an option. We tried a R16 just got angry. LSW is comological interventions to use of had any contact with R16 back to her room. No LSW er found in R16's chart since 18. Cotor of nursing (DON) stated to be trying all approaches before cations. DON confirmed that thereventions were not	F 74	4		
	requested, but not pharmacy Srvcs/Pr CFR(s): 483.45(a)(§483.45 Pharmacy The facility must prodrugs and biologicathem under an agre §483.70(g). The fapersonnel to admin permits, but only ur a licensed nurse. §483.45(a) Procedupharmaceutical ser	orovided. rocedures/Pharmacist/Records b)(1)-(3)	F 75	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11/	08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER OF THE PROPERTY)	JLD BE	(X5) COMPLETION DATE	
F 755	dispensing, and adbiologicals) to mee §483.45(b) Service must employ or obpharmacist whospharmacist whospharmacist whospharmacist whospharmacist whospharmacist whospharmacist of the provide facility. §483.45(b)(2) Estarcecipt and disposisufficient detail to reconciliation; and §483.45(b)(3) Deteorder and that an aismaintained and This REQUIREME by: Based on observative review, the facility were established appropriate disposimedication and prehad the potential to resided in the facility finding include: On 11/8/18, at 2:00 administration roor nurse (RN)-A. A la approximately 12 in deep and a paper linches by 12 incheoverflowing with m	Iministering of all drugs and at the needs of each resident. Consultation. The facility tain the services of a licensed rides consultation on all rision of pharmacy services in ablishes a system of records of the facility of all controlled drugs in enable an accurate remines that drug records are in account of all controlled drugs periodically reconciled. Note that the facility of the facility	F 75	55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING	i			11/0	08/2018
NAME OF PROVIDER OR SUF		HEALTHCARE CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
PREFIX (EACH DEF	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD E	BE	(X5) COMPLETION DATE
medications of staff placed the returned to the house. RN-A facility documents the boxes of the	he man state of the man	A explained when resident discontinued or changed, the edications in to the boxes to be armacy or to be destroyed in ed she was unaware how the d which medications were to be		755				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/	/08/2018	
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 755	Continued From p	page 42	F 7	55				
	Review of the narcotic log books indicated the following information:							
	destroyed on 10/8 - R277's 8 tablets from the narcotic - R276's Ativan 0. narcotic cabinet b - R27's Ativan 1 m discontinued withou	s of Oxycodne had been /18 but two staff members. of Tramadol had been removed box on 10/8/18. 5 mg had been locked in the y a staff members. ng 19 tablets had been but documentation as to why he medication cart.						
	narcotics were mi incorrectly docum medications. The	DON confirmed none of the ssing, however, the staff had ented the disposition of the DON confirmed the facility had policy regarding medication						
	the staff to store of	ication Storage Policy, directed controlled medications ttely from the non controlled						
	indicated all medic longer in use mus note stating dispo signature of two n	abstances Policy dated 2/15/18, cations that are expired or no t be removed from the cart with sition in the narcotic book and urses then given to the director gnees to put in double locked d.						
	Medication Dispos	ervice policy for Controlled sal dated 4/2014, indicated two e the destruction of the						

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			OATE SURVEY COMPLETED
245323	B. WING			11/08/2018
& HEALTHCARE CENTER			DDE	
STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
he criteria set forth in paragraph for an unnecessary drug. ies noted by the pharmacist must be documented on a report that is sent to the an and the facility's medical ctor of nursing and lists, at a sident's name, the relevant drug, ty the pharmacist identified.	F 7			
	& HEALTHCARE CENTER STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 43 ations. The witness may inistrator, DON and the ervices policy dated 4/2014, for ledication Disposal indicated if nedication was able to be narmacy, the staff were to return. If the medications were to be tate regulations. eview, Report Irregular, Act On Extra termination of each resident dat least once a month by a cist. Is review must include a review medical chart. The pharmacist must report any is attending physician and the director and director of nursing, is must be acted upon. Include, but are not limited to, any he criteria set forth in paragraph for an unnecessary drug, its noted by the pharmacist of must be documented on a report that is sent to the an and the facility's medical ctor of nursing and lists, at a sident's name, the relevant drug, ty the pharmacist identified.	## A. BUILDIE ## 245323 ## A HEALTHCARE CENTER ## A	### A BUILDING ### 245323 ### A BUILDING ##	R 245323 R 245323 R 3TREET ADDRESS, CITY, STATE, ZIP CODE 29 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PAGE 10 PREFIX TAG TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 755 F 755 F 756 Regimen Review. e drug regimen of each resident date tegulations. et at least once a month by a cist. sis review must include a review medical chart. e pharmacist must report any e attending physician and the director and director of nursing, is must be acted upon. nclude, but are not limited to, any he criteria set forth in paragraph for an unnecessary drug. less noted by the pharmacist roust by the pharmacist of the pharmacist roust document do n a report that is sent to the an and the facility's medical to the facility's medical to physician must document in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING			11/	08/2018
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER	•	20	REET ADDRESS, CITY, STATE, ZIP CODE 9 BIRCHWOOD AVENUE WEST PO BOX ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 756	action has been to be no change in the physician should of the resident's med §483.45(c)(5) The maintain policies a drug regimen reviellimited to, time fraithe process and standard the process and standard to act upon the requires urgent act This REQUIREME by: Based on intervier failed to act upon the recommendations reviewed for unnear the process and standard to act upon the recommendations reviewed for unnear the process including disease and major R19's After Dischalated 10/10/18, included the process including disease and major R19's After Dischalated 10/10/18, included the process including disease and major R19's After Dischalated 10/10/18, included the process including disease and major R19's After Dischalated 10/10/18, included the process and major R19's After Dischalated 10/10/18, included the process and major R19's After Dischalated 10/10/18, included the process and major R19's After Dischalated 10/10/18, included the process and the process an	en reviewed and what, if any, ken to address it. If there is to e medication, the attending ocument his or her rationale in	F 7	56			
	Review dated 10/1 had identified R19 the Federal Drug A established the mapeople over 60 years.	Pharmacist's Medication 5/18, indicated the pharmacist 's Celexa order and indicated Administration (FDA) had aximum does of Celexa for ars old to be 20 mg per day, al for cardiovascular					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ¹ A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	complications and I doses greater than The pharmacists in displaying an adequing daily, it was applicated the physic concerns as soon adays. Review of R19's clithe pharmacist conthe physician. Review of R19's MR Record dated 11/1/Celexa 40 mg daily On 11/8/18, at 12:1 (DON) stated she in pharmacist recommendations of the person over 60. The person over 60 in aware of the identity of the pharmacy review of the identity	ack of documented efficacy at 20 mg per day in patients. dicated if the patient is not uate response with Celexa 20 propriate to switch her to a sant. The pharmacist cian was to address the as possible but no later than 30 mical record lacked indication cern had been addressed with edication Administration 18, included an order for 18. 4 p.m. the director of nurses received the consultant nendations via email. The pon 10/15/18, had been 18, however, she had not had them. The DON confirmed ted the physician was to be possible and a physician contacted regarding the dose commended dose for a ne DON confirmed she had not rom the pharmacist until the	F7	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245323	B. WING		11	/08/2018		
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DE	30/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	requested and none Free from Unnec P CFR(s): 483.45(c)(s) \$483.45(c)(s) A psy affects brain activiti processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-depressant (iv) Hypnotic Based on a compressident, the facility \$483.45(e)(1) Resign psychotropic drugs unless the medicati specific condition a in the clinical record \$483.45(e)(2) Resign drugs receive grade behavioral intervents	charmacist reviews was e was provided. sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. ychotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following chensive assessment of a must ensure that dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented	F 756					
	psychotropic drugs unless that medical	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and						
	§483.45(e)(4) PRN	orders for psychotropic drugs						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		245323	B. WING_		11	/08/2018		
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 758	§483.45(e)(5), if the prescribing practitical appropriate for the beyond 14 days, he rationale in the resindicate the duration of the second state	ays. Except as provided in the attending physician or oner believes that it is a PRN order to be extended to or she should document their ident's medical record and on for the PRN order. Norders for anti-psychotic to 14 days and cannot be to 15 and the extending physician or oner evaluates the resident for the soft that medication. ENT is not met as evidenced that in, interview and document to alled to evaluate, monitor and the duse of a psychotropic of 1 residents (R16) reviewed the dications. The mum data set (MDS) dated that R16 was severely cognitively constrated no mood or behavior to oses included dementia without the expectation of the expect	F 75	58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11	/08/2018		
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE			
(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 C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 758	impaired thought p Staff were directed order to determine communicate with regarding residents reorient and superv also directed to mo needed any change specifically change memory, recall and expressing self, dif level of consciousn made to care plan anti-anxiety med us Physician orders up included aspirin 32 sulfamethoxazole/t tablet twice daily (E mg daily PRN for c Additional medicati - on 10/18/18 loraz anxiety - on 10/23/18 loraz anxiety - on 10/30/18 loraz agitation (in additio - on 11/6/18 risperied disorder (antipsych Fax's sent to physic - On 10/18/18, at 3 having increased c 17th). Pacing floor oxygen, crying out. lorazepam or pain. to pain?	itive function/dementia or rocesses related to dementia. to ask yes/no questions in the resident's needs, the resident/family/caregivers is capabilities and needs, cue, vise as needed. Staff were enitor/document/report as es in cognitive function, is in: decision making ability, if general awareness, difficulty ficulty understanding others, it is mental status. Additions on 11/7/18 includes is a pain pon admission 10/4/18, 5 milligrams (mg) daily; rimethoprim (antibiotic) 1 milligrams (mg) d	F 75	8				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVII		(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
		245323	B. WING	i		11/	08/2018
NAME OF PROVIDER OR SUP		EALTHCARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DIE BIRCHWOOD AVENUE WEST PO BOX FALKER, MN 56484	700	
PREFIX (EACH DEFI	CIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
yelling out sex knife stabbing region between with staff inter amount 7 freed of urine on flood 1:1 reassure, Phone call to term (5-10) m Tylenol #3 effect at bedtime. For PRN lorazer on 11/5/18, with anxiety reply, difficulty anon-pharmal of depressed standard depressed standar	i, no time vere core should redirect daughte inutes sective in the part of the	e noted.: restless, agitated, implaints of pain. "feels like and mid-upper back/spinal lder blades. Increase yelling, increase incontinence soiling bed & leaving puddles having brief on. Cold pack, it, distraction all ineffective. For re: dog effective short scheduled lorazepam & PRN in AM. Lorazepam scheduled azepam discontinued when ineduled. Requesting: OK in addition to scheduled. Inoted; - Continues present ment & dog. Increases in alating with terventions. Crying is. Reassuring dog is with cularly - effective at times in ed deffectiveness in PM/night. In addition to implement addition to implement for in-house psychallowing: sepam was administered in each of the paint of the pain	F	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245323	B. WING_		11	/08/2018		
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 758	Continued From pa	age 50	F 75	58				
		rveyor to help find her dog - please look in the throom and outside.						
		p.m. R16 was observed sitting ng to put on socks "oh god, oh						
	"where's my puppy - At 8:46 a.m. licen entered room with LPN-B where her o	sed practical nurse (LPN)-B medications and R16 asked log was. was observed crying "Oh						
	calling out for her of dog is dead on the redirection as her of Resident voiced the can see her dog or not consistently eff - PN dated 10/17/1 wandering out in he Staff redirected see evening PN dated 10/19/1 agitated, came out where my dog was dog was at daughter redirected seed of the control of the	, at 12:41 p.m. has been dog and has stated her white road being eaten by a crow, dog is with her daughter. at staff is lying to her and she in the road. Attempts to redirect ective. 8, at 11:29 p.m. resident allway looking for her dog. weral times throughout the 8, at 2:14 p.m. resident to the nurse station and asked. Writer told resident that her er's. Resident stated I saw my						
	dog run down the h several times. Res went back to room her reassurance th come back in. - PN dated 10/20/1 crying this afternoon	nallway. Writer tried to redirect sident became irritated and . Left resident's door open for at she thinks her dog may 8, at 3:15 p.m. upset and on regarding dog. Call placed II bring dog in this afternoon.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	- PN dated 10/21/1 agitated and asking she saw him go to Redirected PN dated 10/22/1 visibly upset, crying redirect. Resident she would "blow he administered. Res of distress, 15 minuhad been on 1:1 sii with resident she wher wrists" and "bur Daughter called an room PN dated 12:31 a ready to return to fabored PN dated 10/25/1 agitated and lookin television turned or given PN dated 10/25/1 anxious this AM lood og was with daughlying to her PN dated 10/29/1 regarding dog. Diff Attempted to call deriving and repeated feels like someone and pain radiates a ribs. Tylenol #3 ad - PN dated 11/3/18 and yelling out at 6 anxiety regarding dog.	8, at 4:40 a.m. resident g where her dog was. States the end of the hallway. 8, at 8:37 p.m. resident is g that dog is missing. Tried to verbalized is she had a gun er brains out." lorazepam ident continued to exhibit signs atte checks instilled but resident nce 7:10 p.m. While staff was erbalized she was going to "slit st her head into the wall." d wanted sent to emergency acility - no longer suicidal just g for dog. Redirected, n. Ineffective. Lorazepam 8, at 3:44 p.m. resident pking for dog. Writer voiced inter, resident voiced they were g, at 12:19 p.m. anxious in AM ficulty to reassure or distract. The aughter x2 - no answer. The aughter x2 - no answer. The aughter x2 - no answer. The aughter x3 - no answer. The aughter x4 - no answer. The aughter x4 - no answer. The aughter x5 - no answer. The aughter x6 - no answer. The aughter x6 - no answer. The aughter x8 - no answer. The a	F	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245323	B. WING_		11	/08/2018		
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	.00,2010		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 758	afternoon, in similar regarding dog and interventions with service to the lorazepam nor did target behaviors or related to the lorazepated to include R16 did not have a since admission. Requested dictation was not provided. On 10/8/18, at 12:28 R16 cries daily. We comfortable but it is daughter brings the the visits because sees her dog. We or doll but not sure medication is order faxed the physician comes in tomorrow. Non phetried before we give evaluation has been the survey) but is 30 issues are back particles at least of the cries at leas	upper back. Repeated similar effectiveness noted. plan did not include the use of it include any monitoring of side effects/adverse reactions epam use. (care plan was this on 11/7/18) consultant pharmacist visit from physician visit which to public part of the stated in the state of it upsets R16 more after she have not tried a stuffed animal it would work. When a new red it is because we have in with symptoms. The local in every other Friday - due armacological interventions are in requested (since the start of its weeks out. Some of R16's in and other is Alzheimer's soking into a possible unit for ed to. When we give PRN ument what she is doing. In gassistant (NA)-A stated that once per hour looking for her	F 75	58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD I E APPROPR	BE	(X5) COMPLETION DATE	
F 758	non-pharmacologi administering med determine why risp morning as there windicate communic confirmed that the behaviors or side of for R16. DON cout (face to face) or a continued use of low (was initiated 10/1). Review of undated policy indicated that may be considered but only after med psychological, emerovironmental cauthave been identified Antipsychotic med lowest possible do time and are subject and re-review. If a administered as P several days, the psituation with staff needed to determine appropriate and the mediations. Note and report any of the several days of the consequence of the con	cal approaches before dications. DON was unable to berdone was ordered this were not progress notes to cation with physician. DON y were not monitoring for target effects of the use of lorazepamuld not provide a physician visit pharmacy consultation for the prazepam PRN past 14 days 9/18). Antipsychotic Medication Use at antipsychotic medications defor residents with dementia ical, physical, functional, otional, psychiatric, social and uses of behavior symptoms and addressed. Itication will be prescribed at the psage for the shortest period of eact to gradual dose reduction antipsychotic medications are RN dosages repeatedly over onlysician should discuss the and evaluate the resident as the whether the use is the symptoms are responding to ursing staff shall monitor for the following side effects and ences of antipsychotic attending physician: the ergic: constipation, blurred urinary retention, sedation orthostatic hypotension,	F 7	758				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING_		_ 11	/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, ST. 209 BIRCHWOOD AVENUE WALKER, MN 56484	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
	- neurological: akat effects, akinesia, ta Free of Medication	hisia, dystonia, extrapyramidal rdive dyskinesia, stroke Error Rts 5 Prcnt or More	F 75				
SS=D	percent or greater; This REQUIREMENT by: Based on observative review, the facility for medication error raidentified during obwith 3 errors for one resulted in an error. Findings include: On 11/8/18, at 7:58 and pass had been licensed practical nobserved to set up follows: - Advair diskus aeromorning and at been expected to set up follows: - Escitalopram 10 not time a day for depresence of the second for the	on Errors. sure that its- cation error rates are not 5 NT is not met as evidenced cion, interview and document called to be free from the of 5 percent or greater servations of 27 medications ce resident (R22) which rate of 11.11% percent. a.m. R22's medication set-up observed and completed by urse (LPN)-B. LPN-B was the 8:00 a.m. medications as cosol one puff inhaled every fitime for asthma milligrams (mg) one tablet one					
	- Senna-Docusate constipation	3.6-50 mg 1 tablet daily for g take 1 $\frac{1}{2}$ tablet in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (209 BIRCHWOOD AVENUE WEST I WALKER, MN 56484	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 759	morning for edem - Gabapentin 400 for fibromyalgia - Levothyroxine 2 daily for hypothyropotassium Chlor tablet daily for hypotassium Chlor masthma -Ranitidine 150 m fish oil 1000 mg -Acetaminophen tablets every 8 hours of the cover the bed table breakfast of eggs LPN-B handed RR22's dished med the over the bed tinhale the Advair LPN-B. LPN-B was offer an oral rinse R22 was observed and began taking observed to take aforementioned more consume her bread mastering her Levothyroxine an administered with	mg capsule 1 three times daily 5 micrograms (mcg) one tablet oidism ide 10 milliequivalents (meq) 1 pokalemia g one tablet twice daily for ng 1 tablet daily for reflux twice daily extended release 650 mg two ours as needed for pain ng 1 daily for health care It was observed sitting on the R22's breakfast was on the R22's breakfast was on the R22 had begun eating her had begun eating	F 7	759			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		209 B	ET ADDRESS, CITY, STATE, ZIP CODE IRCHWOOD AVENUE WEST PO BOX 7 KER, MN 56484		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	times refuse to swiinhalation of the Ad she did not provide benefits of complet administration of the - at 8:20 a.m. intervnursing (DON) regar R22's medications. Levothyroxine, and administered with finave been provided Advair diskus. The the nurse to administrequired. The facility Administred undated, indicated	sh and spit following the lvair diskus, LPN-B confirmed d R22 with the risks and ling a rinse following the	F 7	59			
F 921 SS=F	CFR(s): 483.90(i) §483.90(i) Other Ender The facility must proposed and comformation of the facility must proposed and comformation of the facility must proposed and comformation of the facility must be supported by:	nitary/Comfortable Environ nvironmental Conditions ovide a safe, functional, ortable environment for	F 9	21			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 921	the kitchen were fre	ge 57 ailed to ensure the all areas of ee of dust and debris. This tential to affect all 25 residents	F 92	21			
	residing in the facili						
	completed with the ceiling fan was obs table and food serv observed to be placedirectly below the cobserved to turn the layer of dust, greas substance was observed to turn the layer of dust, greas substance was observed to turn the layer of dust, greas substance was observed to turn the layer of dust, greas substance was observed in the layer of dust, greas substance was observed in the layer of dust, greas substance was on or other than the layer of the l	0 a.m. the sanitation tour was registered dietitian (RD). A erved to be on over the steam ice area. Cook-A was sing items in the steam table eiling fan. The RD was e ceiling fan off and a thick e and unidentified black erved to coat the blades of the 0 stated the fan was to be ver the food service area and potential of falling into the					
	(CDM)-A stated the monthly basis. Upo fan, CDM-A confirn dust/debris and wa	certified dietary manager fan was to be cleaned on a on observation of the ceiling ned the fan was covered with s in need of cleaning. CDM-Ad be cleaned after the noon					
	blowing directly on next to the dishwas turn the fan off and dust and grease wa CDM-A stated the f	solating fan was observed the freshly cleaned dishes her. CDM-A was observed to a layer of thick black layer of as observed on the fan blades. an was to be clean while shes. CDM-A stated the fan weekly.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11/	/08/2018	
	PROVIDER OR SUPPLIER R REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE	
F 921	Review of the undanot include a procecleaned. Review of the undanot Environmental cleaning of the fandaning of the fandanitation checklisthe staff to clean the updated the policy.	ated, Sanitation checklist did ess to ensure the fans were ated, Cleaning and Disinfection Surfaces did not address the	F9	21			

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		245323	B. WING		1.	1/08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	ODE	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	Emergency Prepar conducted on Nove during a recertificat compliance with the Preparedness Req		FO	000		
	survey was comple Minnesota Departn your facility was in of 42 CFR Part 483	5, 7, and 8th, 2018, a standard sted at your facility by the nent of Health to determine if compliance with requirements 3, Subpart B, and ong Term Care Facilities.				
	allegation of compl enrolled in the elec (ePOC), a signatu	ion will serve as your facility's iance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form.				
	revisit of your facility validate that substa	acceptable ePOC an on-site ty may be conducted to antial compliance with the en attained in accordance with				
	complaint investiga the time of the star of complaint H#532 found not to be sub	scntnue Trmnt;FormIte Adv Dir		78		12/17/18
22=D	§483.10(c)(6) The	right to request, refuse, and/or ent, to participate in or refuse				

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

(X6) DATE

Electronically Signed 12/04/2018

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.

TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245323	B. WING _		11	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 209 BIRCHWOOD AVENUE WEST I WALKER, MN 56484	CODE	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 578	to participate in exp formulate an advar §483.10(c)(8) Noth construed as the righth provision of me services deemed in inappropriate. §483.10(g)(12) The requirements specially subpart I (Advance (i) These requirements of the construction of the c	perimental research, and to note directive. ing in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or e facility must comply with the ified in 42 CFR part 489, Directives). ents include provisions to written information to all adult ng the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives the law. ermitted to contract with other his information but are still for ensuring that the	F 57	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11/	08/2018	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP (00/2010	
WALKER	R REHABILITATION 8	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 578	Based on intervier facility failed to ensemergency care a reflected in all area ensure resident wis correctly in an emeresidents (R4, R22 directives. Findings include: R4's admission Mi 7/05/18, identified R4's current Order identify a cardioput do not resuscitate medication administatus. R4's medic on the binder of the R4's Provider Order Treatment (POLST for cardiopulmona has no pulse and idirected staff to "D DNR allow for a naindicated selective treatment, antibiot monitor, no intubate comfort-focused trial period of artific POLST had been a POLST lacked a policy of the policy	w and document review, the sure advanced directives for and treatment were accurately as of the medical chart to shes would be implemented ergent situation for 3 of 3 and 2, R17) reviewed for advanced was cognitively intact. Summary Report did not almonary resuscitation (CPR) or (DNR) status. R4's electronic stration form indicated full code and chart had a full code sticker are chart. The sustaining of the code in the c	F 57	1. Resident R22 have been from facility. R4 and R17 reviewed for most current POLST/Advanced Directive have been confirmed and pand chart label updated. 2. All Residents charts we for most current POLST/AdDirective, confirmed for acceptaced in chart. 3. Staff were educated or where to find Advanced Dir in patients chart when nedetermine Life-Sustaining Social Worker will address each quarterly care confers sure the wishes of the residenter responsible party are 4. Social Worker will audi month for 3 months to make residents chart has most POLST. Audits/Findings wiin following months QAPI Market Policy and part of the par	e. Their wishes blaced in chart ere reviewed dvanced curacy and 12/3/2018 on rectives/POLST eding to Freatment. POLST at ence to make dent and/or up to date. It 5 charts per se sure up to date II be discussed		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	FIPLE CONSTRUCTION NG	-		E SURVEY PLETED
		245323	B. WING		_	11/0	08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STA 209 BIRCHWOOD AVENUE WALKER, MN 56484		00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
F 578	stated she was not code or DNR. R4 s be involved with that On 11/7/18, at 2:30 identified, C4's POI medical director on lacked documentat reviewed the POLS her family. -At 2:37 p.m. the diconfirmed R4's clin presented conflictin status choices. On 11/08/18, at 8:3 (DON) stated the molecated in Connectin POLST had been family and returned to the confirmed R4, her for physician had not be R4's POLST signed. The facility Advanced to the confirmed R4, indicated a resident charts upon the attending physician reviews and updates needed but at least the resident's plan of R22's admission M 10/25/18, identified.	p.m., during an interview R4 sure if she should be a full tated "I would like my family to at decision". p.m. R4's record review LST had been signed by the 11/7/18. The clinical record ion indicating the facility had is choice of DNR with R4 or rector of nursing (DON) ical record and POLST ag information related to code to a.m. the director of nursing nedical director (MD) was cut. The DON confirmed the axed to the MD for signature facility via fax. The DON ramily, and primary medical seen consulted prior to having the DOLST would be added to all an admission. Nursing contacts cian to obtain appropriate are directives. Social Services as a quarterly in conjunction with	F 5	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 578	identify a cardiop do not resuscitate chart had a full co chart. R22's Provider O Treatment (POLS Section A for card	ulmonary resuscitation (CPR) or e (DNR) status. R22's medical ode sticker on the binder of the orders for Life-Sustaining ST) dated 10/22/18, included: liopulmonary resuscitation	F 5	578			
	section, directed resuscitation/DNF Section B indicate medical treatmen cardiac monitor, receive comfort-fe was signed by R2 D was signed by Section E indicate	is no pulse and is not breathing" staff to "Do Not Attempt" R allow for a natural death. ed selective treatment, to include t, antibiotics, intravenous fluids, no intubation, all patients will ocused treatments. Section C 22, although not dated. Section a physician and dated 10/22/18. ed no artificial nutrition by tube, intramuscular and oral					
	on 11/06/18, at nurse (LPN)-B status by checkin medical chart. LF	20 p.m. during an interview R22 not remember what she put to be full code (CPR). 1:38 p.m. licensed practical ated she would know the code g the chart or the electronic PN-B stated, "I do most of the retty much know all the ratus'."					
	(NA)-C stated the green for go & re- to demonstrate a room and the doo stickers were obs	:39 p.m. nursing assistant are should be stickers on door -d for no CPR. NA-C proceeded and checked the door of R22's are of two other residents. No erved on the room doors for 2 residents. NA-C then stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	00.20.10	
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	medical record. On 11/06/18, at 1: (RN)-B stated she electronic record of the chart. On 11/06/18, at 1: should be someth they are DNR/DNI looked in 3 rooms stated I should fin rooms. RN-C statistickers on the chart. - At 2:31 p.m. NA-NA care sheet that produced a care sheets. On 10/8/18, at 12: director of nursing have been aware resident's name, of indicate the residestated she was not match the stickersident's wishes. R22's code status electronic chart.	the sticker on the outside of the sticker on the outside of the would check the POLST, or the sticker on the outside of the sticker on the sticker on the stays if the sticker on that says if the sticker on that says if the sticker on that says if the sticker on the stays if the sticker on the stays if the sticker on the stays if	F 5	578			

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		245323	B. WING		11/	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DDE	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	8/08/18, identified R R17's current Orde do not resuscitate (R17's electronic me indicated DNR. R1 sticker on binder of R17's Code Status of paper chart indic resuscitation (CPR 8/09/06. When interviewed of stated it was chang conference, to DNR current wishes. When interviewed of stated the Code Status was not updated af	R17 had cognitive impairment. r Summary Report identified a (DNR) status ordered 8/14/18. edication administration form 7's medical chart had full code	F 57	8		
F 655 SS=D	Provider Orders for (POLST) had been was received back current wishes. Baseline Care Plan CFR(s): 483.21(a)(§483.21 Comprehe Planning §483.21(a) Baselin §483.21(a)(1) The implement a baseli that includes the incl	1)-(3) ensive Person-Centered Care	F 65	5		12/17/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 9 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	that meet profession. The baseline care in the baseline care in the paseline care plan if the condition of the baseline care in the paseline care in the pas	onal standards of quality care. Colan mustithin 48 hours of a resident's mum healthcare information orly care for a resident mited to-led on admission orders. Solar mendation, if applicable. If acility may develop a replan in place of the baseline apprehensive care planthin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary replan that includes but is not of the resident. The resident's medications and and treatments to be refacility and personnel acting	F	655			
		tion, interview and document ailed to ensure a baseline care			 Resident R23		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 19 BIRCHWOOD AVENUE WEST PO BOX		
				VV	ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 655	Continued From pa	age 8	F 6	55			
	plan was developed hours of admission individualized need recently admitted to (R25) reviewed for Findings include: R23's Resident Facadmitted to the facidiagnoses including disease, damage of disease, congestive thrive, cardiac pace cell lymphoma. R23's Care Area As 10/30/18 indicated disorientation and fextensive assistance (ADL) and required	d and implemented within 48 which addressed the soft of 1 resident (R23) to the facility and 1 of 1 resident closed discharge record. The Sheet indicated R23 was sility on 10/19/18, with g encephalopathy (brain or malfunction), Parkinson's enheart failure, adult failure to emaker, and diffuse large B The Seessment (CAA) dated R23 had confusion, forgetfulness. R23 required the with activities of daily living a lextensive assistance with ity and at risk for falls.			based on Current Physician orders Current Dietary orders, Current Th services, Current Social services at PASARR recommendations. 2. All Residents charts have beer reviewed to make sure that their B. Care Plan reflects Initial goals base Current Physician orders, Current orders, Current Therapy services, Social services and PASARR recommendations. 3. Nursing staff educated on time Baseline Assessments and Care P be completed within 48 hours of admissions. 4. An audit will be conducted 48 hafter new admission of resident to that Baseline Care Plan was create Audits/Findings will be discussed in following months QAPI Meeting.	erapy and asseline ed on Dietary Current eline of Plans to nours verify ed.	
	needs assist of one one to stand, incon hours, at high risk t disease and monito						
	care plan to direct t	ord lacked evidence of an initial the staff how to implement eventions were required to care					
	(RN)-A stated she of plan for R23. RN vibeen done, it must	58 p.m. registered nurse could not find a baseline care vent on to say one should have not have been completed, and a done upon admission.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11	/08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	(DON) stated she of care plan and state completed upon ad R25's resident face admitted to the faci including arthritis drhypertension, type depressive disorde R25's medical reconome on 8/31/18. On 11/08/18, at 12:10 to stay long in the have had a baseling 48 hours. RN-A stay one in his medical in the should have had a even though his stated she was not plan for R25.	6 p.m. the director of nursing could not locate the baseline d it should have been mission. The sheet indicated R25 was lity on 8/24/18, with diagnoses ue to bacteria right knee, 2 diabetes mellitus, major rand end stage renal disease. The director of baseline staff how to care for his sion, end stage renal disease, isorder and arthritis due to be. The property of particular to the staff how to care for his sion, end stage renal disease, isorder and arthritis due to be. The property of particular to the should the care plan completed within the she was unable to locate.	F 65	5		
	requested and was	not provided. ecrease in ROM/Mobility	F 68	8		12/17/18

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11/	08/2018		
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOWALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 688	resident who enter range of motion do range of motion ur condition demonst of motion is unavous §483.25(c)(2) A remotion receives apservices to increase prevent further deceives appropriate assistance to main the maximum praceduction in mobility This REQUIREME by: Based on observative review, the facility splints for upper extended to the facility splints for upper extended impairment and diadisease, quadriple minimum data set 9/12/18, indicated of two staff for bed activities of daily lifty functional limitation upper and lower extended.	facility must ensure that a state facility without limited bes not experience reduction in alless the resident's clinical rates that a reduction in range idable; and sident with limited range of propriate treatment and se range of motion and/or to be rease in range of motion. Sident with limited mobility at earning of motion. Sident with limited mobility with esticable independence unless a sty is demonstrably unavoidable. ENT is not met as evidenced ation, interview and document failed to provide the use of extremity contractures for 1 of 1 served with contractures. Inimum Data Set (MDS) dated R10 had severe cognitive agnoses including: Parkinson's gia and depression. The (MDS) assessment dated R10 required total assistance I mobility, transfers and all ving (ADLs), and had bilateral in in range of motion of the	F 68	1. Therapy, DON and spouse meeting regarding splints and of due to discomfort of splinting ar potential for rehabilitation splint discontinued. R10 has limited communicative ability but did ag the plan. Spouse aware of pote further decrease in ROM. DON confirmed Care Plan and care shave been updated. 2. DON has identified any other sidents that are currently usin assistive devices and confirm the of device is specified in Care Plan. Staff have been educated of 12/3/2018 on monitoring for decrease in ROM and assistive device applied well as watching for pressure and devices. Care plans will be asset	letermined and no s will be gree with ntial for has sheets er ag any nat the use lan. on cline in ication as reas from			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D9 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	all ADLs, required of Parkinson's diseas indicated R10 was own and had contra indicated R10 was motion (ROM) decl braces to arms, and for decline in ROM R10's Therapy and dated 6/5/18, indicated worn at all times dressing and during range of motion (Plindicated a need to notify therapy, and should be trained of An inservice training indicated 10 staff horaces and PROM An Occupational TI Encounter note for the OT had educate proper application of Additionally, the noted and important prolonged stretching benefits and important prolonged an order sto be worn at all times bathing, dressing an anticolor and the proper application of R10's Order Summing and important prolonged stretching benefits and important prolonged s	R10 required assistance with extensive to total care due to e and quadriplegia. The CAA unable to perform tasks on his actures. The CAA also at risk for ADL and range of lines, worked with therapy on d was being monitored by staff. Nursing Communication note ated all orthotics/splints were to swith the exception of bathing, g daily stretching and passive ROM) exercises. The note also watch for pressure areas and indicated all nursing staff on ROM and splint application. In grecord dated 5/28/18, and received training on use of for R10. Therapy (OT) Treatment R10 dated 4/25/18, indicated ed nursing staff present on of bilateral elbow splints. It indicated staff had been acture management such as any of bilateral elbows, and tance of applying splints. Therapy Report dated 10/8/18, stating all orthotics/splints were the swith the exception of and during daily PROM and ort indicated the order had	F 6	688	quarterly and upon any significate of in status to assess assistive device used. 4. DON will audit all residents with splints and assistive devices twice week for one month to confirm appropriate use of assistive device. Audits/Findings will be discussed in following months QAPI Meeting	es to be	

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	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		209	EET ADDRESS, CITY, STATE, ZIP CODE BIRCHWOOD AVENUE WEST PO BOX 7 LKER, MN 56484		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	R10's care plan date experienced a decloprevious fracture, in Parkinson's disease and inability to repointerventions direct at all times to rever dressing and bathir minutes per shift to potential for impairs. On 11/7/18, at 11:1 in wheelchair in roowearing the elbows 11/7/18, the resider splints. On 11/7/18, at 2:48 services was interviated where R10's was supposed to where R10's rigonal repoints. On 11/8/18, at 7:06 sitting up in a wheelsplints on. R10's rigonal repoints on. R10's rigonal repoints. On 11/8/18, at 7:10 provides R10 his Phreakfast.	ted 5/9/18, indicated R10 had ine in physical condition due to reurologic decline, and e, as evidenced by poor ROM osition. The care plan ed staff to "apply hand splints se contractures- off for cares, ng. May have off for 20 allow skin to heal due to ed skin integrity." 5 a.m. R10 was observed up om. He was not observed to be splints. Again at 2:47 p.m. on at was not wearing the elbow p.m. the director of therapy iewed and stated she did not splints were, but verified R10 rear them at all times. p.m. nursing assistant (NA)-E ked at the facility since 9/5/18, wn R10 to wear any type of a.m. R10 was observed elchair and did not have elbow ght arm was observed to be 0 was holding his arm	F 6	88			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 688	on 11/8/18, at 8:54 services confirmed wearing his splints. R10's room for his splints were located in room. At that tim working at facility seen R10 wearing into bed, NA-A still splints for R10. On 11/8/18, at 11:0 (LPN)-B stated, "[R try to splint him, he On 11/8/18, at 11:1 services stated she Therapist (PT) by the being unaware R10 splints. In addition, services said the P passing, he would worsened. The PT was not av prior to exit. Review of the interindicated R10 was following dates: 9/24, 9/25, 9/27, 9/10/14, 10/17 - 10/2 11/7 and 11/8/18. Edocumentation to indepartment was not tolerating the splints.	rled up towards his chest. a.m. the director of therapy R10 was supposed to be She searched throughout elbow & hand splints. The dunder items on the spare bed e, NA-A stated she had been ince April 2018, and had never the splints. After assisting R10 did not apply the hand/elbow 4 a.m. licensed practical nurse [10] will yell at you when you will yell non-stop." 1 a.m. the director of therapy e'd spoken to the Physical elephone and he'd reported of was not tolerating wearing his the director of therapy T had stated, by seeing R10 in say R10's contractures had ailable on-site for interview disciplinary progress notes not tolerating his splints on the [28, 10/1, 10/6 - 10/9, 10/11, 1, 10/25, 11/1, 11/2, 11/4, 11/5, dowever, there was no noticate the Physical Therapy of tified of R10's difficulty	F 68	8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11/08/2018	
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 109 BIRCHWOOD AVENUE WEST PO BOX 1 WALKER, MN 56484		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 688	(DON) stated the neither R10 was tole the use of splints. It the documentation tolerating." The DC have been contacted R10 had not been to the facility's Splint ensure there is an ensure the splint is plan and physician around the splinted all sprints need to to ensure proper cifit, refer to therapy The policy further include any sign of refusal of application Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mathematical Theorem Steel With provided to resident consistent with provided to resident consistent with provided to resident consistent with provided to residents with provided to residents with provided to residents and the residents' game and the residents' game and the facility facts assess pain and idinterventions for 1 complaints of pain.	residency of that serating, or was not tolerating, or was not tolerating, The DON verified most days reflected R10 was "not DN said physical therapy should end by now to let them know tolerating his splints. Policy dated 3/8/18, included: order for the splinting device, being put on according to care order, ensure skin is protected area and splint fits properly, be removed for periods of rest reculation, and if splint does not or physician for new order. Indicated: documentation may discomfort, changes in skin, on, or changes to ROM. Anagement. Insure that pain management is atts who require such services, fessional standards of practice, a person-centered care plan, goals and preferences. In its not met as evidenced tion, interview and document ailed to comprehensively entify non-pharmacological of 1 resident (R16) who voiced This resulted in actual harm ained of increased pain rated	F 697	DON immediately care planner and appropriate interventions for R Included were symptoms of pain a documentation. Resident Has been discharged from the facility. All Residents who are currently receiving standing orders for PRN medications who are showing sign.	nd nd n n y pain	

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		245323	B. WING _			11/0	08/2018
	PROVIDER OR SUPPLIER R REHABILITATION &	HEALTHCARE CENTER		209	REET ADDRESS, CITY, STATE, ZIP CODE D BIRCHWOOD AVENUE WEST PO BOX ALKER, MN 56484		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	Findings include: R16's 14-day mining assessment dated severely cognitively including: demential disturbance, chronic disease (COPD) are infection. The MDS pain, and was not reneeded (PRN) pair. Care area assessment 10/18/18, included: urinary incontinence pressure ulcer. A Pain Evaluation of indicated R16 had and legs. Analgesis effective. Summar (PRN) analgesics, staying seated in orders upincluded: aspirin 32 sulfamethoxazole/t tablet twice daily (E 600 mg daily PRN). Additional pain med follows: On 10/16/18 acetal hours PRN for pain On 10/18/18 acetal	num data set (MDS) 10/18/18, indicated R16 was vimpaired and had diagnoses a without behavioral c obstructive pulmonary nd recent urinary tract also indicated R16 had no receiving any scheduled or as n medications. The ents triggered for R16 on cognitive loss/dementia, re, falls, nutritional status and completed on 10/4/18, recasional pain in low back c pain medication was y indicated use of as needed rest, movement and not replace. I not address pain as a reyor review. The ents triggered for R16 on cognitive loss/dementia, re, falls, nutritional status and recasional pain in low back c pain medication was y indicated use of as needed rest, movement and not replace. I not address pain as a reyor review. The ents triggered for R16 on required to a service of the ents of the ents replace	F 69		symptoms of pain will have a comprehensive pain assessment completed with appropriate care pin place. 3. Nursing staff will be educated 12/3/2018 on the necessary steps when a resident is having signs ar symptoms of pain, including reach to doctor when necessary. 4. Audit of pain assessments will completed weekly for 3 months to if completed accurately and intervity completed was appropriate.	on to take and ing out I be assess	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 697	pain by facsimile (FOn 10/18/18, at 3:3 for something for p 650 mg Tylenol. W pain?" The physicia 10/18/18, at 4 p.m. tablet every 6 hrs Freceived 10/20/18 at Tylenol to 500 mg 2 3000 mg (per day). A fax to the physici included: "restless complaints of pain. located mid-upper shoulder blades. In intervention. Cold p distraction all ineffere: dog effective sh Scheduled lorazepam scheduled lorazepam disconti scheduled. Reque in addition to schedincrease Tylenol #3 Review of R16's M Records indicated 6 doses of PRN ac administered in Oc Tylenol #3 were ad doses of Tylenol #3 November 8, 2018.	informed about the resident's fax) as follows: 30 p.m. "[R16] has been asking ain. Only thing she has is PRN ondering if agitation is due to an response was received on with orders for Tylenol #3 one PRN. A physician response at 4:25 p.m. included, "change 2 tablets every 6 hrs PRN- max an on 10/29/18, no time noted, agitated, yelling out severe 'Feels like knife stabbing' back/spinal region between creased yelling with staff back, 1:1 reassure, redirect, ective. Phone call to daughter fort term (5-10) minutes. am & PRN Tylenol #3 effective. If #3 again at 3:45 ineffective. If #3 again a	F 6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11/	08/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	•	
(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 APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	laying herself down R16 was grimacing On 11/7/18, at 2:51 on the edge of her IR16 was heard stated (LPN)-B was observed asked LPN-B where On 11/8/18, at 9:07 crying and stating, die." R16 had not experience of the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain was abeing the worst. Refrom being able to reform the back pain able to reform the back pain and	in bed from a sitting position. and stated, "Oh God." p.m. R16 was observed sitting bed trying to put on her socks. Iting, "Oh god, oh god." a.m. licensed practical nurse ved to enter R16's room with complained of back pain and e her dog was. a.m. R16 was observed 'Oh God, Oh God I want to eaten any breakfast. 9 a.m. R16 told the surveyor an 8 on a 1-10 scale with 10 16 stated, "The pain stops me move about and enjoy things." 1 p.m. LPN-A and LPN-B daily, we assess her pain and a prescribed." 4 p.m. the director of nursing not been comprehensively and a care plan had not been fy pharmacological and	F 69			
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) Dialysis.	sure that residents who	F 69	8		12/17/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		SURVEY PLETED
		245323	B. WING		11/0	08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484		
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F 698	require dialysis recowith professional st comprehensive per the residents' goals This REQUIREMENT by: Based on observative review, the facility for monitoring of dialyst comprehensive car reviewed for dialysis. Findings include: R21's admission re R21's admission re R21's had a diagnor Disease (ESRD) ar R21's admission M 9/12/18, indicated for was independent wutilizing a wheelchal indicated he received R21's Physician's Coreceive a renal diet (cc) fluid restriction on Monday, Wednemonitor for dependent R21's Physician's Commonitor the dialysis. On 11/8/18, at 7:15 have a tunneled callocated in the right.	eive such services, consistent andards of practice, the son-centered care plan, and and preferences. NT is not met as evidenced tion, interview and document ailed to ensure consistent is access sites and develop a e plan for 1 of 1 resident (R21) s. cord dated 11/8/18, indicated uses of End Stage Renal and was dependent on dialysis. inimum Data Set (MDS) dated R21 was alert and orientated, with transfers and mobility while air. R21's assessment	F 698	1. Confirmed Resident R21□s can has been updated to reflect tunnel catheter and appropriate intervention related to monitoring port. Care Planeflects hemodialysis facility, fluid intake/diet restrictions, and what doe dialyzed prior to Dialysis run. 2. Audit was completed to confirmany other residents that are received hemodialysis have a care plan that identifies appropriate interventions to port, hemodialysis facility informal fluid intake/diet restrictions, and medications dialyzed out of body be dialysis runs. 3. DON educated all nursing staff how to properly care plan for reside who are receiving dialysis to insure necessary interventions are in place. 4. DON will audit Dialysis Patient plans once per month to make sur interventions put in place are curred Audits/Findings will be discussed it following months QAPI Meeting.	ed ons ons on also rugs will on that ing to related ation, refore of on ents e all sec. s care e that ent.	
	dialysis, however, t	ed the site was utilized for he facility staff did not monitor d the dressing was changed at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018
	A. BUILDING 245323 B. WING STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY	STREET ADDRESS, CITY, STATE, ZIP CODI 209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 698	the dialysis unit. R21's Medication A and Treatment Adr 11/2018, lacked dir dialysis port. R21's dialysis Care the following: - Do not draw blood in arm with graft. - Encourage R21 to appointments. - Dialysis 3 times a - Monitor labs and - Monitor labs and - Monitor/document and symptoms of richanges in level of skin turgor, oral mulung sound. - Monitor/document and symptoms of themorrhage, bacter and symptoms of themorrhage and symptoms of themorrhage and symptoms of themorrhage and symptoms of themorrhage and symptoms of	Administration Record (MAR) ministration Records (TAR) for rection for monitoring of the Plan dated 9/25/18, included d or take B/P (blood pressure) to go for the scheduled dialysis week- M-W-F. doutput. report to doctor as needed. Preport as needed for signs enal insufficiency such as: consciousness, changes in ucosa, changes in heart and Preport as needed for signs he following: bleeding, the following: bleeding, the following: bleeding, the modialysis, CHF; R21 minimum of 1100-1200 cc's and ment intake and output as per disidentified that R21 had a did not identify R21 had a	F 698	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245323	B. WING		11	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	R HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484		CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 698	show signs of infecare plan did not in R21 received hem them, appropriate foods R21 was rediet. The care plan would be delineate allowed at each mallowed to receive Additionally, the cadrugs would be digiven at 8:00 a.m. Wednesday, and R21's nursing prof 10/18/18-11/4/18, the notes indicated restrictions. The pR21 had been edubenefits of not followed and the fluid material to additionally, the cadeveloped to addressed to addressed to addressed to addressed to a continuation of the R21's dialysis portifacility. The risks a loaded were not drapped to addressed to a contact information.	ction or get dislodged.) The dentify at which ESRD facility rodialysis and how to contact diet restrictions including which stricted from eating in a renal of did not identify how R21's fluid ed as far as how much R21 was eal, and how much R21 was with each medication pass. For all the did not identify which alyzed out of R21's body when prior to dialysis on Monday, friday. Gress notes from were reviewed and almost daily do R21 did not follow the fluid rogress note lacked indication for acted regarding the risk and cowing the fluid restrictions. For are plan had not been ess R21's non-compliance with estriction goal and alterative hirst or drinking water such as candy, ice chips, frozen ice	F6	598		

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	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
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F 698 F 744 SS=D	A policy related to care was requeste	dialysis dependent resident d and none was provided. for Dementia	F 6			12/17/18
	diagnosed with desappropriate treatme maintain his or her mental, and psych. This REQUIREME by: Based on observative tree with a facility of centered dementiation who exhibited behavior and the symptoms and required most activities of dincluded dementiation disturbance, chronic disease (COPD) a infection. Care area assessmincluded cognitive incontinence, falls, ulcer. Recreation service indicated that R16 games, beading, to	sident who displays or is mentia, receives the ent and services to attain or highest practicable physical, osocial well-being. INT is not met as evidenced ation, interview and document ailed to provide person a care for 1 of 1 residents (R16) aviors related to dementia. The mum data set (MDS) dated at R16 was severely cognitively trated no mood or behavior quired limited assistance with laily living (ADL's). Diagnoses without behavioral ic obstructive pulmonary and recent urinary tract The ments triggered on 10/18/18, loss/dementia, urinary anutritional status and pressure as assessment dated 10/5/18, interests included crossword elevision game shows, bingo, siting the birds and 1:1's.		1. R16□s Care plan update person centered intervention include: a. Assisting/cueing to eater room b. Redirection when discueresidents□ pet c. Her interests which includerossword games, beading, game shows, bingo, cards, visiting the birds and 1:1's in or in room activities. d. Need for items that interavailable in patients□ room when needed. Social worker has also chare residents□ behaviors and we with potentially placing residents□ behaviors and we with potentially placing residents□ suitable setting for dementially since survey R16 has been 2. All other residents with dementia/Alzheimer□s□ carbeen assessed to confirm procentered interventions are in 3. All staff will be educated center interventions for residents.	meals while in ssing uded television cribbage, a small group rest her to be for redirection ted on there she is at dent in a more a diagnosis. I discharged. I diagnosis of the plans have berson a place. I don person	

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		245323	B. WING		11//	08/2018
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WALKER	R REHABILITATION 8	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	O BOX 700	
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F 744	Assessment indicagroup or in room a R16's care plan, d had impaired cogrimpaired thought p Staff were directed order to determine communicate with regarding resident reorient and super also directed to me needed any chang specifically change memory, recall and expressing self, di level of conscioust activity of daily livit to provide cues an Additions made to anti-anxiety medic On 11/5/18, at 2:2 surveyor to help fit bathroom and outs On 11/07/18, at 2:2 assisted back to b person who stated barefoot at the end be short of breath. On 11/7/18, at 2:5 sitting on edge of I stating, "Oh god, of On 11/7/18, at 3:04 in bed on left side,	ated R16 preferred 1:1's, small activities. ated 10/19/18, indicated R16 nitive function/dementia or processes related to dementia. It to ask yes/no questions in the resident/s needs, the resident/family/caregivers is capabilities and needs, cue, vise as needed. Staff were ponitor/document/report as ges in cognitive function, es in: decision making ability, digeneral awareness, difficulty inderstanding others, ness, mental status. In the lang section, staff were directed in redirection with meals. In care plan on 11/7/18 includes ation use & pain. 3 p.m. R16 was asking and her dog - please look in the side. 44 p.m. R16 was being ed by an unidentified staff is she found R16 standing in of her bed. R16 was heard to in p.m. R16 was observed to be beed trying to put on socks	F 7	have a diagnosis of dementia/Alzheimer□s as we person-centered intervention residents in facility to meet and psychosocial needs. 4. DON will audit 4 care placed residents with a diagnosis of once per week for 2 months care plan is updated with the effective interventions for each Audits/Findings will be discuted following months QAPI Meets	their emotional lans of of dementia s to confirm e most ach resident. ussed in	

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		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
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F 744	door to the hallwal On 11/08/18, from was observed lyin side. R16 appear On 11/8/18, at 8:0 placed a covered table. On 11/8/18, at 8:2 bed asking, "Whe On 11/8/18, at 8:3 eat breakfast and encourage R16 to On 11/8/18, at 8:4 remained untouch room to offer encourage R16 to On 11/8/18, at 8:4 remained untouch room to offer encourage R16's daughter has asking for he R16's daughter has covers from break breakfast was the On 11/8/18, at 9:0 eat meal and was God, Oh God I was of bacon. On 11/8/18, at 12:3	7:05 a.m. until 8:22 a.m. R16 g in bed facing the wall on left ed asleep. 6 a.m. nursing assistant (NA)-A tray of breakfast on over bed 3 a.m. R16 was sitting up in re's my puppy?" 3 a.m. R16 had not began to no staff have not been in to eat. 4 a.m. R16's breakfast ed and no staff have been to buragement to eat meal. 46 a.m. licensed practical nurse oom with medications. R16 r dog and LPN-B indicated that ed her dog. LPN-B removed cfast and reminded R16 that her re. LPN-B then left the room. 7 a.m. R16 had not begun to observed to be crying, "Oh	F7	744			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 744	Progress Notes (P - PN dated 10/5/18 calling out for her dog is dead on the redirection as her Resident voiced the can see her dog on to consistently eff - PN dated 10/17/19 wandering out in his Staff redirected seevening. - PN dated 10/19/19 agitated, came out where my dog was dog was at daught dog run down the several times. Rewent back to room her reassurance the come back in. - PN dated 10/20/19 crying this afternoof to daughter who we - PN dated 10/21/19 agitated and asking she saw him go to Redirected. - PN dated 10/22/19 visibly upset, cryin redirect. Resident she would "blow headministered. Resof distress, 15 min had been on 1:1 significant she will her wrists" and "slit her wrists" and "slit her wrists" and seen on she will her wrists" and significant she will her wrists and significant she will her wrists.	(N) reviewed as follows: 3, at 12:41 p.m. has been dog and has stated her white road being eaten by a crow, dog is with her daughter. 1 the road. Attempts to redirect	F 7	44		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/(08/2018
	PROVIDER OR SUPPLIER R REHABILITATION 8	HEALTHCARE CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 19 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	- PN dated 12:31 a ready to return to f bored PN dated 10/25/1 agitated and lookin television turned or PN dated 10/25/1 anxious this AM looking was with dauglying to her PN dated 10/29/1 regarding dog. Dif Attempted to call degrading dog. Dif Attempted to call degrading and repeate feels like someone and pain radiates a ribs. Tylenol #3 accepts like someone and yelling out at anxiety regarding of effective short term afternoon, in similar regarding dog and interventions with someone of the property	a.m. indicated resident was acility - no longer suicidal just 8, at 5:11 a.m. resident ag for dog. Redirected, n. Ineffective. 8, at 3:44 p.m. resident oking for dog. Writer voiced hter, resident voiced they were 8, at 12:19 p.m. anxious in AM ficulty to reassure or distract. aughter x2 - no answer. 4, at 11:36 p.m. anxious about issing. Redirected. Resident dly saying, "Ow." States she is stabbing her in the back around the front towards the liministered. 6, at 6:59 p.m. resident crying 6:30 p.m. from upper back and dog. Distraction and redirection n. Behaviors escalated early ar fashion as AM. Crying upper back. Repeated similar effectiveness noted. 87 p.m. activities director (AD) es adult coloring books but m in her room. AD stated R16 a small group but usually does	F	744			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11	/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
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F 744	tried a stuffed anim work. When a new because we have f symptoms. The lo other Friday - due Non-pharmacologi before we give me evaluation has beet the survey) but is 3 issues are back padisease - we are loher to be transferred. On 11/8/18, at 12:4 (NA)-A stated that hour looking for he you a liar." On 11/8/18, at 12:4 (LSW) stated staff looking for her dog daughter of taking allow the dog to livithat was not an open and R16 just got at aware of non-pharmacological aware of non-pharmacological administering med that person centered developed for R16	hal or doll but not sure, it would we medication is ordered, it is faxed the physician with cal physician comes in every tomorrow. cal interventions are tried dications. A psychiatric en requested (since the start of 8 weeks out. Some of R16's in and other is Alzheimer's poking into a possible unit for ed to. 48 p.m. nursing assistant R16 cried at least once per r dog. R16 will "yell and call worker reported R16 was constantly, and would accuse her the dog. The facility would be here but R16's daughter said tion. "We tried a stuffed animal ngry." The LSW was not macological interventions to has not had any contact with the her back to her room. No her were found in R16's chart in 10/4/18. 54 p.m. the director of nursing expected staff to be trying cal approaches before ications. The DON confirmed and interventions were not	F 74	4			

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F 744	Continued From pa	age 27	F 74	4		
F 755 SS=D	requested, but not Pharmacy Srvcs/Pi	rocedures/Pharmacist/Records	F 75	5		12/17/18
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services rovide routine and emergency als to its residents, or obtain eement described in acility may permit unlicensed hister drugs if State law ander the general supervision of				
	pharmaceutical ser that assure the acc dispensing, and ad	ures. A facility must provide rvices (including procedures curate acquiring, receiving, ministering of all drugs and t the needs of each resident.				
		e Consultation. The facility tain the services of a licensed				
		ides consultation on all rision of pharmacy services in				
		blishes a system of records of tion of all controlled drugs in enable an accurate				
	order and that an a is maintained and p	ermines that drug records are in account of all controlled drugs periodically reconciled. NT is not met as evidenced				

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NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		3.2010	
				209 BIRCHWOOD AVENUE WEST PO	BOX 700		
WALKE	R REHABILITATION 8	HEALTHCARE CENTER		WALKER, MN 56484			
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F 755	by: Based on observareview, the facility were established a appropriate dispose medication and prohad the potential to resided in the facility of the ensure a mouth administration of minhaler as directed manufacturer recorresident (R22) who via a dry powder in afterward. Finding include: On 11/8/18, at 2:00 administration room nurse (RN)-A. A la approximately 12 in deep and a paper inches by 12 inches overflowing with more counter. The destroyed." RN-medications were staff placed the more turned to the phanouse. RN-A state facility documented in the boxes to be At 2:10 p.m. the mobserved with RN-19 tablets of 1 mill medication/anti-andication/	ation, interview and document failed to ensure procedures and implemented for ition and storage of narcotic escription medications. This of affect all 25 residents who ity. In addition, the facility failed rinse was provided after the nedication via a dry powder by the medication's mmendations for 1 of 1 or received steroidal medication whaler without a mouth rinse of plastic container inches by 12 inches by 6 inches box approximately 24 x 24 is deep were observed to be edications on the medication in the boxes indicated "to be a explained when resident discontinued or changed, the edications into the boxes to be armacy or to be destroyed in ed she was unaware how the discontinued or when the discontinued or when the discontinued or when the discontinued or when the discontinued or the discontin	F 75	1. Resident R22 has been of from facility. 2. Audit of all med rooms/nowill be conducted to make sure discontinued or expired medit facility and all residents curred a dry powder inhaler have been to show their orders are properto show rinsing mouth with we show their orders are properto show rinsing mouth with we show rinsing staff were eduproper disposal of expired or medication as well as being exproper interventions around the powder inhalers. 4. DON will audit Med Roomexpired or discontinued medit per week for three months. It all residents using dry inhale proper mouth rinse after use week for 3 months. Audits/Fit discussed in following month Meeting.	ursing station are no other ications are in ently receiving the reviewed erly updated eater after use ucated on discontinued educated on the use of dry example once por endings will be		

AND DUAN OF CODDECTION TO THE PROPERTY OF A		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	(narcotic pain med tablets of oxycodor medication) for R2 medications were recounter and should box until they were pharmacist. - At 2:13 p.m. the cobserved the medicanfirmed all of the overflowing boxes medications includ medications, present to be addeducted to the consultant pharma were not to be add medications were for chemical solution were dications which review of the narcofollowing informatical estroyed on 10/8/- R277's 8 tablets of the narcotic cabinet by R27's Ativan 1 medication to the reconsultant pharma were not to be add medications which reduced the narcotic shall be supposed in the narcotic cabinet by R27's Ativan 1 medication to the narcotic cabinet by R27's Ativan 1 medications 1 medications to the narcotic cabinet by R27's Ativan 1 medications 1 medications to the narcotic cabinet by R27's Ativan 1 medications 2 medications	ications) for R277 and 24 ne 10 mg (narcotic pain 77. RN-A stated the narcotic not to be in the boxes on the d have been placed in a locked able to be destroyed with the director of nursing (DON) cation room. The DON e medications in the had been discontinued. The ed oral prescription cription eye drops, insulin and s. The DON confirmed the reater than 75 prescription DON stated the narcotic to be locked in a narcotic were destroyed by the cist. The narcotic medications ed to the random box of destroyed. The non-narcotic to be added to a bottle of which destroyed the taff were to document the were destroyed. otic log books indicated the on: of oxycodone had been 18 buy two staff members. of tramadol had been removed tox on 10/8/18. In mg had been locked in the a staff member. g 19 tablets had been ut documentation as to why	F7	755			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		11	/08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	VENUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	- At 2:20 p.m. the Displayed incorrectly docume medications. The Inot followed their procession of the staff to store controlled Substitutions. The undated Medications. The undated Medications. The Controlled Substitution of the staff to store controlled substitution of nursing or designature of two nursing or designature of two nursing or designature destroyed. The Pharmacy Ser Medication Disposation with the staff to store controlled medication controlled medication pharmacist. The Pharmacy Ser Non-Controlled Methe prescription mereturned to the phathe medications. If	OON confirmed none of the sing, however, the staff had need the disposition of the DON confirmed the facility had olicy regarding medication station Storage Policy, directed entrolled medications ely from the non-controlled stances Policy dated 2/15/18, ations that are expired or no be removed from the cart with ition in the narcotic book and reses then given to the director nees to put in double locked vice policy for Controlled al dated 4/2014, directed two the destruction of the ons. The witness may istrator, DON and the vices policy dated 4/2014, for dication Disposal indicated if edication was able to be rmacy, the staff were to return the medication could not be the medications were to be	F 75	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323 B. WING		11	11/08/2018		
	PROVIDER OR SUPPLIE	₹ & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZII 209 BIRCHWOOD AVENUE WES WALKER, MN 56484	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From p	page 31	F 7	755			
	included an order furoate-vilanterol powder, breath as morning and 1 inh moderate persisted. Medication Guide indicated the possimedication includ or throat (thrush) water without swatto help reduce the On 11/8/18, at 7:5 (LPN)-B was obseon her bed in her medications. LPN R22 placed the in inhaled the medic provided a glass of which she swallow to rinse and spit at medication. LPN her oral medication. LPN her oral medication the remainder of the on 11/8/18, 8:09 a have had R22 do inhaler but had no had swallowed the On 11/8/18 8:20 at (DON) stated her have provided a sadministration of the control of the remainder of the control	a.m. LPN-B verified she should a swish and spit after use of the ot done so. LPN-B verified R22					

245323 B. WII NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 PROVIDER'S PLAN OF CORRECTION (X5)	3
	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 PROVIDER'S PLAN OF CORRECTION (X5)	
WALKER REHABILITATION & HEALTHCARE CENTER		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES I PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR TAG REGULATORY OR LSC IDENTIFYING INFORMATION) T,	DATI	TION
F 755 Continued From page 32 The facility Administering Medications policy, undated, indicated medications shall be administered in a safe and timely manner, and as prescribed.	755	
•	756 12/17/	18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		E SURVEY IPLETED	
		245323	B. WING		11/08/2018		
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 756	maintain policies drug regimen revilimited to, time frathe process and swhen he or she in requires urgent at This REQUIREMI by: Based on intervite failed to act upon recommendations reviewed for unnersiewed	and procedures for the monthly ew that include, but are not armes for the different steps in steps the pharmacist must take lentifies an irregularity that ction to protect the resident. ENT is not met as evidenced ew and record review the facility the consultant pharmacist of 1 of 5 residents (R19) excessary medications. The Sheet indicated R19 was cility on 10/12/18, with angleft hip fracture, Parkinson's or depressive disorder. The arger Orders/ admission orders included multiple orders for ding Celexa 40 milligrams (mg) or the treatment of depression. Pharmacist's Medication 15/18, indicated the pharmacist of daily dose for people over 60 in armacist indicated the Federal on (FDA) had established the form of Celexa for people over 60 in many per day, due to the ovascular complications and end efficacy at doses greater and in particular to the pharmacists tient is not displaying an ewith Celexa 20 mg daily, it is switch R19 to a different	F 7	1. DON has sent recomm pharmacist and physician has recommendations. 2. DON will confirm that a recommendations have becomed to physician for review implemented. 3. DON will be educated to importance of reviewing the recommendations within 48 receiving. Administrator will copied on the pharmacist recommendations as a sect to confirm that DON has retimely manner (within 48 hours. Administrator will audit recommendations with phat their monthly visit to facility. Audits/Findings will be discommendations months QAPI Medits/Findings months QAPI Medits/Finding	and acted on all pharmacist en reviewed, or, and acted on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING		11/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 756	physician was to ac as possible but no last possible but no last pharmacist concern physician. R19's Medication Adated 11/1/18, indicated 11/1/18, indicated 40 mg which was a last completed on 10/16/18, at 12:1 (DON) stated she in pharmacist recommender received on 10/16/19 a chance to look at R19's report indicated notified as soon as she had not opened pharmacist until the the most recent received and was unaware of DON stated she sir look at the pharmach ad not been contated to the pharmach ad not been contains the pharmach and not been contains the pharmach ad not been contains the pharmach ad not been contains the pharmach and possible but not be and pharmach and pha	e pharmacist indicated the dress the concerns as soon ater than 30 days. d lacked indication the had been addressed with the dministration Record (MAR) cated R19 an order for Celexa	F 756			
F 758 SS=D	requested and none	sychotropic Meds/PRN Use	F 758	3		12/17/18
		tropic Drugs. /chotropic drug is any drug that es associated with mental				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/08/2018	
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-anxiety; and (ivi) Hypnotic Based on a compressed on a compressident, the facility \$483.45(e)(1) Resispsychotropic drugs unless the medicat specific condition as in the clinical record syde syde of the syde of th	avior. These drugs include, to, drugs in the following; dehensive assessment of a rmust ensure that dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented d; dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F7	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED	
		245323	B. WING		11/6	11/08/2018	
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	§483.45(e)(5) PRI drugs are limited to renewed unless the prescribing practite the appropriatene. This REQUIREME by: Based on observative the facility justify the continual medications for 1 for unnecessary in the same facility justify the continuous medications for 1 for unnecessary in the facility justify the continuous medications for 1 for unnecessary in the same facility justify the continuous for unnecessary in the same facility justify the continuous for 1 for unnecessary in the same facility justify the continuous for unnecessary in the same facility justify the continuous facility justify justify f	N orders for anti-psychotic to 14 days and cannot be ne attending physician or ioner evaluates the resident for ss of that medication. ENT is not met as evidenced ation, interview and document failed to evaluate, monitor and ed use of psychotropic of 1 residents (R16) reviewed nedications. mum data set (MDS) dated d R16 was severely cognitively ionstrated no mood or behavior ioses included dementia without ance, chronic obstructive e (COPD) and recent urinary e MDS also indicated that R16 any antipsychotic, antianxiety or	F7	1. R16□s PRN antipsych reviewed with physician ar provided a standing order antipsychotic medication. I discharged from facility. 2. All residents with PRN orders have been reviewed dose reduction plan has be place where appropriate. 3. Nursing staff educated Antipsychotic Medication U. 4. DON will audit all antipmedications with pharmac month Audits/Findings will following months QAPI Medications with pharmac month audits/Findings will following months QAPI Medications with pharmac month audits/Findings will following months QAPI Medications with pharmac month audits/Findings will following months QAPI Medications with pharmac month audits/Findings will following months QAPI Medications with pharmac month audits/Findings will following months QAPI Medications with pharmac months are provided to the provided with physical provided to the provided to the provided with physical provided to the p	nd physician has for the PRN R16 has been antipsychotic d and a gradual een put into d on Use policy. Paychotic ist once per be discussed in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11/08/2018		
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRIDE DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	needed any chan specifically change memory, recall and difficulty-expression others, level of conditions made to included anti-anx. Physician orders included aspiring sulfamethoxazole tablet twice daily 600 mg daily PRN Additional medication of 10/18/18 long anxiety. On 10/18/18 long disorder (antipsyon of 10/18/18, at having increased 17th). Pacing flooxygen, crying out on 10/18/18, at having increased 17th). Pacing flooxygen, crying out on 10/18/18, at having increased 17th). Pacing flooxygen, crying out on 10/18/18, at lorazepam or painto pain? On 10/18/18, at lorazepam 1 mg on 10/29/18, no yelling out severe knife stabbing" lo region between swith staff interver amount 7 frequer of urine on floor work.	ges in cognitive function, ges in: decision-making ability, and general awareness, and self, difficulty understanding onsciousness, mental status. In R16's care plan on 11/7/18 gety medication use & pain. Suppose admission 10/4/18, getrimethoprim (antibiotic) 1 (BID) for 2 days; guaifenesin of the formal of	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	/08/2018	
	PROVIDER OR SUPPLIE	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL ILATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD G CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Phone call to dau term (5-10) minut Tylenol #3 effectivat bedtime. PRN order received for FRN lorazepa - On 11/5/18, no twith anxiety re: pl PM, difficulty de-enon-pharmalogical depressed statent daughter & visits during day, decre PRN lorazepam uscheduled Lexapi 10-29-18. Requeservice Review of Medical (MAR) indicated the service of PRN October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 8 doses in Nove Review of October 2018 - 9 doses i	ghter re: dog effective short les Scheduled lorazepam & PRN live in AM. Lorazepam scheduled lorazepam discontinued when r scheduled. Requesting: OK m in addition to scheduled. lime noted; - Continues present lacement & dog. Increases in lescalating with lat interventions. Crying linents. Reassuring dog is with later regularly - effective at times lased effectiveness in PM/night. litilized daily in addition to litilized daily in ad	F7	758			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11	11/08/2018	
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 758	"Where's my pupp On 11/08/18, at 8: (LPN)-B entered rasked LPN-B whe On 11/08/18, at 9: crying, "Oh God, of Progress Notes (Fas follows: - PN dated 10/5/1 calling out for her dog is dead on the redirection as her Resident voiced the can see her dog on not consistently et - PN dated 10/17/ wandering out in her Staff redirected see evening. - PN dated 10/19/ agitated, came out where my dog wad dog was at daugh dog run down the several times. Rewent back to room her reassurance to come back in. - PN dated 10/20/ crying this afternoted daughter who we - PN dated 10/21/ agitated and askir she saw him go to Redirected.	46 a.m. licensed practical nurse oom with medications and R16 are her dog was. 07 a.m. R16 was observed Dh God I want to die" PN) reviewed indicated entries 8, at 12:41 p.m. has been dog and has stated her white a road being eaten by a crow, dog is with her daughter. The part of the road. Attempts to redirect	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245323	B. WING		11/08/2018	
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)		(X5) COMPLETION DATE
F 758	visibly upset, cryir redirect. Resider she would "blow hadministered. Re of distress, 15 mi had been on 1:1 swith resident she "slit her wrists" ar Daughter called a room. - PN dated 12:31 ready to return to bored. - PN dated 10/25, agitated and look television turned given. - PN dated 10/25, anxious this AM ledog was with daulying to her. - PN dated 10/29, regarding dog. DAttempted to call. - PN dated 11/1/1 dog thinks he is no crying and repeat feels like someon and pain radiates ribs. Tylenol #3 and yelling out at anxiety regarding effective short ter afternoon, in simi regarding dog and interventions with	ing that dog is missing. Tried to at verbalized is she had a gun her brains out." Lorazepam esident continued to exhibit signs nute checks instilled but resident since 7:10 p.m. While staff was verbalized, she was going to ad "bust her head into the wall." and wanted sent to emergency a.m. indicated resident was facility - no longer suicidal just (18, at 5:11 a.m. resident ing for dog. Redirected, on. Ineffective. Lorazepam (18, at 3:44 p.m. resident boking for dog. Writer voiced ghter, resident voiced they were (18, at 12:19 p.m. anxious in AM ifficulty to reassure or distract. daughter x2 - no answer. 8, at 11:36 p.m. anxious about hissing. Redirected. Resident edly saying, "Ow." States she e is stabbing her in the back around the front towards the	F 7	758		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/08/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	lorazepam nor did target behaviors or related to the loraz R16 did not have a since admission. Requested dictatio was not provided. On 10/8/18, at 12:4 R16 cries daily. W comfortable but it is daughter brings the the visits because sees her dog. We or doll but not sure medication is order faxed the physician comes in tomorrow. Non-ph are tried before we psychiatric evaluation the start of the survof R16's issues are Alzheimer's diseas possible unit for he we give PRN loraze	it include any monitoring of side effects/adverse reactions	F 7	758	BEHOLINOT		
	(NA)-A stated that hour looking for he you a liar. On 10/8/18, at 12:5	18 p.m. nursing assistant R16 cries at least once per r dog. R16 will yell and call					
	non-pharmacologic	expected staff to be trying cal approaches before cations. The DON was unable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/08/2018		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		_D BE	(X5) COMPLETION DATE			
F 758	to determine why rimorning, as there vindicate communic confirmed that they behaviors or side of the continued use	speridone was ordered this were not progress notes to ation with physician. The DON were not monitoring for target affects of the use of lorazepam could not provide a physician or a pharmacy consultation for of lorazepam PRN past 14 10/19/18). Antipsychotic Medication Use at antipsychotic medications for residents with dementia cal, physical, functional, psychiatric, social and ses of behavior symptoms d and addressed. Cation will be prescribed at the sage for the shortest period of cotto gradual dose reduction entipsychotic medications are RN dosages repeatedly over thysician should discuss the and evaluate the resident as the whether the use is a symptoms are responding to cursing staff shall monitor for the following side effects and those of antipsychotic attending physician: the ergic: constipation, blurred curinary retention, sedation on thostatic hypotension,	F 7	58				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245323	B. WING		11/	/08/2018	
			, , ,			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE	
CFR(s): 483.70(h) §483.70(h) Medic §483.70(h)(1) The physician to serve §483.70(h)(2) The for- (i) Implementatio (ii) The coordination This REQUIREMED by: Based on intervier facility failed to enfunctioned as the state license to priese and was located in. The potential to affect residing in the factor in the facility admining to the factor in the	al director. It facility must designate a seas medical director. It medical director is responsible an of resident care policies; and on of medical care in the facility. ENT is not met as evidenced and document review the sure the physician who medical director had a valid actice medicine in the state, in the same state as the facility his deficient practice had the all 25 residents currently ility INTERCED CONTRACT director had a valid actice medicine in the state, in the same state as the facility his deficient practice had the all 25 residents currently ility INTERCED CONTRACT director had a valid actice medicine in the medical and stated he would provide the the facility and the medical and stated he would provide the the facility and the medical director had would ce until terminated in the procedures outlined in the tract had not identified the name	F8	 Administrator continues to medical director in the area w continuing contract with curre director. Administrator will continue with local area clinics and hos identify a physician able to fill Director position. Administrator will continue with local area clinics and hos identify a physician able to fill Director position and will repoeach month at QAPI. 	hile nt medical e working spitals to Medical e working spitals to Medical rt findings	12/17/18	
	REHABILITATION A SUMMARY S' (EACH DEFICIENCY PREGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR RESPONSIBILITIES OF CFR(s): 483.70(h) §483.70(h) Medic §483.70(h)(1) The physician to serve \$483.70(h)(2) The for- (i) Implementatio (ii) The coordination of the facility failed to enfunctioned as the state license to propose and was located in the state license to propose and was located in the state license to propose in the facility admin following in the facility admin following the entra 11:58 p.m. and independent of the medical director, and the state license to provide the state license to propose in the facility admin following the entra 11:58 p.m. and independent of the medical director. The "MEDICAL Directory of the medical director of the medical dir	REMABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician who functioned as the medical director had a valid state license to practice medicine in the state, and was located in the same state as the facility was located in. This deficient practice had the potential to affect all 25 residents currently residing in the facility Findings include: The facility administrator was interviewed following the entrance conference on 11/5/18, 11:58 p.m. and indicated the facility had a new medical director, and stated he would provide the contract between the facility and the medical	REPROVIDER OR SUPPLIER REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician who functioned as the medical director had a valid state license to practice medicine in the state, and was located in. This deficient practice had the potential to affect all 25 residents currently residing in the facility Findings include: The facility administrator was interviewed following the entrance conference on 11/5/18, 11:58 p.m. and indicated the facility had a new medical director, and stated he would provide the contract between the facility and the medical director. The "MEDICAL DIRECTOR CONTRACT" provided by the administrator indicated the contract was with Tapestry Telehealth and would commence on October 30, 2018, and would continue in full force until terminated in accordance with the procedures outlined in the contract. The contract had not identified the name of the medical director, and a physician had not	RECORDECTION IDENTIFICATION NUMBER: 245323	REPORTECTION BENTIFICATION NUMBER: 245323 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) RESPONSIBILITIES of Medical Director CFR(s): 483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(1) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician who functioned as the medical director had a valid state license to practice medicine in the state, and was located in the same state as the facility was located in. This deficient practice had the potential to affect all 25 residents currently residing in the facility administrator was interviewed following the entrance conference on 11/5/18, 11:58 p.m. and indicated the facility had a new medical director, and stated he would provide the contract was with Tapestry Telehealth and would commence on October 30, 2018, and would continue in full force until terminated in accordance with the procedures outlined in the contract. The contract had not identified the name of the medical director and a physician had not of the medical director.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			11/0	08/2018
	PROVIDER OR SUPPLIER REHABILITATION &	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZII 209 BIRCHWOOD AVENUE WES' WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 841	The facility adminis 11/8/18, at 2:15 p.m the medical director. Connecticut and ha occasion in total an weeks prior. The acprovide the exact donsite visit to the fawork the medical difacility was accompe-mail. The administ provide the medical medicine in the state and revealed that the have a license to provide the medical practice expired 12/31/18. Faccompanied the terevealed the following Practice has approved the medical practice has approved the medical that the revealed the following practice has approved the medical practice has a proved	director contract on 8/30/18. trator was interviewed on a during which he stated that relived in the state of deen to the facility on one deep that visit occurred a few diministrator was not able to ates of the medical director's cility, but indicated all of the rector completed for the dished via telephone and strator stated that he would directors license to practice the of Minnesota was reviewed, the medical director did not reactice medicine. The ded a Telemedicine sued by the Minnesota Board dated effective 9/17/18, and deview of the letter that belemedicine registration carding "the Board of Medical wed your application for the medical director contract do by the identified medical all director did not have a reactice medicine in the state of medical director resided in	F 8	41			
F 921		nitary/Comfortable Environ	F 9	21			12/17/18

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		11/	08/2018	
	PROVIDER OR SUPPLIER REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 921 SS=F	CFR(s): 483.90(i) §483.90(i) Other E The facility must p sanitary, and com- residents, staff and This REQUIREME by: Based on observative the kitchen were five practice had the p residing in the facility the kitchen were five practice had the p residing in the facility the kitchen were five practice had the p residing in the facility the kitchen were five practice had the p residing in the facility the kitchen were five practice had the p residing in the facility the kitchen were five practice had the p residing fan was ob table and food served to be pladirectly below the observed to turn the layer of dust, great substance was obtained food. - At 11:10 a.m. the (CDM)-A stated the food. - At 11:10 a.m. the (CDM)-A confir dust/debris and was stated the fan wou meal.	Environmental Conditions rovide a safe, functional, fortable environment for d the public. ENT is not met as evidenced ation, interview and document failed to ensure the all areas of ree of dust and debris. This otential to affect all 25 residents	F9	1. All fans in kitchen area immediately during non-coo 2. All other fans in the kitc cleaned during non-cooking 3. Food Service Director w fans in kitchen weekly durin non-cooking/eating hours. 4. Administrator will audit I once per month to confirm of the con	king hours. hen have been hours. vill clean all g kitchen fans		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING_		11	/08/2018	
NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 921	next to the dishwas turn the fan off and grease was observ stated the fan was the dishes. CDM-A washed weekly. Review of the unda not include a procecleaned. Review of the unda of Environmental Scleaning of the fans On 11/8/18, at 12:1 updated the sanitat direction for the stain addition, he updated	the freshly cleaned dishes her. CDM-A was observed to a layer of thick black dust and ed on the fan blades. CDM-A to be clean while blowing onto a stated the fan was to be ted, Sanitation checklist did ss to ensure the fans were ted, Cleaning and Disinfection urfaces did not address the	F 92	21			

PRINTED: 12/07/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245323 11/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **WALKER REHABILITATION & HEALTHCARE CENTER** WALKER, MN 56484 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Walker Rehabilitation & Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC. A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS** STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/04/2018

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.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		245323	B WING		11/0	06/2018
NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	3. The name and/or responsible for correprevent a reoccurre. This facility was sur Golden Living Cent building with a particonstructed at two building was constructed for the building Type II(111) construction fire barrier. The smoke zones. The building is protifire sprinkler system with smoke detection open to the corridor that is monitored for notification.	ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency reveyed as a single building. er of Walker is a 1-story al basement. The building was different times. The original ucted in 1967 and was f Type II(222) construction. In reas constructed to the east that was determined to be of action and separated with a 2 e main level is divided into 3 ected by a complete automatic on and has a fire alarm system on in the corridors, spaces r system and in common areas r automatic fire department	KO			
	The requirement at NOT MET. Fire Drills CFR(s): NFPA 101 Fire Drills	42 CFR, Subpart 483.70(a) is	K 7	12		1/12/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		11//	06/2018
NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	ΣE		
(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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 712	signal and simulatic conditions. Fire drill unexpected times to least quarterly on ewith procedures an established routine between 9:00 PM announcement maralarms. 19.7.1.4 through 19. This REQUIREMED by: Based on review of interview, it was deto conduct several the NFPA 101 "The edition (LSC) section 12-month period. Taffect 35 of 35 resident procedure in the procedure on 11/06/2018, durifice drill documental maintenance Superfacility did not condition second quarter and quarter.	the transmission of a fire alarm on of emergency fire als are held at expected and under varying conditions, at ach shift. The staff is familiar d is aware that drills are part of the work of the wo	K 71	1. Fire drills are held at experiment of the unexpected times under varying conditions, at least quarterly of the expected and unexpected times varying conditions, at least queach shift. 3. Administrator Educated Moline Director on fire drill regulation 4. Administrator will audit fire once per month for 3 months accurate fire drills.	ng on each shift. held at es under arterly on flaintenance e drill log	