

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 18, 2019

Mr. Blake Dehnke, Evergreen Terrace 2801 South Highway 169 Grand Rapids, MN 55744

Subject: Evergreen Terrace - IDR

CMS Certification Number (CCN) 245495

Project # S5495028

Dear Mr. Dehnke:

This is in response to your letter of September 7, 2018, concerning your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F678 issued pursuant to the complaint survey event LD6V11, completed on August 10, 2018.

The information presented with your letter, the CMS 2567 dated August 10, 2018 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

F678 Scope and severity (S/S) – **J** – **42 CFR §483.24** (a)(3) – Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Intent: "To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs, and the resident's advance directives."

Guidance at §483.24 (a)(3) indicates – "Additionally, facilities should have procedures in place to document a resident's choices regarding issues like CPR. Physician orders to support these choices should be obtained as soon as possible after admission, or a change in resident preference or condition, to facilitate staff in honoring resident choices. Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises. Resident wishes express through a resident representative, as defined at §483.5, must also be honored, although, again physician orders should be obtained as soon as possible.

Evergreen Terrace January 17, 2019 Page 2

Appendix Q of the SOM provides guidance for surveyors in determining whether or not residents are in an Immediate Jeopardy situation:

- Only ONE INDIVIDUAL needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
- Serious harm, injury, impairment, or death does NOT have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ. If the team identifies an IJ situation, the following points are to be considered:
- The entity either created or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.
- The entity had an **opportunity to implement corrective or preventive measures**.

Summary of the facility's reason for the IDR of these tags: The facility asserts their primary failure with respect to the findings at F678 for R46 and R58 was to ensure a current copy of the resident's advanced directive wishes was in the resident's medical record. The facility indicated that while a Physician's Orders for Life Sustaining Treatment form (POLST) is one document used to communicate advanced directives for a resident, it is not the sole document that should be considered when determining the course of action in the event of an arrest. Further, the facility stated that R46's instance did not meet criteria for immediate jeopardy, as no instance of cardiopulmonary arrest actually occurred.

Summary of facts: R46 was a severely cognitively impaired resident who was admitted to the facility on 6/2/18, with diagnoses including epilepsy, major depression and cognitive impairment. R46's physician's order summary printed on 8/7/18 indicated a full code status (perform CPR following cardiopulmonary arrest). R46's POLST form which was on file in the active medical record reflected a resuscitation status of DNR (do not resuscitate), which conflicted with the physician's orders as well as the R46's care plan, which indicated R46 was full code.

A change in R46's preferences for CPR was expressed at a care conference held on 6/13/18 and a new POLST form was initiated indicating she wished CPR be administered in the event of cardiac arrest. The POLST form remained unsigned and was located during the course of the survey on 8/08/18, nearly two months after R46's care conference. In addition, R46 was noted to have had a recent medical emergency on 8/2/18, related to a seizure lasting approximately 10 minutes, which required transfer to the local emergency room. Interviews with facility nursing staff and the director of nursing indicated the POLST was the document nursing staff were to reference in the event a resident experienced cardiopulmonary arrest.

R58 was a cognitively intact resident that admitted to the facility on 4/18. R58's current physician orders indicated a code status of DNR/DNI, however, the POLST form R58 and the nurse practitioner had signed, as well as R8's care plan indicated CPR should be performed in the event of an arrest. R58's code status was clarified on 8/7/18 during the course of the survey to be a full code.

Summary of findings: R46's instance met the required components of noncompliance at F678 at immediate jeopardy. The facility had been aware of R46's wish to change their code status for nearly two months, failed to ensure documentation was forwarded to the physician for signature, and failed

Evergreen Terrace January 17, 2019 Page 3

to ensure the POLST in R46's chart reflected their current desired code status. R46 had recent hospital visits due to underlying medical conditions, making it especially important for staff to be aware of R46's wishes. R58 was cited as a secondary example of noncompliance as the current physician's orders indicated a code status of DNR/DNI, however, the POLST indicated a full code. The discrepancy between the physician's orders and POLST was not clarified until nearly four months later, when called to the facility's attention by survey staff. F678 is a valid deficiency and is properly cited at the scope and severity of "J', immediate jeopardy.

This concludes the Minnesota Department of Health informal dispute resolution process. Please note, it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Holly Kranz, RN, PHN, Mankato Unit Supervisor

Licensing and Certification Program

Health Regulation Division

Hally Kranz

Telephone: (507) 344-2742 Fax: (507) 344-2723

Cc: Office of Ombudsman for Long-Term Care Pamela Kerssen, Assistant Program Manager Kathleen Lucas, St. Cloud B Unit Supervisor Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		ID: LD6V Facility ID: 00299
1. MEDICARE/MEDICAID PROVIDER (L1) 245495 2.STATE VENDOR OR MEDICAID NO. (L2) 606318700	R NO.	3. NAME AND ADE (L3) EVERGREEN (L4) 2801 SOUTH (L5) GRAND RAP	N TERRACE HIGHWAY 169	Y.	(L6) 55744	4. TYPE (1. Initial 3. Termin 5. Valida 7. On-Sit	nation 4. CHOW tion 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) 6. DATE OF SURVEY 10/04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2018 (L34) (L10)	7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 09 06 PRTF 10 07 X-Ray 11	9 ESRD 0 NF 1 ICF/IID 2 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Su	AR ENDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	93 (L18) 93 (L17)	B. Not in Com	ce With		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A*	6. S 7. M 8. F	uirements: Scope of Services Limit Medical Director Patient Room Size Beds/Room
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 93 (L37) (L38)	VN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(1	L15)
at an isolated pattern, level D.	6/13/18 on F0678 C	ardio-Pulmonary Res removed on 8/9/18, a	ucitation (CPR).		liance remained at a lower scope	e and severity l	evel of no more than minimal harm
Kathleen Lucas, Unit S	Supervisor	Date: 10/08/		(L19)	Alison Helm, Enforce		Date: pecialist 10/08/2018 (L2)
P	ART II - TO BE	COMPLETED E	BY HCFA REGI	IONAL	OFFICE OR SINGLE STA	ATE AGEN	
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible	articipate		PLIANCE WITH CIV HTS ACT:	TIL	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above	l Interest Disclos	ICFA-2572) sure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1987	23. LTC AGREEM BEGINNING		LTC AGREEMENT ENDING DATE	Т	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure		(L30) INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIV A. Suspension	VE SANCTIONS of Admissions:	(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal		06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	pension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/CA	ARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

03001

09/26/2018

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 8, 2018

CMS Certification Number (CCN): 245495

Administrator Evergreen Terrace 2801 South Highway 169 Grand Rapids, MN 55744

Dear Administrator:

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

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

Effective October 4, 2018 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely.

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

October 8, 2018

Administrator Evergreen Terrace 2801 South Highway 169 Grand Rapids, MN 55744

RE: Project Number S5495028

Dear Administrator:

On August 29, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 2, 2018. (42 CFR 488.422)
- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 10, 2018 that included an investigation of complaint number H5495058. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On October 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 4, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2018, as of September 21, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 21, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated August 29, 2018:

- Per day civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 10, 2019 be rescinded as of September 21, 2018. (42 CFR 488.417 (b))

Evergreen Terrace October 8, 2018 Page 2

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

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

[

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAL	D CERTIFICATION	N AND TRANSI	MITTAL
PART I - TO BE COMPI	LETED BY THE ST	TATE SURVEY	AGENCY

ID: LD6V Facility ID: 00299

		1							
MEDICARE/MEDICAID PROVIDE (1.1) 245405	R NO.	3. NAME AND AD (L3) EVERGREE		ITY			4. TYPE OF ACTION:	<u>2 (</u> L8)	
(L1) 245495 2.STATE VENDOR OR MEDICAID NO)	(L4) 2801 SOUTH		59				2. Recertification	
(L2) 606318700	,.	(L5) GRAND RA		,,	(I	L6) 55744		4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	<u> </u>	RY	_02	(L7)	7. On-Site Visit	9. Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Comp	laint	
	0/2018 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING DA	ATE: (L35)	
ACCREDITATION STATUS: Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	E	12/31	(===)	
2 AOA 3 Other		0.0.1	00 01 1/01		10 1100110	-			
11. LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY	IS CERTIFIED AS	:					
From (a):		A. In Complia			-	-	e Following Requirements:	-	
To (b):			Requirements ce Based On:			Technical Personnel	_ 6. Scope of Service		
		1 1	Acceptable POC			24 Hour RN 7-Day RN (Rural SNF)	7. Medical Director 8. Patient Room Siz		
12.Total Facility Beds	93 (L18)		receptable 1 0 0			Life Safety Code	9. Beds/Room		
13.Total Certified Beds	93 (L17)		mpliance with Progr			•			
14. LTC CERTIFIED BED BREAKDO	WN	Requirements	and/or Applied Wai	vers:	* Code: 15. FACILI	B*	(L12)		
14. LTC CERTIFIED BED BREARDO	WN 19 SNF	ICF	IID) or 1861 (j) (1):	(L15)		
93	19 311	ICF	Ш		1801 (e) (1) or 1801 (j) (1).	(213)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):									
	An immediate jeopardy began on 6/13/18 on F0678 Cardio-Pulmonary Resucitation (CPR). The administrator and clinical vice president were notified of the immediate jeopardy on 8/8/18, at 12:17 p.m. and the immediate jeopardy was removed on 8/9/18, at 12:05 p.m., but non-compliance remained at a lower scope and severity level of no more than minimal harm at an isolated pattern, level D.								
17. SURVEYOR SIGNATURE		Date:			18. STATE	SURVEY AGENCY A	APPROVAL	Date:	
Lisa Ciesinski, HFE N	EII	09/19	0/2018	(I 10)	Alison I	Helm, Enforce	ement Specialist	_ 09/25/2018	
	PART II - TO BE	E COMPLETED	BY HCFA RE	(L19) EGIONAI	OFFICE	OR SINGLE STA	ATE AGENCY	(L20)	
19. DETERMINATION OF ELIGIBILI			IPLIANCE WITH		21. 1. Statement of Financial Solvency (HCFA-2572)				
1. Facility is Eligible to l	Participate	RIG	RIGHTS ACT:			 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligibl	_						<u> </u>		
	(L21)								
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEM	ENT	26. TERM	INATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTAR	<u>00</u>	INVOLUNTAR	RY	
08/01/1987					01-Merger, C		05-Fail to Meet	Health/Safety	
(L24)	(L41)		(L25)			ction W/ Reimburseme	nt 06-Fail to Meet	Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS				voluntary Termination	<u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Otner Rea	ason for Withdrawal	07-Provider Sta	tus Change	
(L27)	B. Rescind Sus	spension Date:	(L44)				00-Active		
	D. Resema su	pension Bate.	(L45)						
28. TERMINATION DATE:	29). INTERMEDIARY/0	CARRIER NO.		30. REMARI	KS			
		03001							
	(L28)	05001		(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION (OF APPROVAL DA	AΤΕ					
	(L32)			(L33)	DETERM	INATION APPRO	OVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

REVISED LETTER

August 30, 2018

Evergreen Terrace Attn: Administrator 2801 South Highway 169 Grand Rapids, MN 55744

RE: Project Number S5495028 and H5495058

This revised letter will replace the letter dated August 29, 2018. We have made the following corrections in the letter; the IJ removal date is August 9, 2018. All remedies dates will be based of the letter from August 29, 2018.

Dear Administrator:

On August 10, 2018, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 which was found to be unsubstaniated.

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

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 9, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343

Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

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

this Department is imposing the following remedy:

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

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

- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Evergreen Terrace is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 9, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800)

397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

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

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

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by November 10, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 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.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted August 29, 2018

Mr. Lee Harwarth, Administrator Evergreen Terrace 2801 South Highway 169 Grand Rapids, MN 55744

RE: Project Number S5495028 and H5495058

Dear Mr. Harwarth:

On August 10, 2018, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 which was found to be unsubstaniated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495058 that was found to be unsubstantiated.

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate

jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 10, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be

imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

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

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

- Civil money penalty for the deficiency cited. (42 CFR 488.430 through 488.444)
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2018.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Evergreen Terrace is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 10, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

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

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

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 10, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 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.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

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,

Alison Helm, Enforcement Specialist Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IG	E SURVEY IPLETED
		245495	B. WING _		C 10/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
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	Preparedness Requirements Requirements.	s-Volunteers and Staffing	E 02	24	9/21/18
	develop and impler policies and proced plan set forth in parassessment at para and the communicathis section. The poreviewed and upda	ocedures. The [facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a ies and procedures must ing:]			
	volunteers in an em staffing strategies, for integration of St	as noted above] The use of nergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy.			
	procedures. (6) The emergency and oth strategies to address emergency. This REQUIREMED by: Based on interview facility failed to ens	203.748(b):] Policies and e use of volunteers in an er emergency staffing ss surge needs during an entry and document review, the ure their emergency ies and procedures addressed		Immediate corrective action: *The use of volunteers in an emergency or other emergency staffing strategies,	
ARODATOD		DER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IRE	TITLE	(X6) DATE

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

TITLE

Electronically Signed

09/07/2018

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	` '	E SURVEY PLETED
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E 026 SS=C	Roles Under a Waix CFR(s): 483.73(b)(8	ver Declared by Secretary 3)	E 0	26	Maintenance Birestein taminenate		9/21/18
	develop and implen policies and proced plan set forth in par assessment at para	ocedures. The [facilities] must nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, tion plan at paragraph (c) of					

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E 026	this section. The previewed and upd minimum, the poli address the follow (8) [(6), (6)(C)(iv), [facility] under a win accordance with provision of care a care site identified officials. *[For RNHCIs at § procedures. (8) The waiver declared by with section 1135 at an alternative comanagement office This REQUIREMED by: Based on intervie facility failed to enprocedures addresunder a waiver deaccordance with sprovision of care accare site identified officials. Findings include: The facility emerg 6/18, lacked identification providing care and alternate site, und the facility's Emerg Plan.	colicies and procedures must be ated at least annually. At a cies and procedures must ring:] (7), or (9)] The role of the aiver declared by the Secretary, a section 1135 of the Act, in the and treatment at an alternate by emergency management (403.748(b):] Policies and are role of the RNHCl under a sy the Secretary, in accordance of Act, in the provision of care are site identified by emergency	EC	Immediate Corrective action *The need for care at an altsite during an emergency was and added to the facility's Er Preparedness Plan. Action as it applies to others *The Policy and Procedure for Caress at Alternate Facility'' developed. *Education for all staff on the held on 8/28/18 to review the the Emergency Preparedness Date of completion: 9/21/18 Recurrence will be prevented the facility will engage in condisaster Drill annually, will conditions.	ernative care as developed nergency : or "Resident was e policy was e updates to ss Plan. d by: mmunity	

PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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E 026	environmental serv	ice manager (ESM) stated the essed the 1135 waiver as part	E 0	26	drills, and will conduct "Table Top" discussion to include a scenario an challenge questions to include care alternative care site to test the reviewergency Preparedness Plan. The correction will be monitored by	e at an sed	
	EP Testing Require CFR(s): 483.73(d)(E 0	39	Maintenance Director/Administrator		9/21/18
	RNHCIs and OPOs test the emergency	cility, except for LTC facilities, i] must conduct exercises to plan at least annually. The RNHCIs and OPOs] must do					
	The LTC facility mu the emergency plar unannounced staff	at §483.73(d):] (2) Testing. st conduct exercises to test at least annually, including drills using the emergency C facility must do all of the					
	community-based of exercise is not acceptable. If the actual natural or marequires activation of [facility] is exempt from full-scale exercise of the actual event. (ii) Conduct an additional include, but is not line (A) A second full-	cull-scale exercise that is or when a community-based essible, an individual, as [facility] experiences an en-made emergency that of the emergency plan, the rom engaging in a per individual, facility-based for 1 year following the onset of eitional exercise that may entitled to the following: -scale exercise that is or individual, facility-based.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING	· ,	E SURVEY IPLETED
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E 039	(B) A tabletop ex discussion led by a clinically-relevant e of problem stateme prepared questions emergency plan. (iii) Analyze the [fac maintain document exercises, and eme [facility's] emergency *[For RNHCls at §4§486.360] (d)(2) Te must conduct exercises and eme [following: (i) Conduct a pape least annually. A talk discussion led by a clinically relevant el of problem stateme prepared questions emergency plan. (ii) Analyze the [RN to and maintain docexercises, and eme [RNHCl's and OPO needed. This REQUIREMED by: Based on interview facility failed to ens to test their emerge including participatiexercises. This has	ercise that includes a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 3.748 and OPOs at sting. The [RNHCI and OPO] cises to test the emergency and OPO] must do the rebased, tabletop exercise at coletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency events, and revise the elementation of all tabletop ergency plan at least annually, on in a full scale and table top of the potential to affect all 72 residing in the facility, as well are elementation of all tabletop ergency plan at least annually, on in a full scale and table top of the potential to affect all 72 residing in the facility, as well are	EO	Immediate Corrective action: *Exercised to include participa community disaster plan drill in (the specific date has not beer well as "Table Top" on 9/21/18 with scenario to prepare for ar was developed and added to t Emergency Preparedness Pla	n April, 2018 n set yet) as , discussion n emergency he facility's	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMI	E SURVEY PLETED
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E 039	A review of the faciliplan dated 6/18, fail conducted exercise During interview on environmental serv	ge 5 lity's emergency preparedness led to indicate the facility had as to test their emergency plan. 8/10/18, at 11:35 a.m. with ice manager (ESM) stated the conducted any exercises.	E 0:	39	Action as it applies to others: *The Policy and Procedure for "Participation in Community Based Emergency Plan Testing" was deve *Education for all staff on the policy held on 8/28/18 to review the updat the Emergency Preparedness Plant Date of correction: 9/21/18 Recurrence will be prevented by: *The facility will engage in commun Disaster Drill annually, will conduct internal drills, and will conduct "Tab Top" discussion to include a scenar alternative care site and challenge questions and use of volunteers and professionals to test the revised Emergency Preparedness Plan.	was tes to i. ity le io of	
F 000	A recertification sur 6th-10th and completed at the tir investigation of con completed and was An extended survey 10, 2018, due to an F678. Life Sustainin R46's record that w 6/13/18, as full code reviewed in R46's r in R46's record since	rvey was conducted August aint a investigation was also ne of the extended survey. An aplaint H5495058 was	F 0	000	The correction will be monitored by: Maintenance Director/Administrator		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		110/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	interview, several oresident was found they would look first code status and wo POLST. In the case DNR. This failure to resident record that wished to be resust immediate jeopardy. The facility's plan or as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. Resident Rights/Ex CFR(s): 483.10(a) (1) §483.10(a) (2) (3) (4) (4) (4) (5) (4) (5) (5) (6) (6) (7) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	f the nurses identified that if a to be in need of resuscitation, to the POLST for direction on all follow the directive of the e of R46, this would have been of file a correct POLST in the indicated the residents citated, resulted in an a visituation for R46. If correction (POC) will serve of compliance upon the otance. Because you are four signature is not required a first page of the CMS-2567 ic submission of the POC will cion of compliance. Cacceptable electronic POC, andur facility may be conducted to ntial compliance with the en attained in accordance with ercise of Rights 1)(2)(b)(1)(2)	F 00			9/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	` ´COM	E SURVEY PLETED
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F 550	§483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercis The resident has thrights as a resident or resident of the U §483.10(b)(1) The resident can exerci interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or h subpart. This REQUIREMED by: Based on observareview, the facility fenvironment for 1 capoor fitting high riurinating on self and Findings include:	cility must protect and of the resident. facility must provide equal are regardless of diagnosis, and, or payment source. A facility maintain identical policies and transfer, discharge, and the sounder the State plan for all sof payment source. The of Rights are right to exercise his or her of the facility and as a citizen nited States. Facility must ensure that the se his or her rights without on, discrimination, or reprisal are sident has the right to be and collity in exercising his or her rights as required under this er rights as required under this er rights as required under this alled to provide a dignified of 1 residents (R114) who had se commode resulting in	F 55	Immediate Corrective Action Resident #114 was discharge 8/27/18. Action as it applies to others: *The Policy and Procedure for dignity was reviewed and rem *The residents who could be who's bathrooms have high ri	ed on or Resident nains current. affected	

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F 550	completed as R114 facility for a short to revision. She requires trengthening of left R114's Care Plan in intact, makes own needs, independent assist of one but tracontinent of bowel During an interview 11:03 a.m. houseke has a problem with fitting properly over stated the seat doe because of the lid. room may need the may not, and when demonstrated the gloor. HK-A stated to residents voiding a related to commod stated the high rise and are not steady were currently in us R114 which was sha resident from and commode was in a residents in 204-1 a commodes were old poorly with the from sticking out 4-5 incolleaving a large gap. During an interview stated there are different commodes and the commodes and the states.	was recently admitted to erm stay following a right knee red rehabilitation and it knee. Indicated R114 was cognitively decisions, communicate the with activities of daily living, ansfers self with walker, and and bladder. In and observation on 8/9/18, at eeper (HK)-A stated the facility the high rise commodes not the existing toilets. HK-A is not go back far enough HK-A stated one person in the exhigh rise toilet and the other it gets moved around (she gap) urine and feces get on the hey have problems with other all over the bathroom floors es not fitting properly. HK-A commodes do not fit properly. Two high rise commodes es, one in the bathroom of lared with her room mate and other room. The other high rise bathroom shared by 2 and 204-2. Both bathroom oserved to be fitting/positioned to portion of the commode seat thes from the front of the toilet,	F 550	commodes, will have them reneeded replaced with a bette *All nursing staff were trained dignity on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented *Audits of 5 random resident interviewed weekly x 90 days their resident rights regarding being met and the results of be shared with the facility Queommittee for input on the neincrease, decrease, or disconaudits. The correction will be monito *Social Services/Designee	er option. Id on resident If by: Is will be Is to assure If dignity are It the audits will It	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING		I	C / 10/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		710/2010	
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F 550	the floor. HK-B stat far enough and this months. During an interview stated she has bee the floor and on her commode over the R114 stated she she women, her room room. R114 stated hurts her surgical lea healing incision wo following a left total prior. R114 stated srise commode hers However, since it is has to use it. R114 because she does remove the high ris she has urgency to and floor. R114 exp fit properly over the pushes the high rist therefore the urine stated she has wipe with her own clothe embarrassed when stated she did not woided all over the she cleaned it up he R114 stated she fee in trouble and that s R114 stated she do	on 8/9/18, at 2:07 p.m. R114 n voiding on her self, legs, on clothes due to the high rise existing toilet in the bathroom. ares the toilet with two other nate and a women in the next the high rise commode also be when she sits on it, she has with staples and a dressing knee revision from the week she does not need the high elf, it is for her room mate. If over the existing toilet she stated at night it is the worse not have the strength to be commode off the toilet and void at night and voids on self plained the commode does not toilet, the existing toilet lid be commode forward and goes on floor and self. R114 ed up the urine on the floor	F 5				
	to a couple of nursi medication adminis	4 stated she had reported this ng assistants and trained tration assistants about the s not fitting properly and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 550	recall who she talke at it, but nothing wa The facility Resider Nursing Procedures indicates residents	ge 10 d floor, however, she does not ed to. R114 stated they looked s done, so she gave up. It Rights and Dignity for all s policy dated March 2013, are to be treated with dignity	F 5	50			
F 558 SS=D	S483.10(e)(3) The services in the facil accommodation of preferences except endanger the health other residents.	right to reside and receive ity with reasonable	F 5	58		9/21/18	
	Based on observate review, the facility fallight was provided f	ion, interview, and document ailed to ensure access to a call or 1 of 1 residents (R6) nable accommodations of		*The call light for resident #6 was within reach as soon as the discre was identified. Action as it applies to others: *The Policy and Procedure for An Call Lights which includes placem call lights was reviewed and rema	swering ent of		
	indicated moderate assistance with actimechanically altere tracheostomy with itreatments to help it quarterly MDS indiccerebral vascular a	num Data Sets (MDS) ly impaired cognition, total vities of daily living, d diet and feeding tube, and a regular scheduled nebulizer keep airway open. The rated R6 had diagnoses of ccident (stroke) was unable to self, had a history of seizures,		call lights was reviewed and rema current. *A facility wide audit was complete assure all residents had call lights reach. *Education for all nursing staff on placement of call lights within reacheld on 8/21/18. Date of completion: 9/21/18	ed to within proper		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 558	muscle weakness a R6's Care Plan dat history of seizures a time communicatin follow include: antic her call light within During observation was in her bed with light was at the end At 2:43 p.m. R6's of her bed. At 3:51 p. reach on her abdor During observation was in her recliner and her call light wa of the recliner (call appear as though s During interview on nursing assistant (I to bend forward to well. NA-D further s to her. During interview on licensed practical in not reach the call light the call light and pla LPN-A stated she w a clip for the call ligh she found a clip an R6 so it would not s The facility's Answereviewed and indica	and difficulty communicating. ed 7/11/18, indicated R6 had a and falls and had a difficult g her needs. Interventions to cipating her needs and having her reach. on 8/8/18, at 2:19 p.m. R6 her eyes closed and her call I of her bed and out of reach. all light remained at the end of m. her call light was within her men. on 8/10/18, at 10:47 a.m. R6 chair with the legs elevated as on the end of the foot rest light was by her feet) it did not the could reach it. 18/10/18, at 10:51 a.m. NA)-D stated R6 might be able reach the call light but not very stated the light could be closer 18/10/18, at 10:54 a.m. hurse (LPN)-B stated R6 could ght by her feet. LPN-B moved acced call light on R6's lap. would call maintenance and get ht. At 10:58 a.m. LPN-B stated d placed it on the call light for	F 55	Recurrence will be prevented *Visual audits of call light place e conducted for 5 random residuely x 90 days and results the facility QAPI committee for the need to increase, decreased discontinue the audits. The correction will be monitore *DON/Designee	ement will b dents shared with input on e or		

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NAME OF D	PROVIDER OR SUPPLIER	243433	I D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08	/10/2018	
NAIVIL OI I	TROVIDER OR SUFFEIER			2801 SOUTH HIGHWAY 169			
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F 558	Continued From pa	ge 12	F 5	58			
		the general guidelines is to be within easy reach of the					
		ig (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii)	F 6	76		9/21/18	
	assessment of a re- resident's needs an provide the necessare ensure that a reside daily living do not di of the individual's cl	on the comprehensive sident and consistent with the d choices, the facility must ary care and services to ent's abilities in activities of minish unless circumstances inical condition demonstrate in was unavoidable. This ensuring that:					
	treatment and servi or her ability to carr	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)					
	, ,	ovide care and services in ragraph (a) for the following					
	§483.24(b)(1) Hygic grooming, and oral	ene -bathing, dressing, care,					
	§483.24(b)(2) Mobil including walking,	lity-transfer and ambulation,					
	§483.24(b)(3) Elimi	nation-toileting,					
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	`	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
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	(i) Speech, (ii) Language, (iii) Other functiona This REQUIREMEI by: Based on observat review, the facility f nursing services to for 1 of 1 resident (nursing programs a R54's quarterly Min 5/17/18, indicated F R54 needed extens transfers, moving fi position, and walkir impairment on both R54's care plan dat restorative nursing ambulate 40 feet in one staff with stand transfer belt and wh for four weeks. R54's Diagnosis Re indicated R54's dia right humerus fract knee amputation. During an observat at 11:42 a.m. R54 v R54's room. R54's	I communication systems. It is not met as evidenced stion, interview, and document ailed to provide restorative maintain ability to ambulate R54) reviewed for restorative and have ability to ambulate. Imum Data Set (MDS) dated R54's cognition was intact. Sive assistance of one staff for rom seated surface to standing ag. R54 had lower extremity a sides. Ited 6/5/18, indicated a program (RNP) for R54 was to the parallel bars with assist of I by assist (SBA), use a neelchair three times a week eport provided 8/10/18, gnoses included diabetes, ure, and left leg below the ion and interview on 8/10/18, was sitting in the wheelchair in stated once in a while nursing ones in to help with her	F 676	Immediate corrective action: *Education on alerting supervisor if un to provide Restorative Program on any day scheduled was provided to Restorative Aide on 8/22/18. *Resident #54 was evaluated by OT or 8/19/18 and it was determined the resident was able to perform her Functional Maintenance exercised independently and no longer needed the existing FNP. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed an remains current. *All residents will be reviewed to determine need for Restorative program which program, how often and a plant assure these programs are provided be Restorative Aide or Nursing staff. All nursing staff and Restorative staff trained on 8/21/18 on the Restorative Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random residents	n he ad am, to by
	R54's room. R54 s assistant (NA)-A co restorative program R54's task informat	stated once in a while nursing omes in to help with her		Recurrence will be prevented by:	the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	COMI	E SURVEY PLETED	
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F 676	rehab program was parallel bars three of A review of Unit 4 F Schedule form date indicated R54 rece of 7/30/18 through RNP one day. The 8/12/18, indicated F During an interview stated, "When I wadid not get complet pulled to work on the week for short staff walking program whou it did not work the enough staff or end stated the most implied a walking program independence. During an interview interim director of restorative aides are be made to ensure The Restorative National The Restorative National The Restorative Progress documented quarter progress notes. Restorative Restorative Restorative progress notes.	walking 10 to 20 feet in the	F 676	The results of the audits will with the QAPI committee for need to increase, decrease the audits. The correction will be monito *DON/Designee	input on the or discontinue	

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F 678	was found to be in a would look first to the code status and wo POLST. In the case DNR. The administ president were notion 8/8/18, at 12:17 jeopardy was remobut non-compliance and severity level of at an isolated patte. Findings include: R46's Admission Residented R46 was 6/2/18, with diagnosmild cognitive imparting major depressive depr	need of resuscitation, they he POLST for direction on buld follow the directive of the e of R46, this would have been rator and clinical vice fied of the immediate jeopardy p.m. and the immediate ved on 8/9/18, at 12:05 p.m., a remained at a lower scope of no more than minimal harm rn, level D. ecord, printed 8/7/18, admitted to the facility on ses including encephalopathy, irment, epilepsy, anxiety and isorder. inimal Data Summary (MDS) ated a brief interview of mental e of 3 which is consistent with	F	678	the medical record while awaiting signature on an original POLST. *All resident charts were reviewed assure most current POLST was in medical record and that MD orders matched POLST. *Education was provided to all licer nurses during the Survey after the was revised. Date of completion: 9/21/18 Recurrence will be prevented by: *Reviewing all POLST was added daily Quality Conference Tool to as all new revised POLST are reviewed matching documentation is confirm. This will be an ongoing audit shares the facility's QAPI committee. An additional audit of 5 random resides week will be completed x 90 days a results shared with QAPI for input need to increase, decrease or discounted the audits. The correction will be monitored by *DON/Desingee	to the ssure ed and ned. d with on the on the ontinue	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	CON	TE SURVEY MPLETED
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F 678	8/7/18, at 10:16 a.m status was full code R46's care plan dato of "Advanced Direct status." Further incappropriately if I sh resuscitation." During an interview asked if a resident without a pulse, lic stated she would lo Administration Reccode status, "it is used available to me." During an interview asked if a resident without a pulse, regishe would look at the POLST, or she depends on what is During an interview unit manager indicated polsoft for R46 did this as a problem. In POLST in the front and dated 6/2/18. In the front and dated 6/2/18. In the front and dated bolder behind are sent with if the transferred to the holder behind are sent with if the transferred to the holds and further stated if a reand without a pulse and status	ted 6/20/18, indicated a focus stives: I have a Full Code dicated, "Staff will intervene ould need cardiac on 8/7/18, at 1:42 p.m. when was found unconscious and ensed practical nurse (LPN)-B ook at the electronic Medication ord (EMAR) for resident's sually what I have open and on 8/7/18, at 2:06 p.m. when was found unconscious and gistered nurse (RN)-B stated the front of the paper chart at might look at the EMAR, it				

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F 678	R46's progress no had a seizure arou about 10 minutes, unable to move lef one word answers call MD was notified emergency room (note dated 8/7/18, foot got caught belt to stand and fell for glasses lacerated sent to ER for an element of ER	te dated 8/2/18, indicated R46 and 5:00 p.m. which lasted R46 was slow to respond, was it arm and could only answer. The note further indicated on ed, orders to send to ER). A subsequent progress at 9:45 p.m. indicated R46's hind a foot pedal and attempted rward. When R46 fell her her right eyebrow. R46 was evaluation. During interview on a LPN-A stated a copy of the inthe residents when hospital, the POLST on 8/2/18, at would have been in the dicated DNR and was dated interview, the interim director provided an electronic form, Hospital Transfer Form dated indicating full code. IDON was POLST dated 6/2/18, indicating in to the hospital for these missions.	F 67	,		
	filled out to represe and/or family signs witness and that the dated. IDON state by the resident or to placed in front of the original is kept for	ner stated POLST are then ent their wishes, the resident is the POLST, staff sign as a see POLST form should be and when the POLST is signed family, a copy is made and the resident's chart and the the nurse practitioner (NP) to see rounds. Once the POLST is				

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F 678	signed by NP the cand replaced with to on to say, staff are to determine code signed by the NP is POLST when entercomputer.	copy is removed from the chart the signed original. IDON went directed to look at the POLST status. The POLST, once is the order. Staff refer to the ring the order into the	F 67	8		
	asked if a resident without a pulse, RN at the resident's PO is the first place sh code. "I would expeat the POLST if the a POLST indicated indicated full code, wishes on the POL code and electronic	on 8/8/18, at 7:04 a.m. when was found unconscious and N-A stated first she would look DLST in the paper chart. That e would go if told there was a ect the rest of my staff to look ere was a code." RN-A stated if I DNR and the electronic chart she would go with patient .ST. If POLST indicated a full c chart indicated DNR, she POLST that is the resident's				
	asked if a resident without a pulse, RN resident's POLST t chart. RN-C went of	w on 8/8/18, at 7:11 a.m. when was found unconscious and N-C stated she would check the first, it is in the front of the on to say she was told staff OLST because that is the				
	asked if a resident without a pulse, RN look at the paper c what the code state go with the POLST with the electronic	on 8/08/18, at 7:14 a.m. when was found unconscious and N-D stated the first thing is to hart at their POLST to see us is. RN-D stated she would for there was a discrepancy orders and the POLST she POLST as it is the most				

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	PROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, 2 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	ZIP CODE	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 678	updated sheet, and signs the POLST. During an interview referred to the facillation and physicithe advance directive followed immediated advanced directive prior to the physicity whatever the POL R46's paper chart reviewed with the chart contained a indicating DNR, diprepared the POL 6/2/18. Nurse pradundated. Electron indicated full code was 6/5/18, for DN record was changed IDON stated R46's services (SS)-A sp 6/13/18, in regards was decided at the order was entered code. When asked and the POLST form on 6/13/18, as full signature. When a found, the IDON sworker's office. WNP-E's signature, not gotten to her. I process should be	age 20 d the medical doctor (MD) w on 8/8/18, at 7:17 a.m. IDON ility's policy which directed, ian's notification and order for tive should be obtained, the should be honored and ely after the individual e is determined, which may be ans order." IDON stated ST states is what staff go by. and electronic chart were IDON. The front of the paper POLST signed by R46 rector of admissions (DOA)-E ST and signed and dated it ctitioner (NP)-D signed POLST, ic chart orders dated 8/7/18, . Initial order in electronic chart IR. Order in the electronic ed to full code on 6/13/18. The stadughter, RN-A, and social ooke at a care conference on sto code status and full code at time. On 6/13/18, computer by RN-A/Unit Manager as full d about the electronic order of matching, the IDON left her d with a POLST form for R46. was signed by R46 and SS-A code. POLST lacked NP-E asked where the form was tated it was found in the social then asked why the form lacked IDON-A stated it just must have DON went on to say the sto make a copy of the new	F6	578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER EVERGREEN TERRACE			STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
paper chart, IDON-A stapaper chart at this time 6/2/18. IDON-A stated staff would have looked indicated DNR and not IDON stated, "This is or LPN-A into the office. It was left for the family of status, however, had not yet. During an interview on stated R46 wanted to be after transferring from a care plan meeting in Judecided on a full code at the updated POLST should chart. SS-A stated, "It will should have been put in office." SS-A also indicated R46's updated POLST that morning. R46's family member (18/8/18, at 9:47 a.m. R46/13/18, R46's code stated stated she added, "I was looking the and noticed she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the stated she was a understand what she were stated in the s	ing NP-E's signature. ot done. After reviewing ated the POLST in the is the DNR POLST dated if R46 would have coded, dat the POLST and seen it initiate resuscitation. If concern." IDON called LPN-A stated a message of R46 to confirm code not received a response as a 8/8/18, at 8:53 a.m. SS-A is DNR upon admission another facility. At R46's ine, family and resident and signed a new POLST, ould have been sent to (HUC) and a copy of the land have been put in her was probably my error, it in [R46's] chart, not in my cated that IDON found from 6/13/18, in her office in FM)-A was called on 6's FM-A stated on a tus was changed to full a wanted it changed and in rough [R46's] paperwork DNR, I know she did not as signing, I don't think ing her own decisions, I am dianship."	F6	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	110/2010
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F 678	(indicating severe of During a subsequeral a.m. when asked if unconscious and wishe would look at the if POLST said DNR was full code she won the POLST. If Pelectronic chart ord with the POLST and During an interview asked if a resident without a pulse, RNDNR she would go the POLST and the stated she would go the POLST and the stated she would go their status. She we will have to check, directions, I have to should be done. I'm During interview on asked if a resident without a pulse, IDO trained since immediook at the orders in records and the POLST and the POLST and the stated if a resident without a pulse, IDO trained since immediook at the orders in records and the POLST and the MD When asked what the discrepancy, staff When asked how lot the discrepancy bef stated, "No longer the indicated that prior only to check the Polst indicated that prior only to check t	ge 22 ognitive impairment). Int interview on 8/9/18, at 8:15 a resident was found ithout a pulse, RN-A stated the POLST in front of the chart, and electronic chart order rould go with resident's wishes POLST was full code and ter stated DNR she would go defollow resident's wishes. On 8/9/18, at 8:51 a.m. when was found unconscious and N-C stated if the POLST read by the POLST. When asked if orders did not match, RN-C tet clarification from the MD of ent on to state, "I don't know, I have gotten different to get clarification on what a not real sure what to follow." 8/9/18, at 10:00 a.m. when was found unconscious and DN stated licensed staff were diate jeopardy was called to a the electronic medical bulst to determine code status. That means, IDON stated staff or look in the progress notes. That means, IDON stated staff or look in the progress notes. That means are to be looking into fore initiating CPR, IDON than a minute." IDON further to the retraining staff were OLST in the paper chart. 8/9/18, at 10:23 a.m. IDON,	F 6	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	CON	TE SURVEY MPLETED
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F 678	and VP were notified stating they would be not matching what it trained to do. IDON more education to be the revised Advanced will continue to make not reached evening until they are educated trained as soon. The immediate jeep was removed on 8/ facility updated their provided training are staff that would be resident code status interviewed all licentary Their responses and consistent with the R58's diagnoses included the leg caused by a lymperipheral venous in R58's quarterly MD R58 was cognitively R58's admission coindicated R58 was Review on an interest.	d that at least 2 staff were look at the POLST, which was IDON-A stated they were in stated she would provide the licensed staff in regards to be Directives policy. 8/9/18, at 11:51 a.m. IDON all licensed staff on the floor, I see calls to licensed staff, I have g staff yet, they cannot work atted, I will stay until they can as they come in for their shift." Dardy that began on 6/13/18, 9/18, at 12:05 p.m. after the r Advanced Directives policy, and retraining to the licensed responsible for following s wishes. Surveyors used staff that were on duty. In dunderstanding was Advanced Directives policy. For printed 8/10/18, indicated cluded cellulitis of the left dema (swelling in an arm or inphatic system blockage), and insufficiency. S dated 7/19/18, indicated y intact.	F 6	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED C
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F 678	R58's POLST unda practitioner and R5 to be attempted in a cardiac/respiratory R58's order summa the computer, indic DNR/DNI (do not in 4/13/18, on the day to be active on 8/7/Review of a multidi summary dated 7/2 attend and was mareview area. Review of R58's care R58's code status at During an interview asked about the prestatus in the reside HUC puts the reside Computer and the recorrect in the computer and the recorrect in the computer and the reside HUC puts the resident stated, "I have not a what I am going to During an interview stated if a resident she would look for first, if the computer stated if there was computer, would as and proceed to do	arted, and signed by the nurse 8, indicated R58 wanted CPR the event of a arrest. The event of a arrest. The proof printed 8/7/18, from ated R58's code status was atubate). The order started of admission and continued 18. Sciplinary care conference 20/18, indicated R58 did not ricked a DNR on the care level at a full code. The plan dated 8/3/18, indicated at a full code. The order started to the proof of the plan dated 8/3/18, indicated at a full code. The on 8/7/18, at 2:04 p.m. when process for recording code and record, LPN-A stated the ent's code status in the plan should verify the order is planted. The on 8/7/18, at 2:45 p.m. R58 and the up my mind yet as to put as my code status." The on 8/7/18, at 4:31 p.m. LPN-E and the code status on computer record to be resuscitated, the code status on the sume the resident a full code status on the sume the resident a full code.	F 67	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	COV	MPLETED
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	stated she wrote DI she would look for tresidents from the I wrote full code on the sheet and that infortransferring facility. Unaware of how R5 DNR/DNI on the coons of the status the resident of the status the status the resident of the status the status the status the status the resident of the status t	NR/DNI in the computer and the code status designation for POLST. RN-A stated she he admissions confidence mation was from the RN-A stated she was 8's code status became imputer order. Terified with R58 on what the ident wanted. R58 signed and ST along with LPN-A. R58 code. LPN-A changed the iter to read full code for R58. Tives/POLST policy revised in the POLST, but if order has and resident is discovered to divithout a pulse, the POLST and MD orders, in representative will be always performed in the case erson's code status. The received in ROM/Mobility 1)-(3) Tacility must ensure that a set the facility without limited erson texperience reduction in less the resident's clinical ates that a reduction in range	F 6			9/21/18
	топон госегиез ар	propriate treatment and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
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F 688	services to increase prevent further dec §483.25(c)(3) A respectives appropriate assistance to maint the maximum practiceduction in mobility. This REQUIREMED by: Based on observative, the facility for nursing services to motion for 3 of 3 respectively. The facility for the fac	e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and rain or improve mobility with ricable independence unless a y is demonstrably unavoidable. NT is not met as evidenced rion, interview, and document railed to provide restorative maintain mobility and range of sidents (R46, R35, R8) rative nursing programs. ective payment system (PPS) dicated a brief interview for S) score of 7 (severe cognitive is Diagnosis Report printed on the following diagnoses: specified (any disease or n), epilepsy, hemiplegia and ng cerebral infarction (stroke). dated 7/11/18, indicated R46 rassistance with bed mobility, locomotion off unit, dressing,	F 688	Immediate corrective action: *Education on alerting superviso to provide Restorative Program of day scheduled was provided to Restorative Aide(s) on 8/22/18. included updated documentation performed in POC from paper to for Restorative. *Resident #8, #35, and #46 were evaluated by OT on 8/19/18 and results were to continue resident #46 Programs and Discontinue for #35 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was review remains current. *All residents will be reviewed to determine need for Restorative for which program, how often and a assure these programs are prov Restorative Aide or Nursing staff *Those residents needing Resto Programs will have updated info added to their Care Plan and PC *All nursing staff and Restorative trained on 8/21/18 on the Restor Program and need to provide as	Education to be ol used the #8 & Resident Program, plan to ded by prative ormation of C Tasks. e staff ative	

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F 688	able to complete he assistance. R46's Physical The start of care 6/25/1 referred due to a de encephalopathy, U' R46's physical ther dated 7/15/18, analoutcome/clinical im worked well with the term care and will be program (RNP). R46's PT PN dated instructions indicate skilled nursing facil R46's Occupation a start of care on 6 7/20/18, referred dand function mobili encephalopathy. R46's occupational PN) dated 7/17/18, indicated plan to accontinue to educate program prior to en R46's OT PN dated services with home R46's electronic tas indicated restorativ 7/20/18 to 8/8/18. cycle for 15 minute	er breakfast with minimal erapy Plan of Care indicated 8 with end of care 7/20/18, ecline in strength due to TI and epilepsy. apy progress note (PT PN) lysis of functional pression, indicated that R46 erapy. R46 will remain at long begin restorative nursing 17/20/18, discharge plans and ed, R46 will remain in this	F 688	Scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random reside receiving a Restorative Program value conducted weekly x 90 days to as Program is occurring and is documented to increase, decrease or distinguished to increase, decrease or distinguished audits. The correction will be monitored to *DON/designee	will be ssure the imented. nared ton the continue	

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F 688	was a total of 13 op Restorative Treatm 8/10/18, 3 of 13 op refused by R46, 1 of documented unable opportunities were (NA). R46's Restor printed on 8/10/18, 13 opportunities sin During interview on restorative nursing is documented whe not completed for wany place to chart wand the resident refusal box. NA-A stated, " the floor a lot and I went on to say, shot then she will sit at thours, when she go residents not leaving then it is time for he say, that it is her jol programs and when on vacation, there in NA-A stated registed gets pulled to the flor restorative nursing R46's PT plan of ca order for evaluation 8/2/18-8/4/18. Initial was no functional do restorative nursing	portunities as indicated on the ent Schedule printed on cortunities were documented of 16 opportunities was a to participate, 9 of 13 documented not applicable rative Treatment Schedule revealed she received 0 out of ince starting RNP on 7/20/18. 8/10/18, at 10:00 a.m. assistant/ NA-A stated that NA and the restorative program is whatever reason, there is not why it did not occur other than box or unable to participate To be honest, I get pulled to just can't get to it all." NA-A are gets pulled for appointments the clinic for two or more ests back it is time to help feed ag much time after lunch and er to leave. NA-A went on to to to do the restorative in she is pulled to the floor, or so no one to take her place.	F 6	88			

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F 688	demonstrate funct has a restorative r continue with this R35's quarterly MI	ional decline at this time. R46 nursing program and will	F 6	888			
	MDS indicated R3 to stabilize with sta from a seated to s bed to a chair. The limitations to R35's	sistance with transfers. The 5 was not steady and only able aff assistance when moving tanding position and from the e MDS further identified a range of motion (ROM) of extremity on one side.					
		iagnosis Report dated 8/10/18, s of hemiplegia, hemiparesis, eakness.					
	on a RNP. The camotion (AROM) to (BLE) hip flexion, and ankle flexion a 5 times weekly. Lecontracture of -20 plan updated on 7 frequency of the RThe care plan dire with transfers usin assist with transfer	ated 6/29/18, indicated R35 was re plan directed active range of bilateral lower extremities extension and abduction. Knee and extension 10 repetition/joint of the extension stretching for degree extension. The care /24/18, decreasing the NP program to 2 times weekly. Country of the extension o					
	Schedule from 7/9 following: AROM BLE hip fle	Restorative Treatment /18 to 7/29/18, directed the xion, extension and abduction knee extension stretch of -20 eekly.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
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F 688	-7/9/18 to 7/15/18: offered/completed -7/16/18 to 7/22/18 offered/completed -7/23/18 to 7/29/18 one time. No docur offered/completed dates. After 7/29/18, RNP times weekly to twi -7/30/18 to 8/5/18: completed or refus -8/6/18 to 8/12/18: on Tuesday and Throffered/completed. R35's electronic Poly History task of rest AROM to right and flexion, extension aflexion and extension weekly. Left kneed contracture of -20 of 7/12/18 to 8/9/18, (documented 20 time documentation of ROM.	no documented RNP was on the 5 scheduled dates: no documented RNP was on the 5 scheduled dates: R35 was offered and refused mentation RNP was the remaining 4 scheduled scheduled changed from 5 ce weekly. R35 documented ROM was ed 2 of the 2 scheduled days. R35 was scheduled for RNP nursday and was not so int of Care (POC) Response orative rehabilitation directed: left lower extremities hip and abduction, knee and ankle on 10 reps per joint 2 times extension stretching for degrees extension. From 29 days) "not applicable" nes. The POC lacked completion or refusals of the a 8/10/18 at 9:24 a.m. assistant/ NA-A reviewed the	F 68	8			
	8/9/18NA-A stated for th not offered 5 out of -NA-A stated for th not offered 5 out of was on vacationNA-A stated for th	e week of July 9th, ROM was the 5 scheduled times. e week of July 16th, ROM was 5 scheduled times, as she e week of July 23rd, R35 was done time. R35 was not					

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F 688	offered ROM the retimesNA-A stated for the scheduled 2 times the scheduled 2 tireNA-A stated durin was not offered 2 of During an interview asked about ROM ankle R35 laughed on my own." Where	emainder of the 4 scheduled e week of July 30th, R35 was and was refused or completed	F 6	38		
	and long term mer extensive assistant indicated R8 was restabilize with staff a seated to standing a chair. The MDS R8's ROM of lower R8's electronic Diagrevealed diagnose generalized muscle					
	3/22/18, indicated x 10 minutes rema restorative aide ab R8's care plan data a RNP. The care p frame 3 times a we	apy evaluation only form, dated current RNP of standing frame ins appropriate as R8 and le to complete safely. ed 6/5/18, indicated R8 was on plan directed to use a standing eek. If unable to use the complete 15 minutes on the				

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	PROVIDER OR SUPPLIER	,	•	28	REET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
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F 688	omnicycle to maint directed one staff a using a PAL lift. Review of Unit 2's Schedule directed minutes 3 times a minutes 3 times a revealed the follow -7/9/18 to 7/15/18: offered or complete -7/16/18 to 7/22/18 offered or complete -7/23/18 to 7/29/18 offered or complete -7/30/18 to 8/5/18: 2 of the 3 schedule -8/6/18 to 8/12/18: offered or complete R8's electronic PO nursing rehab from directed "standing week. If [R8] will not 5 minutes on the "Not Applicable" 17 one time during the All dates were bland During an interview member (FM)-J standing the bicycle, is more often. FM-J standing the bicycle, is more often.	ain ROM. The care plan assisted R8 with transfers Restorative Treatment "standing frame 10 to 15 week or omnicylcle for 15 week." Documentation ing: no documented RNP was ed. : no documented RNP was ed. : no documented RNP was ed. documented ROM completed ed days. no documented RNP was		688			
		on 8/9/18, at 9:26 a.m. NA)-D stated the nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 688	assistants working ROM for residents NA-D stated the re ROM program. NA by the aide working documented in PO (NA) is documented to the resident. During an interview restorative aide/ NA the restorative aide/ NA the restorative aide the unit, sometime stated the restoratic completed when stakes about 5 hour 22 residents on the aides document ur ROM is completed the Restorative Tre to 8/9/18. -NA-A stated for th not completed. NA pulled." -NA-A stated for th not offered/comple have been pulled to vacation on Friday not get completed on the unit or is on -NA-A stated for th offered and completed NA-A stated R8's Foffered/completed pulled to work on the united to work on the	on the floor do not complete in the restorative program. storative aide completes the A stated if ROM is completed gon the unit, the completion is C. NA-D stated not applicable d when the ROM is not offered when the gets pulled to work on sup to 3 times a week. NA-A ve program does not get the is pulled. NA-A stated it is to complete the RNP for all the RNP list. NA-A stated the inder the electronic POC if the on the floor. NA-A reviewed the exament Schedule from 7/9/18 are week of July 9th, ROM was ted as she was on vacation. The week of July 23rd, ROM was ted. NA-A stated she must of work on the unit and was on the NA-A stated the ROM does when she gets pulled to work vacation. The week of July 30th. ROM was ted on July 30th. ROM was ted on July 30th. NA-A stated the ROM does when she gets pulled to work vacation. The week of July 30th. ROM was ted on July 30th. NA-A stated the ROM was not on August 3rd, as she was	F 68	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _		08	3/10/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 688	scheduled for RON stated ROM was not so busy helping plans on completin next day, 8/10/18. During an interview physical therapist (a screening to ider since PT discontinus tated the restoration rehab department, aide is pulled, PT-hask her, but it seen a.m. PT-K stated sneither resident has the resident has buring an interview RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents. RN-A stated the rechanged from 7 da "sometimes" the rework on the floor or residents are to complete the rework on the floor or residents. RN-A stated the resident has a stated the restoration of the floor or residents are to complete the rework on the floor or residents are to complete the rework on the floor or residents are to complete the rework on the floor or residents are rework on the floor or residents are rework	of on the 6th and 8th. NA-A of offered to R8 as she "just g on the wing." NA-A stated she g the ROM as scheduled the g the ROM as scheduled the g the ROM as scheduled the g to on 8/10/18 at 9:56 a.m. PT)-K was asked to complete at the graph of the later of later of the later of the later of	F 68	8			

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F 698 SS=D	1/18, indicated rest document the prog care computer. Do restorative progress documented quarte progress notes. Resummary indicated resident needing regain or maintain hig Responsible for protherapist's work an Dialysis CFR(s): 483.25(l) S483.25(l) Dialysis. The facility must errequire dialysis rec with professional stronger dialysis received the residents' goals This REQUIREMED by: Based on observareview, the facility for 1 resident (R9) of dialysis. Findings include:	ursing Program policy revised corative nursing staff will ram performed on the point of ocumentation of the resident's s will be assessed and erly by the RN manager in the estorative nursing job a responsible to work with estorative nursing measure to ghest functional level. Eviding consistency between discarry over on a daily basis. Insure that residents who elive such services, consistent tandards of practice, the reson-centered care plan, and is and preferences. No interview and document failed to track fluid intake for 1 on fluid restrictions reviewed for the reson to the dated 5/18/18,	F 69	Immediate corrective action: *A new calculation of fluids within the restriction was developed for resident #9 to include resident's desire for coffee between meals. Action as it applies to others: *All residents on a fluid restriction were	9/21/18
	disease, stage V and Minimum Data Set indicated R9 was s	nosis included chronic kidney nd hemodialysis. The annual (MDS) dated 5/10/18, everely cognitively impaired. ary Report with a start date of		reviewed to assure calculation includes water/coffee/other liquids offered at activities or in-between medication and meal times. Fluids allotted for each department will be documented each dain the medical record.	,

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM-		E SURVEY IPLETED				
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F 698	11/9/15, indicated F 1500 cc's (cubic ce related to depende Order Summary Recc's per shift with the R9's care plan update to dialysis three times of fluid restriction a pass, Nepro (nutritis specifically designed nutrients that have cc's, 8 ounces (oz) choice for a total of coffee and 4 oz beyode 360 cc's at lunch, a beverage of choice supper. A review of the registroller was possible to drink as stated (R9) did not was able to drink as stated, "I get coffee A review of nursing Question Report, frough the possible to drink as stated, "I get coffee documented R9's finday. The Follow Up that staff did not documented did not documented R9's finday. The Follow Up that staff did not documented did not documente	R9 was on a fluid restriction of entimeter) per day, every shift, nce on renal dialysis. The eport directed staff to give 120 ne medication pass. ated 6/5/18, indicated R9 went les a week and was on a 1500 ns follows: 120 cc's at med onal supplement that is ed to replace protein and been lost during dialysis) 240 coffee and 4 oz beverage of 360 cc's at breakfast, 8 oz verage of choice for a total of and 8 oz coffee and 4 oz for a total of 360 cc's at stered dietician (RD) Nutrition 21/18, indicated R9's weight bounds from 5/22/18 to ocumentation indicated they reight gain. The form indicated s 4.9 (3.5 to 5.0 normal). Ton 8/7/18, at 8:36 a.m. R9 have any fluid restrictions and as much as they like. R9 whenever I want it." assistant charting, Follow Up om the computer dated 7/18, indicated staff luid intake one to two times a p Question Report indicated icument R9's fluid intake on all Staff failed to document R9's	F6	*The Policy and Procedure for Restriction/Promotion was resemains current *Dietary, Activities and nursing trained on how to divide fluid residents on a fluid restriction personal choice when able. Date of completion: 9/21/18 Recurrence will be prevented *An audit of 5 random reside restriction will be conducted a days to assure the fluids are according to resident choice and all fluids are documented results of the audits will be stracility QAPI committee for inneed to increase, decrease of discontinue the audits. A Rist be administered, Care Plant notified if any resident choos abide by their fluid restriction The correction will be monito *DON/Dietary Manager	eviewed an ang staff were s for n to allot for n to allot for the hared with the nput on the or sk/Benefit will ned and MD es not to	

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F 698	A review of R9's Me Record (MAR) date the nursing staff do given during the me however, did not interest for the day outside time. During an observat was sitting in dining for the day and drintable. During an interview trained medication went to dialysis Mor R9 was observed to going to dialysis. The is non-compliant 1500 cc's. TMA-A R9 a cup of coffee, that fluid intake. During an interview certified dietary ma on a 1500 cc fluid in R9 and family mem for R9 and they do was taken at that the stated the nursing a to record residents cc's a beverage con	ge 37 edication Administration ed 7/1/18-7/31/18, indicated cument the total intake of fluid edication administration times, clude the additional fluid intake of medication administration ion 8/08/18, at 7:14 a.m. R9 groom in a wheelchair dressed king coffee with others at the on 8/8/18, at 11:43 a.m. assistant (TMA)-A stated R9 inday, Wednesday, and Friday. o get a cup of coffee prior to MA-A stated everyone knows to with the fluid restriction of stated R9 or family would get and they do not document on 8/8/18, at 2:14 at p.m. inager (CDM) stated R9 was estriction. The CDM stated aber will access a cup of coffee me to nursing. The CDM assistants are trained on how fluid intake and how many intainer holds. The CDM arere looked at when a quarterly	F6	98			
	registered dietician	on 8/9/18, at 1:22 p.m. the (RD) stated R9 had the same stion for the last three years.					

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F 698	The RD stated staf of fluids for R9 at a R9 coffee outside of "I am not sure whe intake." The RD st of R9's potassium increased coffee cof potassium in it. had not been docu correctly. The RD standard to with R9 and the far Even though staff of non-compliance, the risk verses benefits	If should document the intake all three meals and if they get of meal times. The RD stated, re staff are to chart the fluid ated the family was informed being high due to the consumption as coffee has a lot The RD further stated staff menting the fluid intake stated there was no risk verses R9's fluid intake, gone over mily members in R9's chart.	F 69	8		
	LPN-A stated the samount of fluid at a indicated there sho documented by stated LPN-A stated staff alert the nurse priothe nurse determinthat time. LPN-A sfluid intake, the CD previous interview, is looked at on a quatated she did not lidialysis is aware the fluid intake. During an interview LPN-E stated if a rethe nurses need to	taff should document the all three meals taken in. LPN-A wild be more fluid intake off in the computer for R9. Give R9 coffee and should reduce to giving R9 coffee and let e if R9 could have coffee at tated, "I do not look at [R9's] off Moes." (However, in a the CDM indicated fluid intake warterly basis). LPN-A further have any documentation that at R9 is noncompliant with on 8/10/18, at 12:53 p.m. esident is on a fluid restriction know the amount of the fluids. LPN-E stated they				

PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 698	During an interview TMA-B stated family how much they have facility. TMA-B stated input and output (18 However, R9 did not the facility policy E Fluids, dated 3/14, the amount of fluid of the intake and or indicated to docum consumed by the result of the facility must have appropriate comprovide nursing and resident safety and practicable physical well-being of each or resident assessment and considering the diagnoses of the facility must the appropriate comprovide nursing and resident assessment assessment and considering the diagnoses of the facility must the diagnoses of the facility must have appropriate comprovide nursing of each or resident assessment assessment assessment and considering the diagnoses of the faccordance with the at §483.70(e).	fluid intake in the MAR. on 8/10/18, at 1:16 p.m. y should tell the nursing staff re given R9 while they are at ted that R9 should have an (O) tab on the computer. of have one. Incouraging and Restricting indicated staff should record consumed on the intake side utput record. The policy also ent the amount of fluids esident during the shift. Staff 1)(2) Int Staff. Inve sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest II, mental, and psychosocial resident, as determined by ints and individual plans of care is number, acuity and cility's resident population in its facility must provide services irs of each of the following on a 24-hour basis to provide esidents in accordance with its ived under paragraph (e) of	F 7			9/21/18

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S483.35(a)(2 paragraph (6 designate a nurse on each This REQUI by: Based on or review, the first staffing was restorative in ambulation, exercises for R8). This has residents who services. Findings income See F688: Findings i	sing porse aid 2) Except of the license character of the license chara	ersonnel, including but not es. ept when waived under is section, the facility must ed nurse to serve as a charge	F 7	725	Immediate corrective action: *Education on alerting supervisor if to provide Restorative Program on day scheduled was provided to Restorative Aide(s) on 8/22/18. Edi included updated documentation to performed in POC from paper tool for Restorative. *Residents #8, #35 and #46 were evaluated by OT on 8/19/18 and th results were to continue Resident # #46 Programs ad Discontinue Res #35 and #54 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewed remains current. *All residents will be reviewed to determine need for Restorative Pro which program, how often and a pl assure these programs are provide Restorative Aide or Nursing staff. *Those residents needing Restorat Programs will have updated inform added to their Care Plan and POC Those assessed as being able to complete programs independently, longer warranted, or not in need of program as often will be updated a	ducation of be used me #8 and ident d and ogram, an to ed by tive extion Tasks non	

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F 725	Restorative Treatm 8/10/18, 3 of 13 op refused by R46, 1 documented unable opportunities were (NA). R46's Restoprinted on 8/10/18 13 opportunities si During interview or restorative nursing honest, I get pulled can't get to it all." pulled for appointed clinic for two or mosay, that it is her juprograms and whe on vacation, there	nent Schedule printed on opportunities were documented of 16 opportunities was le to participate, 9 of 13 documented not applicable orative Treatment Schedule revealed she received 0 out of nice starting RNP on 7/20/18. In 8/10/18, at 10:00 a.m. It assistant/ NA-A stated, "To be do to the floor a lot and I just NA-A went on to say, she gets nents then she will sit at the ore hours. NA-A went on to obt to do the restorative en she is pulled to the floor, or is no one to take her place.	F 7	focus will be on ability to programs to those in nee *All nursing staff and Retrained on 8/21/18 on the Program and need to proscheduled. *In the case of the Restorneeded to work as a care floor, the Restorative Cocassure the Programs mis be completed a different Date of completion: 9/21 Recurrence will be prevent Visual audits of 5 randor receiving a Restorative Program is occurring	d. storative staff e Restorative vide as rative Aide bein egiver on the ordinator will esed that day wi day that week. /18 nted by: n residents rogram will be lays to assure and is	
	R46's unit, indicate restorative aide ha providing the servium week of 7/16/18: -week of 7/23/18: days, and on vacative week of 7/30/18: dayweek of 8/6/18: days, sent on appoint a	NA-A reassigned to floor one NA-A reassigned to floor two pintment off campus one day. Ition on the computer dated I.m. indicated R54 nursing s walking 10 to 20 feet in the		documented. The results will be shared with the Q/for input on the need to ir decrease or discontinue to The correction will be mo *DON/Designee	API committee ncrease, the audits.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY MPLETED
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F 725	indicated R54 rece of 7/30/18 through RNP one day. The 8/12/18, indicated During an interview stated when she w probably did not go would get pulled to times a week for s stated a walking p residents but it did not enough staff of NA-A stated the m residents was a wa keep their independent	red 7/23/18 through 7/29/18, eived RNP one day. The week 8/5/18, indicated R54 received a week of 8/6/18 through R54 received RNP one day. If you not	F 7	25			
	7/9/18 to 7/29/18 of AROM BLE hip fle 10 reps/joint. Left ledgrees 5 times w -7/9/18 to 7/15/18: offered/completed -7/16/18 to 7/22/18 offered/completed -7/23/18 to 7/29/18 one time. No docu offered/completed dates. After 7/29/18, RNF times weekly to tw -7/30/18 to 8/5/18: completed or refus -8/6/18 to 8/12/18:	no documented RNP was on the 5 scheduled dates 3: no documented RNP was on the 5 scheduled dates 3: R35 was offered and refused mentation RNP was the remaining 4 scheduled P schedule changed from 5 ice weekly. R35 documented ROM was sed 2 of the 2 scheduled for RNP hursday and was not					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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F 725	R35's electronic Politistory task of resta AROM to right and flexion, extension a flexion and extension weekly. Left knee econtracture of -20 of 7/12/18 to 8/9/18 (2 documented 20 time documentation of cROM. During an interview when asked about and ankle R35 lauge much on my own." ROM therapy was obeen done for awhith During interview on reviewed the restor 7/9/18 to 8/9/18. -NA-A stated for the not offered 5 out of -NA-A stated for the not offered 5 out of was on vacation. -NA-A stated for the offered ROM the retimes. -NA-A stated for the scheduled 2 times at the scheduled 2 times at the scheduled 2 times at the scheduled 2 times.	int of Care (POC) Response prative rehabilitation directed: left lower extremities hip and abduction, knee and ankle on 10 reps per joint 2 times extension stretching for legrees extension. From 19 days) "not applicable" es. The POC lacked completion or refusals of the es. The POC lacked completion or refusals of the es. The POC lacked completion or refusals of the es. The POC lacked completion or refusals of the es. The POC lacked completion or refusals of the es. Rom with moving legs, knee hed and stated, "I'm pretty when asked the last time es. Es. B. 10/18 at 9:24 a.m. NA-A lative nursing schedule from es week of July 9th, ROM was the 5 scheduled times. Es week of July 16th, ROM was 5 scheduled times, as she es week of July 23rd, R35 was 1 one time. R35 was not mainder of the 4 scheduled es week of July 30th, R35 was and was refused or completed	F 72	25		

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	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
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F 3	B/22/18, indicated of program (RNP) of standard appropriate able to complete satisfies a view of Unit 2's Schedule directed, minutes 3 times a view aled the follow 17/9/18 to 7/15/18: offered or complete 17/16/18 to 7/22/18 offered or complete 17/30/18 to 8/5/18: of the 3 schedule 18/6/18 to 8/12/18: of the 3 schedule 18/6/18 to 8/12/18: of the 3 schedule 18/6/18 to 8/12/18: offered or complete 15 in 18/6/18 documented 18/6/18 docum	py evaluation only form, dated current restorative nursing standing frame x 10 minutes e as R8 and restorative aide afely. Restorative Treatment "standing frame 10 to 15 week or omnicylcle for 15 week." Documentation ing: no documented RNP was ed. In no documented RNP was ed.	F 72	5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245495	B. WING			10/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		10.20.10
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 725	stated when working gets pulled to work times a week. NA-program does not goulled. NA-A stated complete the RNP list. NA-A stated the electronic POC if the floor. NA-A reviewed Schedule from 7/9/-NA-A stated for the not completed. NA-pulled." -NA-A stated for the not offered/completion on Friday. NA-A stated for the not offered/completion on the unit or is on -NA-A stated for the offered and completed on the unit or is on -NA-A stated for the offered and completed naveled for the offered and completed on the unit or is on -NA-A stated for the offered and completed naveled for stated ROM was completed pulled to work on the -NA-A stated for the scheduled for ROM stated ROM was negot so busy helping plans on completin next day, 8/10/18. During an interview	on 8/9/18, at 1:29 p.m. NA-A ing as the restorative aide, she on the unit, sometimes up to 3 A stated the restorative get completed when she is it takes about 5 hours to for all 22 residents on the RNP is aides document under the ne ROM is completed on the ed the Restorative Treatment (18 to 8/9/18. It is a she was on vacation. It is week of July 9th, ROM was sted as she was on vacation. It is work on the unit and was on NA-A stated the ROM does when she gets pulled to work vacation. It is work on July 30th. ROM was sted on July	F 72			
	registered nurse (F	RN)-A stated the restorative				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245495	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	240400	D: *******	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	10/2018
				2801 SOUTH HIGHWAY 169		
EVERGR	EEN TERRACE			GRAND RAPIDS, MN 55744		
(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 APPROPOLICIENCY)) BE	(X5) COMPLETION DATE
F 921	gets pulled to work appointments with appointments with a floor nursing assistate restorative program completion of the RRNP was not consistated this is "partly stated the facility was program from 7 day restorative aide to a program from 7 day restorative aides are be made to ensure Safe/Functional/Sar CFR(s): 483.90(i) §483.90(i) Other Er The facility must program from 7 day residents, staff and This REQUIREMENT by: Based on observative review, the facility facility facility facility for sanitary bathrooms commodes for 4 of R114) reviewed for environment. In additional section of the sanitary program from 1 day for environment.	times" the restorative aide on the floor or sent out to residents. RN-A stated the ants are to complete the and document the COM in POC. RN-A stated the stently being completed. RN-A staffing and busy." RN-A as switching the restorative is to 5 days and hired another nelp solve the issue. On 8/10/18, at 11:53 a.m. ursing (IDON)-A stated she neerns with the RNP not being a stated if staff have difficulty in the nurse managers or e to contact her so a plan can the RNP gets completed. Initiary/Comfortable Environ invironmental Conditions ovide a safe, functional, ortable environment for the public. NT is not met as evidenced ailed to maintain clean and related to improperly fitted 4 residents (R28, R54, R5,	F 7		, #54 & I with a	9/21/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	СОМ	E SURVEY PLETED
		245495	B. WING			C 10/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 921	R28's admission Mated 6/3/18, indici impairment and harmalnutrition, bipolarinfection. During interview and 10:52 a.m. R28 states she could not use been flooding for the use a public bathrowater on the floor. Heard R28 talking, bathroom to check HK-A stated it was urine. HK-A cleaned During an interview 11:03 a.m. HK-A swith the high rise of fitting properly overstated the seat care because of the toil in the room may not other may not, and does not fit proper and urine and feces stated they have providing all over the highrise commode positioned poorly was ticking out 4-5 in the gap for urine to get floor. During an interview stated there are discommodes and the commodes and	Alinimum Data Sets (MDS) ated moderate cognitive and diagnoses of anemia, ar disease and a urinary track and observation on 8/9/18, at ated her toilet was flooded and it. R28 further stated it had the last month, so she had to foom. R28's bathroom had the housekeeper (HK)-A over came into her room and to out the water on the floor. In not water on the floor it was ad up the bathroom. It and observation on 8/9/18, at the tated the facility had a problem commodes in the facility not in the existing toilets. HK-A in not go back far enough the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise toilet and the lid. HK-A stated one person feed the high rise and on the lid. HK-B ferent size high rise feed on the fit correctly over the problems with urine getting on the problems.	F 9	Maintenance remains cur *All staff were educated of Environmental issues cite door issue as well as the rise commodes used ove 8/31/18. Date of completion: 9/21/ Recurrence will be prever *5 visual audits will be core on various units x 90 days bathroom doors in workin as raised toilet seats are results of these audits will the facility QAPI for input increase, decrease or dis audits. The correction will be more *Maintenance Director/Add *Maintenance Dir	on the ed including the removal of high remova	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COV	TE SURVEY MPLETED
		245495	B. WING			C / 10/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	· · · · · · · · · · · · · · · · · · ·	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 921	the floor. HK-B state far enough and this months. R54's quarterly MD good cognition, had depression, and rer During interview on stated she used the not get urine on the a bathroom and the on the floor. R54 st for her own use, no R54 stated the urine the highrise commolid of the toilet gets out leaving a gap. R5's annual MDS d cognition, and had d hypertension, demetrack infection. During an interview stated the high rise she urinates on the time she goes to the had to get down on stated she has to cl voids, and she had well. R5 stated she however, only one riget the commode of properly when she reported the problem.	ed the seats do not go back had been a problem for S dated 5/17/18, indicates I diagnoses of diabetes,	F 9.	21		

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

PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER EVERGREEN TERRACE STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED.		PLE CONSTRUCTION IG		TE SURVEY MPLETED C
EVERGREEN TERRACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) FREEIX TAG F 921 Continued From page 49 R114's diagnoses list indicated she was fully cognitive and was in facility short term for rehabilitation of her left surgical knee. During an interview on 8/9/18, at 2:07 p.m. R114 stated she had been voiding on her self, legs, on the floor and on her clothes due to a high rise commode herself, it is for her room mate. However, she has to use it as well. R114 stated night time is the worst because she does not have the strength to remove the high rise commode off the toilet and she had urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the loilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and on self. R114 stated she had reported this to a couple of nursing assistants and trained medication assistants about the highrise commodes for fitting properly and urinating on self and floor. R114 stated they looked at it, but nothing was done, so she gave up.			245495	B. WING _			
FREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 921 Continued From page 49 R114's diagnoses list indicated she was fully cognitive and was in facility short term for rehabilitation of her left surgical knee. During an interview on 8/9/18, at 2:07 p.m. R114 stated she had been voiding on her self, legs, on the floor and on her clothes due to a high rise commode over the existing toilet in the bathroom. R114 shared the toilet with two other women, her roommate (R5) and the women in the next room (R54). R114 stated she does not need the high rise commode herself, it is for her room mate. However, she has to use it as well. R114 stated night time is the worst because she does not have the strength to remove the high rise commode off the toilet and she had urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and on self. R114 stated she had reported this to a couple of nursing assistants and trained medication assistants about the highrise commodes not fitting properly and urinating on self and floor. R114 stated they looked at it, but nothing was done, so she gave up.					2801 SOUTH HIGHWAY 169	•	
R114's diagnoses list indicated she was fully cognitive and was in facility short term for rehabilitation of her left surgical knee. During an interview on 8/9/18, at 2:07 p.m. R114 stated she had been voiding on her self, legs, on the floor and on her clothes due to a high rise commode over the existing toilet in the bathroom. R114 shared the toilet with two other women, her roommate (R5) and the women in the next room (R54). R114 stated she does not need the high rise commode herself, it is for her room mate. However, she has to use it as well. R114 stated night time is the worst because she does not have the strength to remove the high rise commode off the toilet and she had urgency to void at night and voids on self and floor. R114 explained the commode does not fit properly over the toilet, the existing toilet lid pushes the high rise commode forward and therefore the urine goes on floor and on self. R114 stated she had reported this to a couple of nursing assistants and trained medication assistants about the highrise commodes not fitting properly and urinating on self and floor. R114 stated they looked at it, but nothing was done, so she gave up.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION
During a tour of the facility on 8/6/18, at 4:31 p.m. room 409's bathroom door was difficult to open for the surveyor. The resident in this room stated it was very difficult for the residents to open the bathroom door because the residents were in wheel chairs. During an environmental tour on 8/10/18, at 2:09	F 921	R114's diagnoses I cognitive and was rehabilitation of her During an interview stated she had been the floor and on he commode over the R114 shared the toroommate (R5) and (R54). R114 state rise commode hers However, she has night time is the work have the strength to commode off the townid at night and we explained the commode forw goes on floor and or reported this to a commode she to illet, the existing rise commode forw goes on floor and or reported this to a commode she to illet, the existing and floor. R114 nothing was done, A facility policy was During a tour of the room 409's bathroom for the surveyor. Tit was very difficult bathroom door become wheel chairs.	ist indicated she was fully in facility short term for releft surgical knee. You 8/9/18, at 2:07 p.m. R114 en voiding on her self, legs, on relothes due to a high rise existing toilet in the bathroom. Silet with two other women, here determined the women in the next room deshe does not need the high self, it is for her room mate. It is for her room mate. It is self, it is for her room mate. It is to use it as well. R114 stated orst because she does not or remove the high rise of illet and she had urgency to olds on self and floor. R114 mode does not fit properly overing toilet lid pushes the high rard and therefore the urine on self. R114 stated she had ouple of nursing assistants and assistants about the highrise on properly and urinating on a stated they looked at it, but so she gave up. It facility on 8/6/18, at 4:31 p.m. of the resident in this room stated for the residents to open the sause the residents were in	F 92	.1		

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

PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		245495	B. WING	i		C 08/10/2018	
	PROVIDER OR SUPPLIER			ST 28	REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 921	stated room 409's k rusted and the rust door is hard to open demonstrated the k open. The EVS ma time for rust to com bathroom door jam maintenance shoul a deep clean and a The EVS manager EVS manager of ro sticking. The facility Room F indicated maintena and bathroom door	service (EVS) manager pathroom door frame was has swollen so the bathroom n. The EVS manager pathroom door was difficult to anager stated it takes some neelike what is on room 409's b. The EVS manager stated do be checking the doors after fter someone leaves a room. Stated no one had notified the om 409's bathroom door jamb. Readiness Checklist undated not		921			

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

Printed: 08/14/2018 FORM APPROVED OMB NO. 0938-0391

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

245495

B. WING_

08/09/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EVERGREEN TERRACE		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)	GULATORY PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	K	000			
	FIRE SAFETY					
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Sire Marshal Division on August 9, 2018. time of this survey Evergreen Terrace 01 Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (Chapter 19 Existing Health Care.	State At the Main e 2012 ation				
	Evergreen Terrace is a 1-story building we partial basement and was constructed at different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of II(111) construction. In 1968 a one story without a basement, was constructed so west of the original building, and was det to be of Type II (111) construction. In 198 story addition was constructed to the nor original building, was determined to be a (111) construction, and is separated with fire barrier. This building is no longer use residents and is staff only. In 2001 two c story additions were built, one north of the wing (a chapel) and one south of the wes (special cares unit) which were determin Type II (111) construction and separated 2-hour fire barriers. The building is divide smoke zones by 30-minute and 2-hour fire barriers.	tial Type addition, uth and ermined 0 a one th of the type V a 2-hour d by other one e west st wing ed to be with ed into 8				
LABORATO	 RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE!	NTATIVE'S SIGNATU	IRE	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.

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

Printed: 08/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245495		B. WING		08/0	9/2018
ı	PROVIDER OR SUPPLIER REEN TERRACE		2801 S	ADDRESS, CITY, STATE, ZIP CODE I SOUTH HIGHWAY 169 ND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	The facility is fully sfire alarm system we corridor system and monitored for automotification. The facility has a concensus of 71 at the	age 1 sprinkler protected ar vith smoke detection d in all sleeping room matic fire department apacity of 93 beds are time of the survey. t 42 CFR Subpart 48	in the as that is t	K 000			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 29, 2018

Mr. Lee Harwarth, Administrator Evergreen Terrace 2801 South Highway 169 Grand Rapids, MN 55744

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5495028 and H5495058

Dear Mr. Harwarth:

The above facility was surveyed on August 6, 2018 through August 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5495058 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Evergreen Terrace August 29, 2018 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas, Unit Supervisor at (320) 223-7338 or brenda.fischer@state.mn.us.

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

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

Please feel free to call me with any questions.

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					С	
		00299	B. WING		08/1	0/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EVERGR	EEN TERRACE		JTH HIGHWA RAPIDS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is				
	found that the defici	iency or deficiencies cited				
		ected, a fine for each violation be assessed in accordance				
		ines promulgated by rule of				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lices the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infelicensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 09/07/18

TITLE

STATE FORM 6899 If continuation sheet 1 of 30 LD6V11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00299	B. WING		I	C 10/2018	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 000	you electronically. is necessary for State enter the word "cornetext. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's staff the following correction that you and identify the date in your completed at the tir investigation of completed. The completed. The completed. The completed at the tir investigation of completed. The completed are state Licensing federal software. The assigned to Minnes Nursing Homes. The assigned tag in column entitled "ID statute/rule out of complete statement, and replaces the "Torrection order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Cornection for	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. I, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. It investigation was also me of the licensing survey. An applaint H5495058 was mplaint was not substantiated. The ent of Health is documenting and numbers have been onto a state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis violation of the state statute a wing the surveyors findings Method of Correction and	2 000				

Minnesota Department of Health STATE FORM

ATE FORM LD6V11 If continuation sheet 2 of 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMPI	
			A. BUILDING.		C	
		00299	B. WING		08/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVERGR	REEN TERRACE		TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETE DATE
2 000	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC		2 000			
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.		2 800			9/21/18
	by: Based on observati review, the facility fa staffing was availab restorative nursing ambulation, range of exercises for 4 of 4 R8). This had the p residents who receive services. Findings include: See F688: The face	on, interview and document ailed to ensure sufficient ole in order to implement programs related to of motion and strengthening residents (R46, R54, R35, otential to affect all 22 eved restorative nursing sility failed to routinely provide es for 4 of 4 residents (R46,		Immediate corrective action: *Education on alerting supervisor if to provide Restorative Program on day scheduled was provided to Restorative Aide(s) on 8/22/18. Ed included updated documentation to performed in POC from paper tool for Restorative. *Residents #8, #35 and #46 were evaluated by OT on 8/19/18 and th results were to continue Resident # #46 Programs ad Discontinue Resi #35 and #54 Program.	any ucation be used ne £8 and	

Minnesota Department of Health

STATE FORM 6899 LD6V11 If continuation sheet 3 of 30

Minnesc	<u>ita Department of He</u>	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
=\/===		2801 SOU	TH HIGHWA	XY 169		
EVERGR	REEN TERRACE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 800	Continued From pa	ge 3	2 800			
2 800	R54, R35, R8) revie program. R46's physical theradated 7/15/18, analoutcome/clinical im worked well with the term care and will be program (RNP). R46's electronic tasindicated restorative 7/20/18 to 8/8/18. If cycle for 15 minutes bike for 15 minutes was a total of 13 op Restorative Treatm 8/10/18, 3 of 13 opprefused by R46, 1 of documented unable opportunities were (NA). R46's Restor printed on 8/10/18 r 13 opportunities sin During interview on restorative nursing honest, I get pulled can't get to it all." No pulled for appointmed clinic for two or more say, that it is her jour programs and where on vacation, there is Review of the week R46's unit, indicated	ewed with a restorative nursing apy progress note (PT PN) yesis of functional pression, indicated that R46 erapy. R46 will remain at long regin restorative nursing section, starting R46 was to use the Omni s, 3 times per week, and arm, 3 times per week. There reportunities as indicated on the rent Schedule printed on cortunities were documented of 16 opportunities was a to participate, 9 of 13 documented not applicable revealed she received 0 out of rice starting RNP on 7/20/18. 8/10/18, at 10:00 a.m. assistant/ NA-A stated, "To be to the floor a lot and I just IA-A went on to say, she gets ents then she will sit at the re hours. NA-A went on to b to do the restorative in she is pulled to the floor, or so no one to take her place.	2 800	Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewer remains current. *All residents will be reviewed to determine need for Restorative Promise and a passure these programs are provided Restorative Aide or Nursing staff. *Those residents needing Restoral Programs will have updated informadded to their Care Plan and POC Those assessed as being able to complete programs independently longer warranted, or not in need of program as often will be updated a focus will be on ability to provide the programs to those in need. *All nursing staff and Restorative trained on 8/21/18 on the Restorative trained on 8/21/18 on the Restorative Aid needed to work as a caregiver on floor, the Restorative Coordinator assure the Programs missed that be completed a different day that the Date of completion: 9/21/18	ogram, lan to ed by tive nation Tasks non f a and ne staff tive e being the will day will	
	say, that it is her jo programs and wher on vacation, there is Review of the week R46's unit, indicated restorative aide have	b to do the restorative n she is pulled to the floor, or s no one to take her place. Ily restorative worksheet for				

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 10/2018	
	PROVIDER OR SUPPLIER	2801 SOL	DRESS, CITY, ST JTH HIGHWAY RAPIDS, MN 5	169			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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) COMPLETE DATE	
2 800	-week of 7/16/18: Noweek of 7/23/18: Noweek of 7/23/18: Noweek of 7/30/18: Noweek of 8/6/18: Noweek of 8/10/18, at 11:57 a. The state of 11:57 a. The	NA-A on vacation this week. NA-A reassigned to floor two con two days. NA-A reassigned to floor one NA-A reassigned to floor two intment off campus one day. Ition on the computer dated m. indicated R54 nursing walking 10 to 20 feet in the imes a week. Restorative Treatment ed 7/23/18 through 7/29/18, ved RNP one day. The week 8/5/18, indicated R54 received week of 8/6/18 through R54 received RNP one day. I on 8/10/18, at 1:02 p.m. NA-A as on vacation the RNP t completed. NA-A stated she work on the floor a couple of nort staffing or ill calls. NA-A ogram was attempted for the not work because there were enough time to complete it. lost important thing for lking program for them to	2 800				
	7/9/18 to 7/29/18 di AROM BLE hip flex	reatment Schedule from rected the following for R35. tion, extension and abduction nee extension stretch of -20					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		C		
		00299	B. WING		1	0/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EVERGE	REEN TERRACE		TH HIGHWA APIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 800	offered/completed of 17/16/18 to 7/22/18 offered/completed of 17/23/18 to 7/29/18 one time. No docur offered/completed of dates. After 7/29/18, RNP times weekly to twice 17/30/18 to 8/5/18: completed or refused 18/6/18 to 8/12/18: on Tuesday and Theoffered/completed. R35's electronic Poly History task of restance AROM to right and flexion, extension and flexion, extension and flexion and extension weekly. Left knee extended 20 time documented 2	no documented RNP was on the 5 scheduled dates in no documented RNP was on the 5 scheduled dates in R35 was offered and refused mentation RNP was the remaining 4 scheduled schedule changed from 5 de weekly. R35 documented ROM was ed 2 of the 2 scheduled days. R35 was scheduled for RNP dursday and was not with the form of the control	2 800				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		00200	B. WING		00/4	
		00299			08/1	0/2018
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
EVERGR	REEN TERRACE		TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROPERTY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 6	2 800			
2 800	-NA-A stated for the not offered 5 out of was on vacationNA-A stated for the offered and refused offered ROM the retimesNA-A stated for the scheduled 2 times at the scheduled 2 times as the scheduled 2 timeNA-A stated during was not offered 2 or R8's physical theral 3/22/18, indicated oprogram (RNP) of sremains appropriate able to complete sat Review of Unit 2's Schedule directed, minutes 3 times a varieve aled the followiting -7/9/18 to 7/15/18: 10 offered or complete -7/16/18 to 7/22/18: 10 offered or complete -7/30/18 to 8/5/18: 10 offered or complete -7/30/18 to 8/5/18: 10 offered or complete -7/30/18 to 8/5/18: 10 offered or complete -7/30/18 to 8/12/18: 10 of	e week of July 16th, ROM was 5 scheduled times, as she week of July 23rd, R35 was 1 one time. R35 was not mainder of the 4 scheduled week of July 30th, R35 was and was refused or completed res. In the week of August 6th. ROM of the 2 scheduled days. The week of August 6th. ROM of the 2 scheduled days.	2 800			
	8/9/18 (28 days) dir	ing rehab from 7/13/18 to ected, "standing frame 10 -15 ek. If [R8] will not stand have				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.		С	
		00299	B. WING		1	0/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVEDGE	REEN TERRACE	2801 SOU	TH HIGHWA	Y 169		
EVENGR	LEN TERRACE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 7	2 800			
	[R8]] complete 15 r Staff documented " was completed one	ninutes on the onmicycle." Not Applicable" 17 times. RNP time during the 28 day time I dates were blank under				
	During an interview on 8/8/18, at 3:48 p.m. family member (FM)-J stated she visits almost every afternoon. FM-J stated at times staff have R8 riding the bicycle, but wished they would do it more often. FM-J stated "I think they have given up." FM-J stated she had not seen the stand platform in use.					
	stated when workin gets pulled to work times a week. NA-A program does not goulled. NA-A stated complete the RNP list. NA-A stated the electronic POC if the floor. NA-A reviewe Schedule from 7/9/-NA-A stated for the not completed. NA-pulled." -NA-A stated for the not offered/completed. NA-A stated for the not offered/completed of the not offered of the	e week of July 9th, ROM was A stated, "I must have been e week of July 16th, ROM was ed as she was on vacation. e week of July 23rd, ROM was ed. NA-A stated she must o work on the unit and was on NA-A stated the ROM does when she gets pulled to work				
	offered and comple	e week of July 30th. ROM was ted on July 30th. NA-A stated ed 2 of the 3 scheduled days. OM was not				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 10/2018
	PROVIDER OR SUPPLIER	2801 SOU	DRESS, CITY, S TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	pulled to work on the -NA-A stated for the scheduled for ROM stated ROM was not got so busy helping plans on completing next day, 8/10/18. During an interview registered nurse (R program is being che RN-A stated "someting gets pulled to work appointments with restorative program completion of the Render RNP was not consistent this is "partly stated the facility was program from 7 day restorative aide to help to be made to ensure SUGGESTED MET The director of nursidevelop, review, an procedures to ensure available to complete.	on August 3rd, as she was e unit. week of August 6th, R8 was on the 6th and 8th. NA-A of offered to R8 as she "just on the wing." NA-A stated she gethe ROM as scheduled the on 8/10/18, at 11:13 a.m. N)-A stated the restorative ranged from 7 days to 5 days. The restorative aide on the floor or sent out to residents. RN-A stated the rand document the OM in POC. RN-A stated the stently being completed. RN-A staffing and busy." RN-A as switching the restorative rs to 5 days and hired another	2 800			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	,	(3) DATE SU	
	-		A. BUILDING:			
		00299	B. WING		C 08/10 /	2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVERGR	EEN TERRACE		TH HIGHWA			
			APIDS, MN			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
2 800	Continued From pa	ge 9	2 800			
		ongoing compliance and to the quality assurance				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895		9	9/21/18
	that is directed towarthrough positioning implemented and macomprehensive resion nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	receives appropriate	n a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Based on observation review, the facility factorisms are reviewed for 3 of 3 reserviewed for restorations include: R46's 14 day prosp MDS on 7/11/18, includes.	ent is not met as evidenced on, interview, and document ailed to provide restorative maintain mobility and range of sidents (R46, R35, R8) ative nursing programs. ective payment system (PPS) dicated a brief interview for S) score of 7 (severe cognitive		Immediate corrective action: *Education on alerting supervisor if use to provide Restorative Program on a day scheduled was provided to Restorative Aide(s) on 8/22/18. Eduincluded updated documentation to be performed in POC from paper tool use for Restorative. *Resident #8, #35, and #46 were evaluated by OT on 8/19/18 and the results were to continue resident #8 #46 Programs and Discontinue Resi	cation be sed	

Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l c	
		00299	00299 B. WING		08/10/2018	
			ı		1 00/1	0,2010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVEDGE	REEN TERRACE	2801 SOU	TH HIGHWA	XY 169		
LVLINOIN	LLIN ILINIAOL	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 10	2 895			
2 895	impairment). R46's 8/7/18, indicated the encephalopathy undisorder of the brain hemiparesis following R46's 14 day MDS required extensive a locomotion on unit, toilet use and personal part of the complete heat assistance of one stable for breakfast, able to complete heat assistance. R46's Physical The start of care 6/25/18 referred due to a deencephalopathy, UTR46's physical there dated 7/15/18, analoutcome/clinical imworked well with the term care and will be program (RNP). R46's PT PN dated instructions indicate skilled nursing facility R46's Occupation Ta start of care on 6/25/18 referred the care and will be program (RNP).	B Diagnosis Report printed on e following diagnoses: specified (any disease or n), epilepsy, hemiplegia and ng cerebral infarction (stroke). dated 7/11/18, indicated R46 assistance with bed mobility, locomotion off unit, dressing, and hygiene. on 8/10/18, at 9:32 a.m. R46 y propelling her wheelchair ning room. She required at taff to propel to her spot at the After meal set up, R46 was er breakfast with minimal rapy Plan of Care indicated and evit and epilepsy. apy progress note (PT PN) ysis of functional pression, indicated that R46 erapy. R46 will remain at long pegin restorative nursing 7/20/18, discharge plans and ed, R46 will remain in this ity on RNP.	2 895	#35 Program. Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewer remains current. *All residents will be reviewed to determine need for Restorative Program, how often and a passure these programs are provid Restorative Aide or Nursing staff. *Those residents needing Restorative Programs will have updated informadded to their Care Plan and POC *All nursing staff and Restorative strained on 8/21/18 on the Restorative Strained on 8/21/18 on the Restorative Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random resident receiving a Restorative Program we conducted weekly x 90 days to assert Program is occurring and is document to the QAPI committee for input need to increase, decrease or discontinuation. The correction will be monitored be *DON/designee	ogram, lan to ed by ative mation c Tasks. staff tive atswell be sure the mented. ared on the continue	
	7/20/18, referred du	/25/18 with end of care ue to a decline of self-cares ty due to seizures, and				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			A. DOILDING.		c	
		00299	B. WING		I	, 0/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FVFRGR	EEN TERRACE		TH HIGHWA			
LVERO		GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 11	2 895			
	R46's occupational PN) dated 7/17/18, indicated plan to ad continue to educate program prior to en R46's OT PN dated services with home R46's electronic tasindicated restorative 7/20/18 to 8/8/18. If cycle for 15 minutes bike for 15 minutes was a total of 13 op Restorative Treatm 8/10/18, 3 of 13 op refused by R46, 1 of documented unable opportunities were (NA). R46's Restor printed on 8/10/18, 13 opportunities sin During interview on restorative nursing	therapy progress note (OT update to treatment approach, dress discharge plan and restorative nursing on dof week discharge. 7/20/18, discharged from OT exercise program with RNP. k tracking printed on 8/10/18, e nursing section, starting R46 was to use the Omnis, 3 times per week, and arm, 3 times per week. There exportunities as indicated on the ent Schedule printed on cortunities were documented of 16 opportunities was e to participate, 9 of 13 documented not applicable retive Treatment Schedule revealed she received 0 out of ice starting RNP on 7/20/18. 8/10/18, at 10:00 a.m. assistant/ NA-A stated that NA in the restorative program is				
	not completed for wany place to chart w	whatever reason, there is not why it did not occur other than				
	the resident refusal box or unable to participate box. NA-A stated, "To be honest, I get pulled to the floor a lot and I just can't get to it all." NA-A					
	then she will sit at the	e gets pulled for appointments ne clinic for two or more ets back it is time to help feed				
	residents not leavin then it is time for he	g much time after lunch and er to leave. NA-A went on to to do the restorative				
	3	she is pulled to the floor, or				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00200	B. WING		00/4	
NAME OF I	PROVIDER OR SUPPLIER	00299		CTATE ZID CODE	00/1	0/2018
			TH HIGHWA	STATE, ZIP CODE Y 169		
EVERGE	REEN TERRACE		APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	ILD BE	(X5) COMPLETE DATE
2 895	on vacation, there in NA-A stated register gets pulled to the fluorestorative nursing. R46's PT plan of coorder for evaluation 8/2/18-8/4/18. Initial was no functional distribution of the coorder for evaluation 8/2/18-8/4/18. Evaluation 8/2/18-8/4/18. Evaluation 8/2/18-8/4/18. Evaluation 8/2/18-8/4/18. Evaluation state function has a restorative nursing that is a restorative nursing extensive staff assist MDS indicated R35 to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assist to stabilize with staffrom a seated to stabed to a chair. The limitations to R35's upper and lower extensive staff assistant and the staff assi	s no one to take her place. Fred nurse (RN)-A is aware she foor, making it difficult to get completed. Fred ated 8/7/18, indicated an a only after being hospitalized al assessment revealed there ecline noted and current program remain appropriate. Fred ated 8/8/18 indicated an a only after being hospitalized duation indicates R46 does not conal decline at this time. R46 fursing program and will rogram. S dated 6/28/18, indicated impairment. R35 required stance with transfers. The forwas not steady and only able fif assistance when moving finding position and from the MDS further identified range of motion (ROM) of tremity on one side. Frequency Fr	2 895	DETIGIENT		
	(BLE) hip flexion, e and ankle flexion a 5 times weekly. Lef	xtension and abduction. Knee and extension 10 repetition/joint three extension stretching for legree extension. The care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		7 ti Boilebii (o.			С	
	00299	B. WING		l l	10/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EVERGREEN TERRACE		ITH HIGHWA RAPIDS, MN				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
frequency of the RN The care plan direct with transfers using assist with transfers assistance of 1 staff Review of Unit 2's F Schedule from 7/9/f following: AROM BLE hip flex 10 reps/joint. Left k degrees 5 times we -7/9/18 to 7/15/18: n offered/completed of -7/16/18 to 7/22/18: offered/completed of -7/23/18 to 7/29/18: one time. No docum offered/completed t dates. After 7/29/18, RNP times weekly to twic -7/30/18 to 8/5/18: I completed or refuse -8/6/18 to 8/12/18: I on Tuesday and Th offered/completed. R35's electronic Po History task of resto AROM to right and flexion, extension a flexion and extension weekly. Left knee e contracture of -20 of 7/12/18 to 8/9/18, (2 documented 20 tim	24/18, decreasing the NP program to 2 times weekly. Ited one staff assisted R35 a PAL (mechanical device to a) and required extensive if with bed mobility. Restorative Treatment 18 to 7/29/18, directed the cion, extension and abduction nee extension stretch of -20 ekly. In a documented RNP was on the 5 scheduled dates a no documented RNP was on the 5 scheduled dates are R35 was offered and refused mentation RNP was the remaining 4 scheduled scheduled scheduled from 5	2 895				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00299	D. WING		08/1	0/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EVERGE	EVERGREEN TERRACE 2801 SOU GRAND F					
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 895	Continued From pa	ge 14	2 895			
	restorative nursing restorative nursing 8/9/18NA-A stated for the not offered 5 out of -NA-A stated for the not offered 5 out of was on vacationNA-A stated for the offered and refused offered ROM the retimesNA-A stated for the scheduled 2 times at the scheduled 2 times are scheduled 2 timesNA-A stated during was not offered 2 o	g the week of August 6th. ROM f the 2 scheduled days. on 8/10/18, at 9:07 a.m. when with moving legs, knee and				
	ankle R35 laughed on my own." When	and stated, "I'm pretty much asked the last time ROM I R35 stated, "it has not been				
	and long term memextensive assistance indicated R8 was not stabilize with staff at a seated to standing a chair. The MDS from R8's ROM of lower R8's electronic Diagonal control of the standing at the standi	dated 5/10/18, indicated short fory impairment. R8 required be with transfers. The MDS of steady and only able to assistance when moving from g position and from the bed to further identified limitations to extremity on one side. Ignosis Report dated 8/10/18, sof Alzheimer's disease and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING		08/1	0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,1 3333	
FVFRGE	REEN TERRACE		TH HIGHWA			
			APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 15	2 895			
	generalized muscle	weakness.				
	3/22/18, indicated c	by evaluation only form, dated urrent RNP of standing frame ns appropriate as R8 and e to complete safely.				
	a RNP. The care plants a week standing frame, to comnicycle to mainta	d 6/5/18, indicated R8 was on an directed to use a standing ek. If unable to use the complete 15 minutes on the ain ROM. The care plan ssisted R8 with transfers				
	Schedule directed "minutes 3 times a warevealed the followir-7/9/18 to 7/15/18: roffered or complete -7/16/18 to 7/22/18: offered or complete -7/23/18 to 7/29/18: offered or complete -7/30/18 to 8/5/18: offered or complete -7/30/18 to 8/5/18: offered or scheduled	no documented RNP was d. no documented RNP was d. no documented RNP was d. documented ROM completed d days. no documented RNP was				
	nursing rehab from directed "standing f week. If [R8] will no 15 minutes on the c "Not Applicable" 17 one time during the	C Response History task of 7/13/18 to 8/9/18 (28 days) rame 10 -15 minutes 2 times t stand have [R8]] complete onmicycle." Staff documented times. RNP was completed 28 day time frame on 8/2/18. K under resident refused.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						С
		00299	B. WING		08/	10/2018
	PROVIDER OR SUPPLIER	2801 SOU	TH HIGHWA			
	Т		APIDS, MN	55/44		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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) COMPLETE DATE
2 895	Continued From pa	ge 16	2 895			
	member (FM)-J sta afternoon. FM-J sta riding the bicycle, b more often. FM-J st up." FM-J stated sh platform in use.	on 8/8/18, at 3:48 p.m. family ted she visits almost every ated at times staff have R8 ut wished they would do it tated, "I think they have given the had not seen the stand on 8/9/18, at 9:26 a.m.				
	assistants working ROM for residents i NA-D stated the res ROM program. NA-by the aide working documented in POO	NA)-D stated the nursing on the floor do not complete in the restorative program. Storative aide completes the A stated if ROM is completed on the unit, the completion is C. NA-D stated not applicable d when the ROM is not offered				
	restorative aide/ NA the restorative aide the unit, sometimes stated the restorative completed when sh takes about 5 hours 22 residents on the aides document una ROM is completed the Restorative Tresto 8/9/18. -NA-A stated for the not completed. " -NA-A stated for the not offered/complet -NA-A stated for the not offered/complet have been pulled to	on 8/9/18, at 1:29 p.m. A-A stated when working as, she gets pulled to work on a up to 3 times a week. NA-A we program does not get ie is pulled. NA-A stated it is to complete the RNP for all RNP list. NA-A stated the der the electronic POC if the on the floor. NA-A reviewed atment Schedule from 7/9/18 is week of July 9th, ROM was a stated, "I must have been if week of July 16th, ROM was ied as she was on vacation. If week of July 23rd, ROM was ied. NA-A stated she must of work on the unit and was on NA-A stated the ROM does				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		C	
	00299	B. WING		1) 0/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
EVERGREEN TERRACE		TH HIGHWA			
	GRAND R	APIDS, MN	55744		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JIST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
on the unit or is on vaca-NA-A stated for the we offered and completed ROM was completed 2 NA-A stated R8's ROM offered/completed on A pulled to work on the u-NA-A stated for the we scheduled for ROM on stated ROM was not of got so busy helping on plans on completing the next day, 8/10/18. During an interview on physical therapist (PT) a screening to identify since PT discontinued stated the restorative a rehab department. Whaide is pulled, PT-K stated the restorative a rehab department whaide is pulled, PT-K stated she seneither resident had a sum. PT-K stated she seneither resident had a sum of the restoration of the restoration of the restoration work on the floor or seresidents. RN-A stated assistants are to compared program and document ROM in POC. RN-A stated consistently being compartly staffing and bus was switching the restoration.	en she gets pulled to work cation. eek of July 30th. ROM was ton July 30th. NA-A stated 2 of the 3 scheduled days. If was not August 3rd, as she was unit. eek of August 6th, R8 was in the 6th and 8th. NA-A offered to R8 as she "just in the wing." NA-A stated she he ROM as scheduled the ene ROM as scheduled the if a decline had occurred on R8 and R35. PT-K caide gets pulled out of the enen asked how often the enen asked how often the eated, "you would have to quite frequently." At 10:03 screened R8 and R35 and decline. 18/10/18, at 11:13 a.m. rative program is being to 5 days. RN-A stated rative aide gets pulled to ent out to appointments with it the floor nursing olete the restorative in the completion of the	2 895			

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00299	B. WING		08/1	0/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
EVERGR	EVERGREEN TERRACE 2801 SC GRAND					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	 ige 18	2 895			
	interim director of n was unaware of cor completed. IDON-A completing the RNF restorative aides ar	on 8/10/18, at 11:53 a.m. nursing (IDON)-A stated she neerns with the RNP not being A stated if staff have difficulty P, the nurse managers or the to contact her so a plan can the RNP gets completed.				
	1/18, indicated restricted document the progress care computer. Do restorative progress documented quarter progress notes. Resummary indicated resident needing regain or maintain hig Responsible for progress.	ursing Program policy revised corative nursing staff will ram performed on the point of ocumentation of the resident's swill be assessed and erly by the RN manager in the estorative nursing job responsible to work with estorative nursing measure to ghest functional level. Eviding consistency between discrept of the corry over on a daily basis.				
	The director of nurs develop, review, an procedures for rang education to the sta could develop moni	THODS OF CORRECTION: sing (DON) or designee could ad /or revise policies and ge of motion and provide aff. The DON or designee itoring systems to ensure e and report those results to ce committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			9/21/18
	Subp. 6. Activities	of daily living. Based on the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S	
,	o. oo.u.20o		A. BUILDING:	<u></u>		
		00299	B. WING		C 08/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
			TH HIGHWA	,		
EVERGREEN TERRACE GRAND I		GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 19	2 915			
	home must ensure A. a resident is treatments and ser abilities in activities deterioration is a no the resident's condi part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the as, and groom; d ambulate;				
	by: Based on observati review, the facility for nursing services to for 1 of 1 resident (nursing programs at R54's quarterly Min 5/17/18, indicated FR54 needed extens transfers, moving frosition, and walking impairment on both R54's care plan data restorative nursing ambulate 40 feet in	on, interview, and document ailed to provide restorative maintain ability to ambulate R54) reviewed for restorative and have ability to ambulate. Immum Data Set (MDS) dated R54's cognition was intact. Sive assistance of one staff for form seated surface to standing ag. R54 had lower extremity sides. Interviewed for restorative and have ability to ambulate.		Immediate corrective action: *Education on alerting supervisor to provide Restorative Program or day scheduled was provided to Restorative Aide on 8/22/18. *Resident #54 was evaluated by 8/19/18 and it was determined the was able to perform her Functiona Maintenance exercised independent olonger needed the existing FNF Action as it applies to others: *The Policy and Procedure for the Restorative Program was reviewer emains current. *All residents will be reviewed to determine need for Restorative program.	or any or on or resident al ently and or. d and	

transfer belt and wheelchair three times a week

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which program, how often and a plan to

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´con		(X3) DATE	
			A. BUILDING:		C	
00299		B. WING		1	0/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVERGR	REEN TERRACE		TH HIGHWA APIDS, MN			
(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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 20	2 915			
2 915	for four weeks. R54's Diagnosis Reindicated R54's diagright humerus fraction. During an observation at 11:42 a.m. R54 wr R54's room. R54 some assistant (NA)-A corestorative program R54's task informat 8/10/18, at 11:57 a. rehab program was parallel bars three to A review of Unit 4 R Schedule form date indicated R54 recei of 7/30/18 through 8 RNP one day. The 8/12/18, indicated F During an interview stated, "When I was did not get complete pulled to work on the week for short staff walking program was but it did not work be enough staff or eno stated the most impa walking program in a walk	eport provided 8/10/18, gnoses included diabetes, ure, and left leg below the fon and interview on 8/10/18, was sitting in the wheelchair in tated once in a while nursing mes in to help with her i ion on the computer dated m. indicated R54's nursing walking 10 to 20 feet in the	2 915	assure these programs are provid Restorative Aide or Nursing staff. All nursing staff and Restorative strained on 8/21/18 on the Restorat Program and need to provide as scheduled. Date of completion: 9/21/18 Recurrence will be prevented by: *Visual audits of 5 random resider receiving a Restorative Program v conducted weekly x 90 days to as Program is occurring and is docur. The results of the audits will be sh with the QAPI committee for input need to increase, decrease or disc the audits. The correction will be monitored b *DON/Designee	ataff tive ats vill be sure the nented. ared on the continue	
	interim director of n	on 8/10/18, at 11:53 a.m. ursing (IDON)-A stated she ncerns with the RNP not being				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		c		
		00299	B. WING		1	0/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EVERGR	EEN TERRACE		TH HIGHWA				
0/0.15	CHIMMA DV CTA	TEMENT OF DEFICIENCIES	APIDS, MN		ONI	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 915	Continued From pa	ge 21	2 915				
	completing the RNF restorative aides ar	stated if staff have difficulty P, the nurse managers or e to contact her so a plan can the RNP gets completed.					
	1/18, indicated rest document the progress care computer. Do restorative progress documented quarte progress notes. Re summary indicated resident needing re gain or maintain hig Responsible for pro-	orative nursing staff will ram performed on the point of cumentation of the resident's will be assessed and brilly by the RN manager in the destorative nursing job responsible to work with storative nursing measure to ghest functional level. Eviding consistency between dicarry over on a daily basis.					
	The director of nurs develop, review, an procedures for rest provide education to designee could devensure ongoing cor	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and orative nursing programs and to the staff. The DON or relop monitoring systems to empliance and report those y assurance committee.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one					
21695	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			9/21/18	
	provide housekeep necessary to mainta comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVERGE	REEN TERRACE	2801 SOU	TH HIGHWA	Y 169		
EVENGR	CEN TERRACE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 22	21695			
	and furnishings.					
	by: Based on observatireview, the facility fasanitary bathrooms commodes for 4 of R114) reviewed for environment. In add working order of a lateral Findings include: R28's admission Midated 6/3/18, indicating airment and had malnutrition, bipolar infection. During interview and 10:52 a.m. R28 starshe could not use if been flooding for the use a public bathroom water on the floor. The ard R28 talking, bathroom to check HK-A stated it was a urine. HK-A cleaned During an interview 11:03 a.m. HK-A stawith the high rise confitting properly over stated the seat can because of the toile in the room may ne	dition, failed to ensure proper pathroom door (room 409). Inimum Data Sets (MDS) atted moderate cognitive didiagnoses of anemia, disease and a urinary track disease and		Immediate corrective action: *The door for bathroom #409 was on 9/5/18. *the high rise commodes that are will be removed and replaced with option based on the resident need. Action as it applies to others: *The Procedure for Preventive Maintenance remains current. *all staff were trained on resident on 8/31/18. Date of completion: 9/21/18 Recurrence will be prevented by: *5 visual audits will be conducted on various units x 90 days to assubathroom doors in working order as raised toilet seats are not ill fitti results of these audits will be shar the facility QAPI for input on the nincrease, decrease or discontinue audits. The correction will be monitored be *Maintenance Director/Administra	ill-fitting a better l. dignity weekly life as well life med with life eed to life the life y:	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:		С		
		00299	B. WING		1	0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVERGR	EEN TERRACE		TH HIGHWA APIDS, MN			
(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) COMPLETE DATE
21695	and urine and feces stated they have pr voiding all over the highrise commode positioned poorly w sticking out 4-5 incl gap for urine to get floor. During an interview stated there are difficommodes and the toilet so they have p the floor. HK-B stat far enough and this months. R54's quarterly MD good cognition, had depression, and rer During interview on stated she used the not get urine on the a bathroom and the on the floor. R54 st for her own use, no R54 stated the urint the highrise commolid of the toilet gets out leaving a gap. R5's annual MDS d cognition, and had hypertension, demonstrack infection.	y (she demonstrated the gap) is gets on the floor. HK-A oblems with other residents bathroom floors as well. The was noted to be fitting/ ith the front portion of seat nes leaving a large enough on person, clothes and on the on 8/9/18, at 1:56 p.m. HK-B ferent size high rise y do not fit correctly over the problems with urine getting on ed the seats do not go back had been a problem for S dated 5/17/18, indicates diagnoses of diabetes, nal insufficiency. 8/9/18, at 11:45 a.m. R54 inhighrise commode and does in the high rise commode is ther bathroom roommate urinates ated the high rise commode is the bathroom roommate use. In egets on the floor because ode does not fit properly, the in the way and it sticks to far ated 5/3/18, indicates good diagnoses including diabetes, entia, depression and a urinary entities.	21695			
		on 8/9/18 at 11:49 a.m. R5 commode is out to far and				

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AND DI AN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
	00299	B. WING		08/1) 0/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EVERGREEN TERRACE		TH HIGHWA				
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE	
21695 Continued From pa	ge 24	21695				
she urinates on the time she goes to the had to get down on stated she has to cl voids, and she had well. R5 stated she however, only one riget the commode of properly when she is reported the problem nurses but could not were. R114's diagnoses licognitive and was in rehabilitation of her. During an interview stated she had been the floor and on her commode over the R114 shared the toil roommate (R5) and (R54). R114 stated rise commode hers. However, she has to night time is the wool have the strength to commode off the tovoid at night and volve explained the commode forward goes on floor and oreported this to a control to the commode of the toles.	floor, and it happened every e bathroom. R5 stated she the floor to clean it up. R5 lean up urine every time she gotten her own pants wet as had told staff about it registered nurse had helped over the toilet correctly so it fits used it. R5 stated she had m to housekeeping and other of identify who these nurses ast indicated she was fully in facility short term for left surgical knee. on 8/9/18, at 2:07 p.m. R114 in voiding on her self, legs, on a clothes due to a high rise existing toilet in the bathroom. It is for her room mate, it is for her room mate. It is for her room mate, it is for her room mate, it is so use it as well. R114 stated and she had urgency to bids on self and floor. R114 mode does not fit properly overing toilet lid pushes the high and and therefore the urine in self. R114 stated she had ouple of nursing assistants and assistants about the highrise ing properly and urinating on stated they looked at it, but					

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00299		B. WING			0/2048	
NAME OF I				PTATE ZID CODE	00/1	0/2018
	PROVIDER OR SUPPLIER		TH HIGHWA	STATE, ZIP CODE NY 169		
EVERGR	REEN TERRACE		APIDS, MN			
(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)	JLD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 25	21695			
	A facility policy was	requested and not received.				
	room 409's bathroo for the surveyor. This it was very difficult to	facility on 8/6/18, at 4:31 p.m. om door was difficult to open he resident in this room stated for the residents to open the ause the residents were in				
	During an environmental tour on 8/10/18, at 2:09 p.m. environmental service (EVS) manager stated room 409's bathroom door frame was rusted and the rust has swollen so the bathroom door is hard to open. The EVS manager demonstrated the bathroom door was difficult to open. The EVS manager stated it takes some time for rust to come like what is on room 409's bathroom door jamb. The EVS manager stated maintenance should be checking the doors after a deep clean and after someone leaves a room. The EVS manager stated no one had notified the EVS manager of room 409's bathroom door jamb sticking.					
	indicated maintenal and bathroom door	Readiness Checklist undated nce would check room entry, s, jambs and hinges for signs If unable to fix immediately,				
	The director of nursidevelop, review, an procedures for care provide education to improperly fitting demaintenance depart	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and e equipment placement and o the staff on reporting evices. In addition, the tment could check all ensure proper working order.				

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Minneso	<u>ita Department of He</u>	ealth			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
711101 12/111	152111110111011101110111		A. BUILDING:		
		B. WING		С	
		00299	D. WING		08/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
EVERGR	EEN TERRACE		TH HIGHWA		
		GRAND R	APIDS, MN	55744	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI
21695	Continued From pa	ge 26	21695		
	systems to ensure or report those results committee.	nee could develop monitoring ongoing compliance and to the quality assurance			
21805	MN St. Statute 144 Residents of HC Fa	-	21805		9/21/18
	Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide a dignified of 1 residents (R114) who had		Immediate Corrective Action: Resident #114 was discharged on 8.	/27/18
		se commode resulting in		Action as it applies to others: *The Policy and Procedure for Resid	
	Findings include:			dignity was reviewed and remains countries. *The residents who could be affecte	urrent.
	completed as R114 facility for a short te	ata Set (MDS) had not been was recently admitted to erm stay following a right knee ed rehabilitation and t knee.		who's bathrooms have high rise commodes, will have them removed needed replaced with a better option *All nursing staff were trained on residignity on 8/31/18.	٦.
	intact, makes own oneeds, independent	ndicated R114 was cognitively decisions, communicate t with activities of daily living, ansfers self with walker, and		Pate of completion: 9/21/18 Recurrence will be prevented by: *Audits of 5 random residents will be interviewed weekly x 90 days to ass	

STATE FORM 6899 If continuation sheet 27 of 30 LD6V11

Minneso	<u>ta Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00299	B. WING		08/1	; 0/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVERGR	EEN TERRACE		TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 27	21805			
	· ·			DEFICIENCY)		
	stated there are diff commodes and the toilet so they have p the floor. HK-B stat	on 8/9/18, at 1:56 p.m. HK-B ferent size high rise y do not fit correctly over the problems with urine getting on ed the seats do not go back has been a problem for				
	stated she has bee the floor and on her commode over the	on 8/9/18, at 2:07 p.m. R114 n voiding on her self, legs, on clothes due to the high rise existing toilet in the bathroom.				

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women, her room mate and a women in the next

Minneso	<u>ta Department of He</u>	alth				
AND DIANIOE CORRECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00299	B. WING		08/1) 0/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			TH HIGHWA			
EVERGR	EEN TERRACE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	hurts her surgical lea a healing incision wo following a left total prior. R114 stated so rise commode hers. However, since it is has to use it. R114 because she does a remove the high rise she has urgency to and floor. R114 exp fit properly over the pushes the high rise therefore the urine stated she has wipe with her own clothe embarrassed when stated she did not woided all over the fishe cleaned it up her R114 stated she fee in trouble and that so R114 stated she do is safe for her as shis on the floor. R114 to a couple of nursimedication adminishigh-rise commode urinating on self and recall who she talked at it, but nothing was the recommoded of the facility Residen Nursing Procedures.	the high rise commode also be when she sits on it, she has ith staples and a dressing knee revision from the week the does not need the high elf, it is for her room mate. Over the existing toilet she stated at night it is the worse not have the strength to be commode off the toilet and woid at night and voids on selfolained the commode does not toilet, the existing toilet lide commode forward and goes on floor and self. R114 and up the urine on the floor	21805			
	indicates residents					

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AND DLAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00000	B. WING		00/4	
		00299	D: 11110		08/1	0/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EVERGE	REEN TERRACE		ITH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	SUGGESTED MET The director of nurs develop, review, an procedures for dign the staff on providin The DON or design systems to ensure of report those results committee.	ge 29 (HODS OF CORRECTION: sing (DON) or designee could d /or revise policies and ity and provide education to ng a dignified environment. ee could develop monitoring ongoing compliance and to the quality assurance R CORRECTION: Twenty-one	21805			