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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02DZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00035

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245516**

2. STATE VENDOR OR MEDICAID NO. (L2) **508613200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAURELS PEAK CARE & REHABILITATION CENTER**
(L4) **700 JAMES AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **8/2/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NE II 12/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/12/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245516

October 12, 2017
By e-POC Only

Laurels Peak Care & Rehabilitation Center
Attn: Administrator
700 James Avenue
Mankato, MN 56001

Dear Administrator:

SUBJECT: SURVEY FINDINGS AND IMPOSITION/DISPOSTION OF REMEDIES
Cycle Start Date: May 4, 2017

SURVEY RESULTS
On May 3, 2017, May 4, 2017, June 1, 2017, June 9, 2017, June 20, 2017, and July 11, 2017, Health Surveys and Life Safety Code (LSC) Surveys were completed at Laurels Peak Care & Rehabilitation Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level G, cited as follows:

- F319 -- S/S: G -- 483.40(b)(1) -- Tx/Svc for Mental/Psychosocial Difficulties
- F323 -- S/S: G -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on May 18, 2017 and July 6, 2017, of the imposition of the following remedy, as well as your appeal rights:

- State Monitoring effective May 23, 2017
- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 4, 2017

Based on the survey findings, the MDH notified you they were recommending that the CMS impose an additional remedy, as follows:

- Federal Civil Money Penalty

The authority for the imposition of remedies is contained in §§1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The MDH conducted a revisit at your facility on August 2, 2017, and found that your facility was in substantial compliance as of July 31, 2017. As a result, the following remedies will not go into effect:

- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective August 4, 2017, is rescinded
- Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective November 4, 2017, will not be imposed

However, based on the period of time your facility was not in substantial compliance, the following remedies have gone into effect:

- State Monitoring, which was effective May 23, 2017, is discontinued effective July 31, 2017
- Federal Civil Money Penalty, see below

CIVIL MONEY PENALTY
On September 6, 2016, the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation Civil Money Penalty (CMP) amounts authorized under the Social Security Act. See 81 Fed. Reg. 61538 (Sept. 6, 2016); see also 45 CFR Part 102. The CMP imposed in this letter reflects the adjusted amounts. In determining the amount of the CMP that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. **Additionally, on July 7, 2017, CMS revised its CMP policies in S&C Memorandum 17-37-NH, effective July 17, 201**7. We are imposing the following CMP in accordance with these revisions:

- Federal Civil Money Penalty of $12,500.00 per instance for the instance of noncompliance at F319 (S/S: G) identified in the CMS-2567 survey ending May 4, 2017
- Federal Civil Money Penalty of $12,500.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 survey ending June 1, 2017

The total CMP amount imposed is $25,000.00. If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Mrs. Charlotte A. Hodder at Charlotte.Hodder@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements

- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification at RO5LTCHearingWaivers@cms.hhs.gov. **Please include your CCN and the Cycle Start Date in the subject line of your email. The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

CMP CASE NUMBER

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245516.
- The start date for this cycle is May 4, 2017.

CMP PAYMENT

When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03

Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago Regional Office. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR §488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10.125%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

As indicated above, a CMP which to date has accrued in the amount of $10,483.00 or more, is being imposed against Laurels Peak Care & Rehabilitation Center. If you fail to request a hearing, in writing, within 60 calendar days from receipt of this letter; or if you submit a written waiver of your right to a hearing, which results in the CMP being reduced to an amount that is still $10,483.00 or more; or if you timely request a hearing and there is a final administrative decision upholding the CMP in the amount of $10,483.00 or more, your facility is subject to a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) prohibition for two years. The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $10,483.00 or more. This prohibition is not subject to appeal. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed the following remedy:

- Federal Civil Money Penalty

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the

internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Health Insurance Specialist, at (312) 353-5169. Information may also be faxed to (443) 380-6614.

Sincerely,

Jan Suzuki

Jan Suzuki
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health
U.S. Department of Justice, District of Minnesota

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 28, 2017

Ms. Jacqueline Grimm, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Numbers S5516025, H5516036 and H5516037

Dear Ms. Grimm:

On May 18, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 23, 2017. (42 CFR 488.422)

In additon, on May 18, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiencies cited at F319. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on May 4, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

On June 1, 2017 and June 9, 2017, abbreviated standard surveys were completed at your facility by the Minnesota Department of Health, Office of Health Facility to investigate complaint numbers H5516037 and H5516036.

The most serious deficiencies found in your facility during the June 1, 2017 and June 9, 2017 abbreviated standard surveys were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

As a result of the findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

On July 11, 2017, 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 May 4, 2017.

In addition, on July 11, 2017, an investigator from the Minnesota Department of Health, Office of Health Facility Complaints completed Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard surveys, completed on June 1, 2017 and June 9, 2017.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2017. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, and the abbreviated standard surveys completed on June 1, 2017 and June 9, 2017. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring remained in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil Money Penalty for the deficiencies cited at F319 and F323 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017. (42 CFR 488.417 (b))

On August 2, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 11, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 31, 2017:

- Civil Money Penalty for the deficiencies cited at F319 and F323 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of May 18, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting

Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 4, 2017.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02DZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00035

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2. STATE VENDOR OR MEDICAID NO. (L2) **508613200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAURELS PEAK CARE & REHABILITATION CENTER**
(L4) **700 JAMES AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

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1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **7/11/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

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10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
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B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 8/1/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 6, 2017

Ms. Jacqueline Grimm, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Numbers S5516025, H5516036, H5516037

Dear Ms. Aanenson:

On May 18, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective May 23, 2017. (42 CFR 488.422)**

In additon, on May 18, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- **Civil money penalty for the deficiencies cited at F319. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for a standard survey completed on May 4, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 1, 2017 and June 9, 2017, abbreviated standard surveys were completed at your facility by the Minnesota Department of Health, Office of Health Facility to investigate complaint numbers H5516037 and H5516036.

The most serious deficiencies found in your facility during the June 1, 2017 and June 9, 2017 abbreviated standard surveys were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- **Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)**

On June 20, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2017. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our LSC survey, completed on May 3, 2017.

However, compliance with the health deficiencies issued pursuant to the May 4, 2017 standard survey and the June 1, 2017 and June 9, 2017, abbreviated standard surveys has not yet been verified. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

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

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017. (42 CFR 488.417 (b))**

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Laurels Peak Care & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 4, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations 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.

APPEAL RIGHTS

If you disagree with this determination, 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 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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2017 (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.

DEPARTMENT CONTACT

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

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 30, 2017

Ms. Jacqueline Grimm, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Numbers S5516025, H5516036 and H5516037

Dear Ms. Grimm:

On May 18, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective May 23, 2017. (42 CFR 488.422)**

In addition, on May 18, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- **Civil money penalty for the deficiencies cited at F319. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for a standard survey completed on May 4, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

On June 1, 2017 and June 9, 2017, abbreviated standard surveys were completed at your facility by the Minnesota Department of Health, Office of Health Facility to investigate complaint numbers H5516037 and H5516036.

The most serious deficiencies found in your facility during the June 1, 2017 and June 9, 2017 abbreviated standard surveys were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

As a result of the findings, the Category 1 remedy of state monitoring would remain in effect.

In addition, on July 6, 2017 this Department recommended to the CMS Region V Office the following actions:

- **Civil money penalty for the deficiencies cited at F319 & F323. (42 CFR 488.430 through 488.444)**

our July 6, 2017 notice also informed the facility of the following remedy imposition:

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017. (42 CFR 488.417 (b))**

On July 11, 2017, 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 May 4, 2017.

In addition, on July 11, 2017, an investigator from the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard surveys, completed on June 1, 2017 and June 9, 2017.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2017. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017. As a result of the revisit findings, we notified you on July 31, 2017 that the Category 1 remedy of state monitoring would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil Money Penalty for the deficiencies cited at F319 and F323 be imposed. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017. (42 CFR 488.417 (b))

On August 2, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 11, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed or recommended remedies in our letter of July 31, 2017:

- Civil Money Penalty for the deficiencies cited at F319 and F323 be imposed. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed or recommended remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245516	A. BUILDING _____ B. WING _____	R 07/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	**700 JAMES AVENUE MANKATO, MN 56001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 7/10/17 and 7/11/17, to determine status of deficiencies issued as a result of the survey exited on 5/4/17. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected, and a new deficiency identified at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 280} SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	{F 280}		7/31/17

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

Electronically Signed | 08/01/2017

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

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{F 280}	Continued From page 1	{F 280}		

amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

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{F 280}	Continued From page 2 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the plan of care for 1 of 3 residents (R41) reviewed for pressure ulcers. Findings include: R41's quarterly Minimum Data Set (MDS) assessment dated 5/24/17, identified R41 with no pressure ulcers. The MDS further identified R41 with a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The care plan dated 6/23/17, indicated R41 had	{F 280}	Affected resident□s (R41) care plan revised to reflect that pressure area had healed. All residents with alteration in skin integrity will have care plan reviewed and revised to reflect current skin integrity. Nurse Managers re-educated 7/12/17 on the importance of revision of care plan to reflect current health status of resident. DON or designee will conduct random	

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{F 280}	Continued From page 3 an actual pressure ulcer (PU) to left lower extremity (LLE). Interventions listed included: wound care, follow orders per nurse practitioner (NP), Medihoney (product used for wound healing) with Mepilex (foam dressing), change every other day and as needed (PRN). When interviewed on 7/11/17, at 11:25 a.m. R41 indicated he did not have any open areas or pressure ulcers stating, "not anymore, I'm all healed up". R41 further indicated he previously had a PU to the left ankle but it had been healed for several months. During interview on 7/11/17, at 12:21 p.m. registered nurse (RN)-E indicated R41 had no current PU's. When interviewed on 7/11/17, at 1:26 p.m. RN-A indicated R41 had PU's to ankles which had been healed for the last three to six months. At 2:04 p.m. RN-A confirmed R41's care plan did not reflect current skin condition and should have been updated/revised as wound care was discontinued in February 2017. When interviewed on 7/11/17, at 2:48 p.m. the director of nursing (DON) indicated the nurse manager was new and still learning care plans. The DON further stated the care plan and pressure ulcer audits implemented for their corrective plan of action should be expanded to include resident's with a history of PU, not just current PU's. The DON stated her expectation was for care plans to be revised to reflect current skin concerns. A facility policy on care plan revision was requested but not provided.	{F 280}	audits of resident□s care plans to ensure interventions for alteration in skin integrity reflect current status of resident. These audits will be completed weekly times 4 weeks then monthly times two and reported to Quality Committee for further review and recommendations.	

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{F 282} SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an ambulation program was implemented in accordance with the care plan for 1 of 3 residents (R111) reviewed for activities of daily living (ADL) and failed to ensure an exercise program for upper extremity strengthening was implemented as directed by the care plan for 1 of 3 residents (R62) reviewed with limitations in range of motion (ROM). Findings include: R111's face sheet dated 7/11/17, indicated diagnoses of mild cognitive impairment, repeated falls and history of left hip fracture. The admission Minimum Data Set (MDS) assessment dated 4/10/17, indicated R111 required extensive assistance of two staff member for transfers and only ambulated once or twice during the look back. The MDS further identified R111 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The Care Area Assessment (CAA) for ADL printed 7/11/17, indicated R111 had potential to	{F 282}	System for ambulation documentation revised for the facility. Affected resident□s (R111) ambulation program updated appropriately with the new system. Affected resident□s (R62) ROM and exercise program reviewed and revised by Physical Therapy. Care plan, care sheets and treatment sheets updated to reflect new ROM and exercise program. Care Plans, care sheets and ambulation/ROM documentation for all residents with ROM and ambulation programs will be checked for accuracy of interventions and updated as needed. Nursing staff educated on the importance of appropriately care planning and implementing CP interventions. Nursing meeting held 7/11/17 and 7/13/17. Nurse Managers and Charge Nurses monitoring completion of ambulation and ROM programs daily DON or designee will conduct random audits of select residents to ensure that	7/31/17

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{F 282}	Continued From page 5 improve in her function and should be assisted in all areas in accordance with therapy recommendations. The goal identified on the R111's assessment indicated return to home. The care plan dated 5/12/17, indicated R11 as a fall risk due to decreased mobility, with a goal of resident being safe and free from falls. The intervention identified that PT/OT instructions were listed. A secondary care plan focus, related to impaired physical mobility related to a left femur fracture indicated R111 walks with assist of one staff and walker. Ambulate 2-3 times per day 150 feet with front-wheeled walker to tolerance. R111's nursing assistant care sheet, updated 6/28/17 indicated to ambulate 2-3 times per day up to 150 feet with front wheeled walker to tolerance. This instruction was highlighted in yellow on the form. R111's physical therapy discharge summary dated 6/8/17, indicated R111 had initially been seen for lower extremity strengthening and transfer training, and was able to walk 200 feet with stand by assistance and was being set up on an ambulation program with nursing staff. During observation on 7/11/17, at 9:21 a.m. R111 was observed lying in her bed, asleep. During observation and interview on 7/11/17, at 11:08 a.m. R11 stated she thought she had been here "about a week," and was unable to state how often staff assisted her to walk. R111 was seated in her wheelchair and a sign was posted on her closet door with a reminder for R111 to request assistance with transfers.	{F 282}	care plan interventions related to ambulation programs and ROM are addressed and being implemented. These audits will be completed weekly times 4 weeks then monthly times two and reported to Quality Committee for further review and recommendations.	

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{F 282}	Continued From page 6	{F 282}		

During observation on 7/11/17, at 12:38 p.m., R111 was seated on her bed in her room, and had not yet been observed to ambulate during the day shift.

During interview on 7/11/17, at 9:14 a.m. nursing assistant (NA)-A stated all residents who were on a walking program were listed on an ambulation sheet, which was noted to include R111, with instructions to ambulate her two to three times per day with a front wheeled walker, up to 150 feet.

During interview on 7/11/17, at 9:53 a.m. registered nurse (RN)-A, who was R111's nurse manager reviewed R111's walking documentation for the previous one-month period, as "not applicable." RN-A was unable to explain the reason the walking documentation was "not applicable" and verified that an ambulation program was suppose to be implemented for R111 and she would expect staff to walk her. Documentation identified only the number of minutes the task was performed and not the distance R111 walked. RN-A further stated there was additional documentation which included the distance (number of feet) R111 would have walked; which she would provide. Although there were additional paper worksheets available for review which were not part of the medical record, documentation did not reflect any additional walking attempts for R111.

During interview on 7/11/17,at 10:10 a.m., the registered physical therapist (PT)-A stated she had set R111 up on an ambulation program when she discharged from physical therapy on 6/8/17. PT-A indicated that to her knowledge R111 had been doing "very, very well with it." PT-A stated

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{F 282}	Continued From page 7	{F 282}		

R111 was generally cooperative about wanting to walk, and she had never heard any concerns from staff related to R111 walking. PT-A stated R111 had been unable to maintain a skilled level of care and had to be discontinued from therapy services as she had reached her potential, and that staff should have been able to perform this ambulation activity. PT-A commented, "Walking was the one good thing we were doing [for R111]."

During further interview on 7/11/17, at 12:30 p.m. RN-A stated all ambulation programs are documented in point of care and she had worked on this along with RN-B to ensure all residents were accurately reflected in their electronic medical record (EMR) system to ensure residents were walked. RN-A was able to print R111's ambulation point of care EMR documents at this time, with feet ambulated. For the dates 6/12/17 through 7/11/17, documentation for R111 was "not applicable" 21 opportunities, 9 refusals and walked 10 times out of 52 opportunities; distances ranged from 15-600 feet.

During interview on 7/11/17, at 1:41 p.m. RN-C stated R111 was not generally resistive to ambulation, and would actually try to transfer herself at times.

During interview on 7/11/17, at 3:41 p.m. the director of nursing (DON) stated she was not aware R111 was not being walked in accordance with her care plan, but would expect care plans to be followed.

A policy related to ambulation services was requested, none was provided.

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R62's face sheet dated 7/11/17, identified diagnoses of scleroderma, peripheral vascular disease and fracture of the lower leg.

The quarterly Minimum Data Set (MDS) assessment dated 6/2/17, indicated R62 required extensive assistance of one with locomotion on and off the unit and had no range of motion deficits in the upper extremities. The MDS also identified a Brief Interview for Mental Status (BIMS) score of 15/15, indicating R62 was cognitively intact.

R62's physician progress note dated 6/22/17, indicated limited ROM in the both shoulders.

The Care Area Assessment (CAA) related to activities of daily living (ADL) printed 7/11/17, indicated R62 required extensive assistance for mobility and required a mechanical lift for transfers. The CAA further identified a goal that R62 become more independent with cares.

R62's nursing assistant care guide, undated, indicated: assist with exercise program between 7 a.m. and 4 p.m.

The care plan updated 6/7/17, included a problem related to limited physical mobility related to weakness. The intervention included: staff assist R62 to complete upper extremity exercises three (3) times per week and as needed per occupational therapy (OT) instruction.

R62's OT discharge summary note dated 6/7/17, indicated "Patient discharged to same SNF [skilled nursing facility] with BUE [bilateral upper extremity] HEP [home exercise program], using endorphin machine in occupational therapy

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{F 282}	Continued From page 9	{F 282}		

room." The note further indicated R62 required staff assistance to set up the machine and the program was designed to strengthen her arms. The form was signed by registered occupational therapist (OTR)-A.

A PT (physical therapy) and OT communication note dated 6/7/17, indicated R62 had been discharged from OT and included instructions to please assist resident in completing bilateral upper extremity exercise program, as needed. Please ensure this is completed during therapy hours (7:00 a.m. - 4:00 p.m.) three times per week, and was signed by OTR-A.

Documentation in R62's clinical record lacked verification that R62's exercise program had been implemented per OT recommendation; documentation was lacking to indicate resident refusal and/or participation in exercise program.

During interview on 7/10/17, at 1:59 p.m. R62 stated she had not been receiving her exercises, indicating staff had never started them because they were too busy.

During interview on 7/10/17, at 2:12 p.m. registered nurse (RN)-D, who was R62's nurse manager, stated she was not aware of any exercises for R62's upper extremities. RN-D indicated there had been no scheduled days during the week to assist R62 with the program; however, the nursing assistants (NA) were to ask the resident when they had been done.

When interviewed on 7/10/17, at 2:13 p.m. NA-B stated she worked with R62 frequently and R62 was often busy so she did not have the opportunity to offer exercises.

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{F 282}	Continued From page 10 Upon further interview on 7/10/17, at 3:08 p.m. RN-D confirmed R62's exercise program had not been implemented after she had spoken with the resident and the staff. During interview on 7/11/17, at 1:13 p.m. OTR-A stated it was "frustrating" to hear the program had not been implemented since R62 had been referred for therapy prior, for strengthening exercises. OTR-A explained the identified program only required about 15 minutes of staff time to ensure R62 had completed. When interviewed on 7/11/17, at 3:19 p.m. RN-D stated R62 was on a "self-directed exercise program", yet needed staff assistance to successfully complete the program required help in setting up the equipment in the gym. During a follow-up interview on 7/11/17, at 4:07 p.m. OTR-A further stated that RN-D had been made aware of the instructions at the time of R62's discharge from OT.	{F 282}		
{F 311} SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an ambulation program was implemented to prevent decline in mobility for 1 of 3 residents (R111) reviewed for	{F 311}	Affected resident□s (R 111) care plan and care sheets were updated to reflect daily ambulation program.	7/31/17

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{F 311}	Continued From page 11 activities of daily living (ADL) . Findings include: R111's face sheet dated 7/11/17, indicated diagnoses of mild cognitive impairment, repeated falls and history of left hip fracture. The admission Minimum Data Set (MDS) assessment dated 4/10/17, indicated R111 required extensive assistance of two staff member for transfers and only ambulated once or twice during the look back. The MDS further identified R111 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The Care Area Assessment (CAA) for ADL printed 7/11/17, indicated R111 had potential to improve in her function and should be assisted in all areas in accordance with therapy recommendations. The goal identified on the R111's assessment indicated return to home. The care plan dated 5/12/17, indicated R11 as a fall risk due to decreased mobility, with a goal of resident being safe and free from falls. The intervention identified that PT/OT instructions were listed. A secondary care plan focus, related to impaired physical mobility related to a left femur fracture indicated R111 walks with assist of one staff and walker. Ambulate 2-3 times per day 150 feet with front-wheeled walker to tolerance. R111's nursing assistant care sheet, updated 6/28/17 indicated to ambulate 2-3 times per day up to 150 feet with front wheeled walker to tolerance. This instruction was highlighted in yellow on the form.	{F 311}	Care Plans and care sheets for all residents with ambulation programs will be checked for accuracy of interventions and updated as needed. Nursing staff educated on the importance of appropriately care planning and implementing CP interventions. Nursing meeting held 7/11/17 and 7/13/17. DON or designee will conduct random audits of select residents to ensure that care plan interventions related to ambulation programs are addressed and being implemented. These audits will be completed weekly times 4 weeks then monthly times two and reported to Quality Committee for further review and recommendations.	

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{F 311}	Continued From page 12	{F 311}		

R111's physical therapy (PT) discharge summary dated 6/8/17, indicated R111 had initially been seen for lower extremity strengthening and transfer training, and was able to walk 200 feet with stand by assistance and was being set up on an ambulation program with nursing staff.

During observation on 7/11/17, at 9:21 a.m. R111 was observed lying in her bed, asleep.

During observation and interview on 7/11/17, at 11:08 a.m. R11 stated she thought she had been here "about a week," and was unable to state how often staff assisted her to walk. R111 was seated in her wheelchair and a sign was posted on her closet door with a reminder for R111 to request assistance with transfers.

During observation on 7/11/17, at 12:38 p.m., R111 was seated on her bed in her room, and had not yet been observed to ambulate during the day shift.

During interview on 7/11/17, at 9:14 a.m. nursing assistant (NA)-A stated all residents who were on a walking program were listed on an ambulation sheet, which was noted to include R111 and included instructions to ambulate R111 two to three times per day with a front wheeled walker, up to 150 feet.

During interview on 7/11/17, at 9:53 a.m. registered nurse (RN)-A, who was R111's nurse manager reviewed R111's walking documentation for the previous one-month period, as "not applicable" (N/A). RN-A was unable to explain the reason the walking documentation was "not applicable" and verified that an ambulation

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{F 311}	Continued From page 13	{F 311}		

program was suppose to be implemented for R111 and she would expect staff to walk her. Documentation identified only the number of minutes the task was performed and not the distance R111 walked. RN-A further stated there was additional documentation which included the distance (number of feet) R111 would have walked; which she would provide. Although there were additional paper worksheets available for review which were not part of the medical record, documentation did not reflect any additional walking attempts for R111.

During interview on 7/11/17,at 10:10 a.m., the registered physical therapist (PT)-A stated she had set R111 up on an ambulation program when she discharged from physical therapy on 6/8/17. PT-A indicated that to her knowledge R111 had been doing "very, very well with it." PT-A stated R111 was generally cooperative about wanting to walk, and she had never heard any concerns from staff related to R111 walking. PT-A stated R111 had been unable to maintain a skilled level of care and had to be discontinued from therapy services as she had reached her potential, and that staff should have been able to perform this ambulation activity. PT-A commented, "Walking was the one good thing we were doing [for R111]."

During further interview on 7/11/17, at 12:30 p.m. RN-A stated all ambulation programs are documented in point of care and she had worked on this along with RN-B to ensure all residents were accurately reflected in their electronic medical record (EMR) system to ensure residents were walked. RN-A was able to print R111's ambulation point of care EMR documents at this time, with feet ambulated. For the dates 6/12/17

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through 7/11/17, documentation for R111 was "not applicable" 21 opportunities, 9 refusals and walked 10 times out of 52 opportunities; distances ranged from 15-600 feet.

During interview on 7/11/17, at 1:41 p.m. RN-C stated R111 was not generally resistive to ambulation, and would actually try to transfer herself at times.

During interview on 7/11/17, at 3:41 p.m. the director of nursing (DON) stated she was not aware R111 was not being walked as stated in the care plan.

A policy related to ambulation services was requested, none was provided.

During interview on 7/11/2017 at 9:53 a.m. registered nurse (RN)-A, who was R111's nurse manager reviewed R111's walking documentation for the previous one-month period,"not applicable." RN-A was unable to state why the walking would have been "not applicable" and verified R111 was supposed to be on an ambulation program, and she would expect staff to walk her. The documentation showed the number of minutes the task was performed only, and not the distance R11 walked. RN-A further stated there was additional documentation with the number of feet R111 would have walked, which she would provide. There were additional paper worksheets, which were not part of the medical record and did not reflect any additional walking attempts charted for R111.

During interview on 7/11/17,at 10:10 a.m., the registered physical therapist (PT)-A stated she had set R111 up on an ambulation program when

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she discharged from physical therapy on 6/8/17, and to her knowledge R111 had been doing "very, very well with it." PT-A stated R111 was generally cooperative about wanting to walk, and she had never heard any concerns from staff about R111 walking. PT-A stated R111 had been unable to maintain a skilled level of care and had to be discontinued from therapy services as she had maximized her potential, and that staff should have been able to perform this activity with her. PT-A further added "Walking was the one good thing we were doing [for R111]."

During further interview on 7/11/17, at 12:30 p.m. RN-A stated all ambulation programs should be documented in point of care, and that she had worked on this with RN-B to ensure all residents were accurately reflected in their electronic charting system in an attempt to make sure residents were being walked. RN-A was able to print R111's ambulation point of care documents at this time, with feet ambulated. For the dates of 6/12 - 7/11/17, R111 was recorded as "not applicable" 21 opportunities, refusal on 9 occasions, and walked 10 times out of 52 opportunities. Distances ranged from 15-600 feet.

During interview on 7/11/17, at 12:39 p.m. RN-B stated she had attended quality assurance committee meetings and had been auditing the walking programs since their survey in 5/17. A paper backup form had been created as a means for staff to document walking programs the end of 6/17, however when completing the walking program audits she had only considered the computerized documentation. RN-B indicated this was an ongoing education effort to the staff, to document walks. Review of the ambulation

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{F 311}	Continued From page 16 program audits at this time revealed RN-B had completed them on 6/7, 6/14, 6/23, and 6/29/17, and all reflected ongoing non-compliance with ambulation programs, with many "missing" entries for whether walks were being done or not done on the units. During interview on 7/11/17, at 1:41 p.m. RN-C stated R111 was not generally resistive to ambulation, and would actually try to transfer herself at times. During interview on 7/11/17, at 3:41 p.m. the director of nursing (DON) stated the facility had not had a quality assurance committee meeting since their survey exited in 5/17, however one was scheduled for 7/12/17. The DON stated the facility talked about their auditing efforts related to ambulation daily, and how staff were doing with charting. The DON stated she was not aware R111 was not being walked in accordance with her walking program. A policy related to ambulation services was requested, none was provided.	{F 311}		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum	F 318		7/31/17

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F 318	Continued From page 17 practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an upper extremity exercise program recommended by occupational therapy (OT) was implemented to prevent loss of range of motion (ROM) in the shoulders and maintain upper extremity strength for 1 of 3 residents (R62) reviewed with limited ROM. Findings include: R62's face sheet dated 7/11/17, identified diagnoses of scleroderma, peripheral vascular disease and fracture of the lower leg. The quarterly Minimum Data Set (MDS) assessment dated 6/2/17, indicated R62 required extensive assistance of one with locomotion on and off the unit and had no range of motion deficits in the upper extremities. The MDS also identified a Brief Interview for Mental Status (BIMS) score of 15/15, indicating R62 was cognitively intact. R62's physician progress note dated 6/22/17, indicated limited ROM in the both shoulders. The Care Area Assessment (CAA) related to activities of daily living (ADL) printed 7/11/17, indicated R62 required extensive assistance for mobility and required a mechanical lift for transfers. The CAA further identified a goal that R62 become more independent with cares. R62's nursing assistant care guide, undated,	F 318	Affected resident□s (R62) ROM and exercise program reviewed and revised by Physical Therapy. Care plan, care sheets and treatment sheets updated to reflect new ROM and exercise program Care Plans, care sheets and ROM documentation for all residents with ROM and exercise programs will be checked for accuracy of interventions and updated as needed. Nursing staff educated on the importance of appropriately care planning and implementing CP interventions. Nursing meeting held 7/11/17 and 7/13/17. Nurse Managers and Charge Nurses monitoring completion of ROM programs daily Nurse Managers and Charge Nurses monitoring completion of ROM programs daily DON or designee will conduct random audits of select residents to ensure that care plan interventions related to ROM and exercise programs are addressed and being implemented. These audits will be completed weekly times 4 weeks then monthly times two and reported to Quality Committee for further review and recommendations.	

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indicated: assist with exercise program between 7 a.m. and 4 p.m.

The care plan updated 6/7/17, included a problem related to limited physical mobility related to weakness. The intervention included: staff assist R62 to complete upper extremity exercises three (3) times per week and as needed per occupational therapy (OT) instruction.

R62's OT note dated 5/19/17, indicated "Patient was referred to occupational therapy services, by [Nurse practitioner name] for shoulder/arm strengthening, as patient was experiencing weakness in BUE's [bilateral upper extremities]."

R62's OT discharge summary note dated 6/7/17, indicated "Patient discharged to same SNF [skilled nursing facility] with BUE [bilateral upper extremity] HEP [home exercise program], using endorphin machine in occupational therapy room." The note further indicated R62 required staff assistance to set up the machine and the program was designed to strengthen her arms. The form was signed by registered occupational therapist (OTR)-A.

A PT (physical therapy) and OT communication note dated 6/7/17, indicated R62 had been discharged from OT and included instructions to please assist resident in completing bilateral upper extremity exercise program, as needed. Please ensure this is completed during therapy hours (7:00 a.m. - 4:00 p.m.) three times per week, and was signed by OTR-A.

Documentation in R62's clinical record lacked verification that R62's exercise program had been implemented per OT recommendation;

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documentation was lacking to indicate resident refusal and/or participation in exercise program.

During interview on 7/10/17, at 1:59 p.m. R62 stated she had not been receiving her exercises, indicating staff had never started them because they were too busy.

During interview on 7/10/17, at 2:12 p.m. registered nurse (RN)-D, who was R62's nurse manager, stated she was not aware of any exercises for R62's upper extremities. RN-D indicated there had been no scheduled days during the week to assist R62 with the program; however, the nursing assistants (NA) were to ask the resident when they had been done.

When interviewed on 7/10/17, at 2:13 p.m. NA-B stated she worked with R62 frequently and R62 was often busy so she did not have the opportunity to offer exercises.

Upon further interview on 7/10/17, at 3:08 p.m. RN-D confirmed R62's exercise program had not been implemented after she had spoken with the resident and the staff.

During interview on 7/11/17, at 1:13 p.m. OTR-A stated she had initially received an order from a physician's assistant to set up and exercise program for R62, due to weakened arm strength. The program involved an endorphin machine, which R62 required help to set up and needed to use during the day hours when the therapy room was available/open. OTR-A stated the exercise program was developed to help R62 have the strength to propel her wheelchair and to reposition herself. In addition, OTR-A stated she had provided staff with colored pictures of the

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exercise program and communicated the specifics to staff and R62. OTR-A stated it was "frustrating" to hear the program had not been implemented since R62 had been referred for therapy prior, for strengthening exercises. OTR-A explained the identified program only required about 15 minutes of staff time to ensure R62 had completed.

When interviewed on 7/11/17, at 3:19 p.m. RN-D stated R62 was on a "self-directed exercise program", yet needed staff assistance to successfully complete the program required help in setting up the equipment in the gym.

During interview on 7/11/17, at 3:41 p.m. the director of nursing (DON) stated she thought the exercise program for R62 was for "weight loss per her [R62's] request," and that R62's exercises had "never been intended for nursing to do."

During a follow-up interview on 7/11/17, at 4:07 p.m. OTR-A further stated the exercise program was not for weight loss but for upper extremity strengthening and that RN-D had been made aware of the instructions at the time of R62's discharge from OT.

A policy related to exercise programs was requested, none was provided.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 30, 2017

Ms. Jacqueline Grimm, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

Re: Reinspection Results - Project Number H5516037

Dear Ms. Grimm:

On July 11, 2017 survey staff of the Minnesota Department of Health, Office of Health Facility Complaints completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 1, 2017, with orders received by you on June 14, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 31, 2017

Ms. Jacqueline Grimm, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Number S5516025, H5516036, and H5516037

Dear Ms. Grimm:

On May 18, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective May 23, 2017. (42 CFR 488.422)**

In additon, on May 18, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- **Civil money penalty for the deficiencies cited at F319. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for a standard survey completed on May 4, 2017 and the abbreviated standard surveys that were completed at your facility by the Minnesota Department of Health, Office of Health Facility on June 1, 2017 and June 9, 2017 to investigate complaint numbers H5516037 and H5516036. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 6, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 4, 2017. (42 CFR 488.417 (b))**

We also notified you in our letter of July 6, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 4, 2017.

This was based on continued non-compliance with the health deficiencies issued at the time of our May 4, 2017 standard survey.

On July 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on May 4, 2017 and the abbreviated standard surveys that were completed at your facility by the Minnesota Department of Health, Office of Health Facility on June 1, 2017 and June 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 4, 2017. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) -- Right To Participate Planning Care-Revise Cp
F0282 -- S/S: D -- 483.21(b)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0311 -- S/S: D -- 483.24(a)(1) -- Treatment/services To Improve/maintain ADL's

In addition, at the time of this revisit, we identified the following deficiency:

F0318 -- S/S: D -- 483.25(c)(2)(3) -- Increase/prevent Decrease In Range Of Motion

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Civil money penalty for the deficiencies cited at F319, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 4, be imposed. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

DEPARTMENT CONTACTS

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

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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,

- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2017 (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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File