

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0RK2

Facility ID: 00633

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

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

28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS
(L28)	03001 (L31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	
(L32)	07/31/2018 (L33)	DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245396

August 14, 2018

Mr. Gerry Gilbertson, Administrator
Centracare Health System - Melrose Pine Villa CC
525 West Main Street
Melrose, MN 56352

Dear Mr. Gilbertson:

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 August 7, 2018 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 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,

A handwritten signature in blue ink that reads 'Alison Helm'.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 delivered

August 14, 2018

Mr. Gerry Gilbertson, Administrator
Centracare Health System - Melrose Pine Villa CC
525 West Main Street
Melrose, MN 56352

RE: Project Number S5396027

Dear Mr. Gilbertson:

On July 16, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 13, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 7, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective August 7, 2018 and therefore remedies outlined in our letter to you dated July 16, 2018, will not be imposed.

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,

A handwritten signature in blue ink that reads 'Alison Helm'.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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: 0RK2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00633

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245396		3. NAME AND ADDRESS OF FACILITY (L3) CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C (L4) 525 WEST MAIN STREET (L5) MELROSE, MN (L6) 56352		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 049021100		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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) 06/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY 06/28/2018 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1. Acceptable POC</u> <u>2. Technical Personnel</u> <u>6. Scope of Services Limit</u> <u>3. 24 Hour RN</u> <u>7. Medical Director</u> <u>4. 7-Day RN (Rural SNF)</u> <u>8. Patient Room Size</u> <u>5. Life Safety Code</u> <u>9. Beds/Room</u> X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 75 (L18)		13.Total Certified Beds 75 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 75 (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 Jennifer Bahr, HFE NE II (L19)		Date: 07/30/2018		18. STATE SURVEY AGENCY APPROVAL Alison Helm, Enforcement Specialist (L20)		Date: 07/31/2018	
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>1. Facility is Eligible to Participate</u> <u>2. Facility is not Eligible</u> (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 16, 2018

Mr. Gerry Gilbertson, Administrator
CentraCare Health System - Melrose Pine Villa CC
525 West Main Street
Melrose, MN 56352

RE: Project Number S5396027

Dear Mr. Gilbertson:

On June 28, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

**Brenda Fischer, Unit Supervisor
St. Cloud A 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: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 7, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 7, 2018 the following remedy will be imposed:

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

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 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 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 December 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Centracare Health System - Melrose Pine Villa C C

July 16, 2018

Page 6

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,

A handwritten signature in cursive script that reads "Alison Helm".

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

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

PRINTED: 07/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2018
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(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
E 000	Initial Comments	E 000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/25/18, through 6/28/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.				
F 000	INITIAL COMMENTS	F 000			
	On 6/25/18, to 6/28/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). CentraCare Health Melrose was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.				
	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.				
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677			7/26/18
	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:				

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

TITLE

(X6) DATE

Electronically Signed

07/25/2018

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2018
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(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 677	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure oral cares were offered or provided for 1 of 1 residents (R8) in the sample who was dependent on staff for assistance with activities of daily living (ADL's). Findings include: R8's quarterly Minimum Data Set (MDS) dated 3/15/18, indicated she had Alzheimers disease, was cognitively impaired and needed extensive assistance with ADL's. R8's care plan revised on 2/4/18, indicated for personal hygiene an intervention to assist of one to brush teeth after each meal. R8's Kardex (report sheet for nursing assistant giving instructions on cares) indicated to brush teeth after each meal. During interview 6/25/18, at 2:43 a.m. family member (FM)-A stated they wanted R8's teeth brushed after lunch which the facility does not complete. FM-A stated they have told the staff several times and sometimes find food in her mouth when they come to visit in the afternoon. During observation 6/27/18, at 12:20 p.m. nursing assistant (NA)-B was observed to wheel R8 in her wheelchair to her room and placed her in front of the television. At 12:30 p.m. NA-A and NA-B were observed to use a EZ-Stand (a lift to help transfer) and place R8 into bed. NA-A and NA-B provided peri-care and then lowered the bed covered her up and left the room. No oral cares were provided as FM-A had requested. During interview 6/27/18, registered nurse (RN)-A stated R8's teeth should be brushed after each meal according to her care plan. RN-A stated this is on her Kardex but he will be adding it as a task	F 677	The task section of the care plan was updated to alert nursing assistants to provide oral care three times a day to this resident. This task now fires to the nursing assistants at the appropriate time. All care plans of dependent residents were reviewed to ensure oral care is provided as directed. Education was provided at a nurse meeting on July 17th and an in-service on July 10th, 2018. Audits of ADL care of dependent residents will be performed 3X weekly by the RN manager for 3 months, or until compliance is met. The LTC Director will monitor the results of these audits. The results of this monitoring will be brought forward to the quality assurance committee.		

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

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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(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 677	Continued From page 2 on the computer so the NA's know oral cares must be completed after each meal. A facility policy revised 4/2018, indicated nursing staff will provide all residents with mouth care to maintain or improve oral hygiene. The policy directed staff to wash hands gather supplies assist the resident with oral hygiene and offer water for rinsing.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review ,the facility failed to comprehensively investigate an incident from the bath chair for 1 of 1 residents (R28), who stated the tub chair broke while bathing. Findings include: R28's annual Minimum Data Set (MDS) assessment dated 4/19/18, indicated R28 had intact cognition and received extensive assistance to complete activities of daily living (ADL's) including transferring and dressing. R28's care plan, also indicated a self care deficit related to functional limitations related to history of a fractured humerus (the long bone in the upper	F 689	The tub chair release mechanism was repaired by maintenance on June 27th. No other residents were affected. Maintenance staff perform checks on the bath tub and chair monthly as recommended. Staff were educated at an in-service on July 10th to follow up with maintenance with any incident involving equipment. Licensed staff were educated on July 17th, 2018 at a nurse meeting to be sure to notify maintenance on any equipment involved during a post fall investigation prior to the equipment being used again. The long term care director or her designee will perform audits of post fall		7/26/18

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

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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
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F 689	Continued From page 3 arm) and arthritis. The care plan dated 3/22/16, directed staff to provide assistance with transfer assistance and bathing. On 6/28/18, at 9:10 a.m. R28 stated she had received a bath on 6/27/18, by staff. When she was assisted out of the tub, the chair broke and she was on the floor. R28 stated "It was hard to get me up from the floor." On 6/28/18, at 9:20 a.m. the tub room on Lilac Lane was observed with NA-D. It was and Apollo tub which opened on the end. The tub chair and base attached to the end of the tub and then the chair was released from the base and glided on rails on either side of the tub. The base was released and the end of the the tub was closed. Following a bath the tub was drained the door at the end of the tub was opened and the tub chair based was locked to the end of the tub. The seat was glided on the rails over the tub chair base and was locked into place. The resident could then be transferred from the tub chair to a wheelchair. NA-D stated she she assisted R28's with her bath in the Lilac Lane tub room on 6/27/18, at approximately 7:50 a.m. NA-D stated after finishing R28's bath NA-D glided the seat on the rails towards the tub chair base. NA-D stated "Something happened. The whole thing moved", indicating the portion of the chair R28 was seated on lifted off the rails and slid back on the track system into the tub. NA-D demonstrated this movement on the Apollo tub on Lilac Lane and the black plastic portion of the seat tilted forward and lifted off of the seat frame. NA-D stated with the movement of the base of the seat forward R28 was unable to gain her balance and NA-D	F 689	investigations on 20% of falls each month x 3 months or until compliance is met. The results of these audits will be brought forward to the quality assurance committee.		

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F 689	Continued From page 4 assisted R28 onto the moveable chair base (without the seat section), placed the base against the wall so she was able to summon help. NA-D did not identify R28 was placed the floor. NA-D stated staff responded and R28 was assessed for injuries. R28 was free from injuries and assisted to complete dressing and transfer into her wheelchair. NA-D stated an unidentified staff member later informed her the tub was broken and "they found a screw on the floor". On 6/28/18, at 10:36 a.m. NA-D stated she had not received any further training or instruction regarding tub use and transfer equipment. On 6/28/18, at 9:50 a.m. the director of maintenance (DM) and maintenance assistant (M)-A stated they were unaware of any incident involving the tub transfer system on Lilac Lane with R28. M-A stated monthly tub maintenance was performed, following manufacturers recommendations. M-A stated when notified by staff with any incidents involving equipment maintenance would evaluate the equipment function to determine need for repair and if it could remain in use. M-A stated he was contacted on 6/27/18, of the tub transfer system not releasing on the tub on Lilac Lane and did fix a piece on the foot lever would not allow the chair to release. However, was not made aware of the incident with R28. M-A observed a piece underneath had busted off, and a nut which had come off. On 06/28/18, at 10:57 a.m. RN-A stated R28 was lowered to the floor after her bath because part of the chair had fallen away when staff were assisting R28 with a transfer out of the tub. RN-A stated R28 was assessed for injuries and vital	F 689			

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F 689	Continued From page 5 signs were checked. R28 denied any injuries and hitting her head. R28 was assisted by four staff members into her wheelchair. RN-A stated the tub chair was placed back on the track of the tub and seemed to be working properly.; however did not notify the maintenance department of the incident for further inspection. RN-A stated he did not complete any follow up education with NA-A after the incident. RN-A stated the Interdisciplinary Team (IDT) reviewed the incident later in the morning, however, there was no documentation about the incident. On 6/28/18, at 11:17 a.m. LPN-A stated she assisted R28 following her being lowered to the floor prior to RN-A's arrival. LPN-A stated no follow up was completed with the maintenance department at the time as it was felt to be an operator error. LPN-A stated following the next bath in the Lilac Lane tub room staff experienced problems with the transfer system and maintenance was contacted for follow up but had not advised him of the previous incident with the tub transfer system. R28's electronic incident report dated 6/27/18, at 10:19 a.m. completed by RN-A indicated R28 was lowered to the floor at 8:00 a.m. "After the tub seat attachment fell off." The incident report did not include any investigation into the cause of the seat detachment or interventions the facility initiated. On 6/28/18, at 12:01 p.m. the director of nursing (DON) stated following an incident it would be her expectation the charge nurse would evaluate the situation which included assessing for injuries and determine the cause of incident. This process should include evaluation of the	F 689			

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F 689	Continued From page 6 equipment, transfer assistance provided, and any training of staff as needed. The DON stated she had been informed of the incident and no concerns were identified regarding user error. Additionally, the DON stated there was no evidence the chair was malfunctioning. The DON stated there would be evaluation of the event at the daily interdisciplinary team meeting which was held daily at 9:00 a.m. The DON stated formal documentation was not completed for these meetings. On 6/28/18, at 1:45 p.m. RN-B stated she was aware of the incident and it was felt to be operator error. A facility policy for investigation of incidents was requested and not received. A request was made for NA-D training documentation for use of the tub but was not received.	F 689			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732			7/18/18

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F 732	Continued From page 7 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to include the total number of staff on the nurse staff posting. In addition, the facility did not display the posting in a manner that was accessible for residents to read. This had the potential to affect all 75 residents, their families and visitors. Findings include: During observation on 6/25/18, at 5:33 p.m. the nurse staff posting was posted on the wall across from the nursing station in a frame. The frame was approximately 4-5 feet from the floor, which	F 732	The posting of nursing staff hours form was changed on 6/27/2018 to a new format to include total number of staff. The posting was lowered to allow residents in wheelchairs to read the information. The policy was reviewed regarding posting of the daily nursing staff. Nurses were educated on 7/17/2018 regarding the posting of nursing staff hours during a staff meeting. The LTC Director will audit the posting of the nursing staffing hours 2X week x 4 weeks or until compliance is achieved.		

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F 732	Continued From page 8 was unable to be viewed from someone seated in a wheelchair. The posting had columns to record the nursing staff, shifts, hours and total hours of work for the week starting on Monday and ending on Sunday. The nurse staff posting did not include the number of staff working each shift. During interview on 6/27/18, at 12:20 p.m. registered nurse (RN)-A stated the health unit secretary (HUC) filled in the nurse staff posting on a daily basis and the charge nurse makes any changes that are needed. RN-C stated a resident in a wheelchair could not view the information as the nurse staff posting was approximately 4 feet from the floor. When interviewed on 6/27/18, at 12:40 p.m. the HUC stated the facility had been using the same form in the same location for the last three to four years. Further, she was not aware the total number of staff working for the shift was required along with the total hours. She did not feel anyone in a wheelchair could read the nurse staff posting if they were seated in a wheelchair. The facility policy Posting of Nursing Hours revised 4/18, identified the posting was to be placed in a prominent area accessible to residents and visitors. Further, the total number and the actual hours worked were to be included for registered nurses, licensed nurses and nursing assistants.	F 732	The results of the audit will be brought forward to the quality assurance committee. Completion date: July 18, 2018		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		7/26/18	

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F 758	Continued From page 9 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758			

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F 758	Continued From page 10 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a physician face to face visit was completed every 14 days for an "as needed" (PRN) antipsychotic medication for 1 of 1 (R65) resident who was prescribed PRN antipsychotic medication. Findings include: R65's quarterly Minimum Data Set (MDS) assessment dated 5/24/18, indicated R65 had moderate cognitive impairment and experienced delusions (an abrupt change in the brain that causes mental confusion and emotional disruption). R65's behaviors included; physical aggression towards others, other behaviors not directed towards others, and daily verbal aggression towards others and rejection of cares. The MDS identified diagnoses of dementia and depression. R65 was identified as having a terminal diagnosis with life expectancy of less than six months. R65 had a physician's order for Haloperidol Lactate Concentrate (an antipsychotic drug) 2 milligrams (mg) per milliliter (ml). Staff to give 0.5 ml (1 mg) by mouth every six hours PRN for agitation or delirium; for yelling, hitting, attempting to self transfer, moving arms and legs. The order was originally placed on 5/24/18, with a discontinuation date of 6/20/18. The order was renewed on 6/20/18, with a discontinuation date	F 758	The PRN medication Haldol was discontinued for the resident. A review of all residents was completed using the electronic record to audit any PRN psychotropic medications to ensure a 14 day stop was obtained upon the medication being ordered. No other residents had anti-psychotic medications ordered PRN for more than 14 days. Other anti psychotropic medications were reviewed. A nurse meeting held on July 17th education was provided to nursing staff. The consulting pharmacist provided education regarding PRN psychotropic medications. The psychotropic medication policy was also reviewed. A Psychotropic Medications guide was e-mailed to each licensed nurse and a copy of the guide was placed on each medication cart for reference. Medical staff were updated on the use of PRN psychotropics on 5/17/2018 at the Medical Staff meeting with the guide being presented by the consulting pharmacist. The LTC Director or her designee will audit all new PRN anti-psychotic medication orders weekly via the EMAR weekly for 3 months. For all other psychotropic PRN medications orders, a weekly audit X 3 months will be completed.		

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F 758	Continued From page 11 of 6/18/19 (363 days after order date). The medicaion administration record from 6/1/18, to 6/26/18, identified Haloperidol Lactate Concentrate was not administered. On 6/27/18, at approximately 1:10 p.m. RN-A stated the order for Haldol previously had a stop date of 6/20/18. RN-A stated it was difficult to complete the renewal periods with shortened end dates and physician follow up. RN-A stated they had previously extended a PRN Ativan (an antianxiety medication) end date and asked the physician to extend the order in the same manner. On 6/27/18, at 1:30 p.m. the director of nursing (DON) stated the facility policy for renewal of PRN antipsychotic medications was for the resident to be evaluated in- person by the physician every 14 days. The DON stated the order should not have been extended beyond the 14 days. A facility policy Psychotropic Medication Management-Long Term care last revised 4/2018, indicated PRN orders for anti-psychotic medications are limited to 14 days and cannot be renewed unless the attending physican or prescribing practitioner evaluates the resident for the appropriateness of the medication.	F 758	Results of this audit will be forwarded to the Quality Assurance committee. Completion Date: July 26th, 2018		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880			7/26/18

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F 880	Continued From page 12 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880			

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F 880	Continued From page 13 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently review and analyze their collected infection control data for potential patterns of infection in the facility, including signs/symptoms of infections not treated with an antibiotic, to prevent the spread of communicable disease and infections. This practice had the potential to affect all 72 residents who currently resided in the facility. In addition, the facility failed to ensure housekeeping staff appropriately disinfected a room for 1 of 1 residents (R25) who was on enteric precautions for C-diff (Clostridium difficile, a highly contagious, spore-forming bacterium which can cause severe diarrhea). This had the potential to affect all 23 residents who resided on Lilac Lane.	F 880	Environmental Service: The affected room was cleaned using bleach cleanser. No other rooms or residents were affected. EVS staff were given hands on education on 7/10/2018 at a mandatory staff meeting. The EVS manager and infection control nurse provided education on cleaning of specific organisms and chemicals needed. A video on the proper precautions for cleaning was reviewed with all staff during the July 10th meeting. Isolation precautions and cleaning of c-diff was added to the EVS orientation checklist for new hires. Education for all EVS staff will be scheduled twice a year with infection control. Each EVS cleaning		

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F 880	Continued From page 14 Findings include: INFECTION CONTROL DATA REVIEW AND ANALYSIS: The facility Resident Illness Symptoms Tracking Logs and Infection Analysis forms from January 2018 thru June 2018 were reviewed. Infection control data was presented on two different documents. One of the "Resident Illness Symptom Tracking Logs" document exclusively line-listed residents receiving antibiotic treatment for infections. A second "Resident Illness Symptoms Tracking Log" line-listed residents with various symptoms, or incidents that may be infection related, such as loose stools, altered mental status, cough, skin abrasion after a fall, and included all residents whether or not they were receiving an antibiotic. Data collected on tracking logs included: resident name, room and location, onset date of the symptom, indicated if the infection was facility acquired or not, a culture date if applicable, symptoms, source of infection, any predisposing factors, the organism identified, the antibiotic intervention, and dated cleared. Another document, Monthly Infection Analysis, identified the number or frequency of: resident symptoms by nursing home unit (North, South, West, Villa Court, Pine Haven and total); resident repeat symptoms by infection type within 30 days; Employee illness reporting by symptom by type (fever, vomiting, diarrhea, skin, eye-conjunctivitis, influenza, respiratory, C-diff [Clostridium Difficile], headache, or other) and number of staff ill; and sources of infection (including respiratory, urinary, eye, ear, skin, wound, gastro-intestinal, or other). The bottom of the page included space to Identify	F 880	cart was audited to be sure that the three ring binders containing isolation precautions and cleaning reference guide was on each cart. The EVS manager or her designee will complete cleaning audits of c-diff isolation rooms for the next 3 residents who are diagnosed with c-diff or until compliance is met. The results of these audits will be brought to the infection control quality meeting by the EVS manager. Analysis of infections: The monthly analysis form was reviewed and updated with current information. The infection control nurse will review infections and symptom log with IDT team at the weekly resident review meeting and document findings, trends and actions taken on the monthly analysis worksheet. Audits of the infection control monthly analysis will be done by the Long Term Care Director for 3 months or until compliance is met. The results of these audits will be brought to the infection control quality meeting by the LTC Director. Completion date: July 26th, 2018		

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F 880	Continued From page 15 trends/action Plan. Review of the collected data from January 2018 through June 2018 identified the following: January 2018 Infection Analysis identified included: -no repeat resident infection past 30 days; -organisms identified: 1 proteus; 2 staph epidermidis; 1 corynebacterium; -11 identified sources of infections: 5 respiratory; 4 urinary tract; 1 eye; and 1 skin. - 34 resident symptoms identified, sorted by source of infection, including 10 respiratory, 5 urinary tract, 1 skin, 1 wound 1 eye, and 1 skin infection; -12 long-term care staff ill, with symptoms including fever, vomiting, diarrhea, influenza, respiratory, headache and other unidentified - 62 total resident symptoms identified by source: 19 respiratory; 2 urinary tract; 1 eye; 7 skin; 16 gastro-intestinal; 17 other, unidentified; and as identified by nursing home location: 8 North; 6 South; 5 West; 14 Villa Court; and 29 (Pine) Haven. In the "Identify trends/action Plan" section identified; "Staff and resident symptoms had no trends identified." There was no further narrative summary, analysis or identification of trends from surveillance data collected for residents who had symptoms of potential infections, but were not receiving any antibiotic therapy treatment. The February 2018 Infection Analysis identified: -11 Health-Care Associated Infections (HAI or	F 880			

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F 880	Continued From page 16 in-house acquired), and no (0) community acquired resident infections; -no repeat resident infection past 30 days; -3 total organisms identified: 1 proteus; 2 staph epidermidis; 1 corynebacterium; -11 total identified sources of infections: 5 respiratory; 4 urinary tract; 1 eye; and 1 skin; and as identified by nursing home location: 1 North; 1 South; 1 West; 8 Villa Court; and 0 (Pine) Haven. -No residents on isolation; -34 total resident symptoms identified by location: 2 North; 5 south; 6 West; 8 Villa Court; 16 Pine Haven; -34 resident symptoms identified by source of infection: 10 respiratory, 5 urinary tract, 1 skin, 1 wound; 5 respiratory; and 12 other unidentified; -12 long-term care staff ill, with symptoms (frequency) including: fever (6), vomiting (3), diarrhea (3), influenza (6), respiratory (6), headache (6) and other unidentified (3). In the "Identify trends/action Plan" section was the following: "Employee tested positive for Influenza. Pine Haven residents exposed, no positive influenza. Majority of illness and illness by symptoms was from resp (respiratory) source. Pine Haven residents exposed to influenza B. No resident tested positive for influenza. No trends noted." There was no further summary or analysis. The March 2018 Infection Analysis identified: -(11) Health-Care Associated Infections (HAI or in-house acquired), and (1) community acquired resident infections; -no repeat resident infection past 30 days; -(6) total organisms identified: C-difficile; (1)	F 880			

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F 880	Continued From page 17 Enterococcus; (3) Klebsiella; and (1) corynebacterium; -(11) total identified sources of infections: (2) respiratory; (6) urinary tract; (1) eye; (2) gastro-intestinal; -(11) total infections as identified by nursing home location: (0) North; (4) South; (3) West; (1) Villa Court; and (3) Pine Haven; -(1) resident on isolation in south unit; -(48) total resident symptoms identified by location: (1) North; (9) South; (7) West; (9) Villa Court; and (22) Pine Haven; -(48) resident symptoms identified by source of infection: (16) respiratory; (2) urinary tract; (10) skin; (1) wound; (8) gastro-intestinal; and (11) other unidentified; -(4) long-term care staff ill, with symptoms (frequency) including: fever (1); eye-conjunctivitis (1); headache (1); and other unidentified (3). In the "Identify trends/action Plan" section was the following: "Exposure to influenza from staff x (times) 2, no resident influenza diagnosis so far this season. Majority of illness and symptoms of illness from respiratory source. Exposed to influenza with no resident testing positive. C diff (Clostridium Difficile) isolation. 2 residents in the same unit were tested for C-Diff and were both negative. There was no further summary or analysis for March 2018. There was no Monthly Infection Analysis for April or May 2018. When interviewed on 6/28/18, at 10:28 a.m., registered nurse (RN)-D stated she was responsible and in charge of the infection control program, in conjunction with the infection control committee. RN-D stated she had been in charge	F 880			

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F 880	Continued From page 18 since September of 2017, and admitted was not completely familiar with the expectations of infection control program for long term care. RN-C stated we did a good job of collecting data, but they could do a better, more thorough job of analysis and summarizing of what the data "showed or did not show." RN-D stated the analysis "was lacking." RN-D cited an example and talked about the facility's "uneventful" flu season, and recalled how a staff member passing medications on a unit went home sick, then subsequently was diagnosed with influenza B. RN-D stated the staff started on Tamiflu, then we monitored the residents' symptoms and vital signs for 7 days, and we had no outbreaks. RN-D stated her monthly infection control report had no documentation about how the facility responded to the situation, and what action was taken to mitigate the spread flu. RN-D stated when looking for trends, she looked for type, location, frequency, same types of bugs and treatments and antibiotics used, and possible staff connections, but "was not documented" in any analysis. RN-D stated the summary reports had the numbers, but did not have the "why" explaining RN-D stated if that were part of the monthly summary, "we'd have evidence" that we looked at what were doing. RN-D stated she had not completed monthly summaries of infection reports for April 2018 or May 2018. A facility policy, Infection Prevention and Control Plan-Long Term Care, last revised 11/2017, indicated as its purpose to establish a comprehensive Infection Control and Prevention Plan to reduce the risks of nosocomial/Healthcare Acquired Infections (HAIs) and to provide a system for preventing, identifying, reporting, investigating, and controlling infections and	F 880			

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F 880	Continued From page 19 communicable diseases in residents, staff, visitors, volunteer, and other individuals providing services under a contractual agreement. Under the responsibilities section, the policy indicated the infection preventionist will maintain records of incidents related to infections and communicable diseases, and analyze epidemiological data, evaluate effectiveness of prevention and control strategies. DISINFECTION of RESIDENT ROOM: R25's quarterly Minimum Data Set (MDS) dated 4/12/18, identified R25 had moderate cognitive impairments and required extensive assistance with toileting. Further, R25 was always continent of bowel. During observation on 5/25/18, at 2:08 p.m. R25 had a cart outside the room with gloves and masks. On top of the cart was a container of Sani Cloth Bleach Germicidal Wipes. R25's door had a sign directing staff and visitors R25 was on enteric precautions. The sign included direction to always glove, gown and to disinfect the environment and equipment using bleach. R25's lab results dated 5/31/18, identified R25 had C-Diff R25's progress note(s) identified the following: -5/31/18, R25 lab results were positive for C-Diff and was placed on precautions. -6/27/18, R25 had formed stools the last three days and was removed from precautions. During interview on 6/26/18, at 3:23 p.m. nursing assistant (NA)-C stated the nursing staff always wear gloves and gowns when providing personal	F 880			

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F 880	Continued From page 20 cares, including toileting to R25. R25 had been incontinent of stool with the C-Diff infection; however, it was contained in her brief. On 6/27/18, at 7:31 a.m. housekeeper (H)-A stated she cleaned all the rooms on Lilac Lane and uses the standard disinfectant Virex (general disinfectant that does not kill C-Diff spores) on all the rooms including R25's. H-A stated she wore gloves and a gown when cleaning R25's room. She cleaned R25's bathroom daily including the toilet and counters with the Virex disinfectant. She cleaned the floors with the standard floor cleaner Stride to wash the bathroom and living area floors. Each resident room was cleaned with a clean separate mop head as well as a clean separate mop head for each bathroom and living area. H-A stated she tried to clean R25's room last, but did not always clean it last. She brought the supplies in from her cart and returned them to her cart after cleaning R25's room. She tried not to set the supplies down in the room "if she could help it." H-A's cart was observed at the time, there was a spray bottle of Virex cleaner and clean rags. There were no bleach products on the cart. On the top of the cart was soapy water H-A stated she used for mopping the floors. She stated a clean mop head went into the water to wash the floor and didn't place a dirty mop head into the water bin. During interview on 6/27/18, at 9:49 a.m. environmental services coordinator (ESC) stated when a resident had C-Diff it needed to be disinfected with bleach products according to the contact time. After coming off the precautions the curtains were washed and all services were	F 880			

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F 880	Continued From page 21 disinfected with Sani Cloth Bleach Germicidal wipes. If a resident has C-Diff the floors were to be cleaned with 1 part bleach to 10 parts water. The Virex disinfectant spray and Stride floor cleaning solution was not effective at killing the C-Diff bacteria. During interview on 6/27/18, at 9:24 a.m. H-B stated when cleaning rooms where the resident had C-Diff she wore gloves and a gown. She used the Quat disinfecting cleaner to clean the bathrooms and used Crossbow cleaner to clean the floors. She cleaned all residents rooms the same and did not use and special products when cleaning rooms of residents with C-Diff. She cleaned the rooms in the order she came to them and did not clean rooms with infection control precautions last. During follow up interview on 6/27/18, at 12:56 p.m. ESC stated a couple of the housekeeping staff approached her on how the should be cleaning a room when the resident had C-Diff. She educated them they needed to be using bleach products. There was supposed to be information on how to clean rooms on a kardex ring on the housekeeping carts that instructed the housekeepers on how to clean rooms depending on the bacteria or virus , but they were not on the housekeeping carts. During interview on 6/28/18, at 9:51 a.m. enviromental service manager (ESM) stated the staff were trained on hire and annually on how to properly clean rooms including when a resident had C-Diff. She stated the training needed to be re-enforced every time a resident was placed on precautions so the staff were reminded on the proper cleaning expectations and had the	F 880			

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F 880	Continued From page 22 supplies to clean with. ESM reported there were 23 residents who resided in the Lilac unit. During interview on 6/28/18, at 10:59 a.m .the director of nursing (DON) stated if R25's room was not disinfected properly it placed other residents, staff and visitors at risk of contracting C-Diff as it was highly contagious. The Centers for Disease Control Guidelines for Environmental Infection Control in Health-Care Facilities dated 2003 identified. "The recommended approach to environmental infection control with respect to C. difficile is meticulous cleaning followed by disinfection using hypochlorite-based germicides as appropriate." The facility policy Clostridium Difficile and Patients with Unformed Stool revised 8/17, identified enteric precautions would be used for all residents with a C-Diff infection. Use of a bleach based disinfecting agent would be used for all environmental cleaning. The undated Virex II manufacturer instructions identified it was effective against blood born pathogens; however, it was not effective at killing C-Diff. The undated Quat 256 manufacturer instructions did not identify it was effective against C-Diff. The undated Stride manufacturer instructions did not identify it was effective against C-Diff.	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2018
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 26, 2018 At the time of this survey, Centracare Health System Melrose (Pine Villa) was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000			

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

TITLE

(X6) DATE

Electronically Signed

07/25/2018

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.

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Centracare Health System Melrose (Pine Villa) was constructed as follows: The original building was constructed in 1961, is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(000) construction; The 1969 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type V(111) construction; The 1994 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction. The 2007 addition is one-story in height, has no basement, is fully sprinklered, and was	K 000			

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K 000	Continued From page 2 determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 71 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 132 SS=E	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a 2 hour fire barrier from a clinic as required by NFPA 101 (12) section 19.1.3.4.1. This deficient practice could allow for the spread of fire or smoke between occupancies affecting 33 of the 75 residents and an	K 132	Both areas were fire caulked and pillowed. The area will be checked again by maintenance for any additional holes. Completed by Dave Primus, Maintenance.		7/17/18

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K 132	Continued From page 3 undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018; 1. Observations revealed the 2 hour fire barrier between the 1961 & 1958 addition, in the environmental service room along the top of wall was not properly fire stopped. 2. Observations revealed the 2 hour fire barrier along the Pine Cove Lounge above the ceiling tile has a bundle of conduit that does not have fire stopping around the annular space. This deficient condition was confirmed by the Maintenance Supervisor.	K 132			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to comply with NFPA 80, Standard for Fire Doors and Other Opening Protective's 2010 edition. This deficient practice could affect the exiting ability of an undetermined amount of residents, staff and visitors.	K 211	Inspected on 7/2/2018 by Mid Central Door. McGough Contractor to review and make corrections.		8/7/18

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K 211	Continued From page 4 Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 documentation review revealed the fire door inspection report was dated 3/17 which exceeded the 12 month (annual) required inspection. This deficient condition was confirmed by the Maintenance Supervisor.	K 211			
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep exits free of obstructions as stated in the Life Safety Code (NFPA 101) 2012 edition sections 19.2.7 & 7.1.10. This deficient practice could restrict the exiting during an emergency and affect an undetermined amount of residents, staff and visitors. Findings Include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 Observations revealed the sidewalk extending from the exit of the chapel exceeded the allowable elevation difference before a bevel or ramp is required.	K 271	Contractor Precision Concrete Cutting checked slope and will grind to required slope. Monitored by Joel Ohmann, Maintenance manager		8/7/18

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K 271	Continued From page 5	K 271		
K 321 SS=E	This deficient condition was confirmed by the Maintenance Supervisor. Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 321		7/19/18
			The door closer was adjusted by Kyle	

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K 321	Continued From page 6 facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 30 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations reveled the door to soiled utility room 21, across from resident room 64 did not latch when tested. This deficient condition was confirmed by the Maintenance Supervisor.	K 321	Funk, maintenance. Door closing will be checked in the PM system and monitored by Joel Ohman, Maintenance manager.		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		7/16/18	

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K 341	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed a smoke detector within 36 inches of an HVAC diffuser in clean utility room 216. This deficient condition was confirmed by the Maintenance Supervisor.	K 341	The smoke detector was relocated. Completed by Dave Primus, maintenance		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code, (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 This deficient practice could affect the	K 347	A smoke detector will be added in the room. Completed by contractor Summit and monitored by Dave Primus, Maintenance.		8/7/18

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K 347	Continued From page 8 ability of the alarm system to sound in a timely manner during a fire event which could affect 36 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed the beauty shop did not have a door, making it open to the corridor, and was not protected by the smoke detection system. This deficient condition was confirmed by the Maintenance Supervisor.	K 347			
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353			7/16/18

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K 353	Continued From page 9 by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 The standard for testing and maintenance of sprinkler systems, section 15.5.2. This deficient condition could allow for the spread of fire. This could affect all of the 36 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed an escutcheon missing from a sprinkler head in the memory care storage room. This deficient condition was confirmed by the Maintenance Supervisor.	K 353	The escutcheon was installed and another one was found and a cover was placed on it. Completed by Dave Primus, Maintenance		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide documentation of the required annual fire extinguisher inspections as required by the Life Safety Code, NFPA 101 2012 edition section 9.7.4.1 and NFPA 10, Portable Fire Extinguishers, sections 7.3.1.1.1 & 7.2.4.4. This deficient practice could render an	K 355	The annual fire extinguisher inspection report was provided on 6/27/2018 via email to Bob Baumann, Fire Marshal.		6/27/18

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K 355	Continued From page 10 extinguisher inoperable and affect all 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 documentation review revealed there was no annual fire extinguisher inspection report. This deficient condition was confirmed by the Maintenance Supervisor.	K 355			
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of all 75 residents and an undetermined	K 372	Fire pillows and fire caulking was done in the affected areas. Dave Primus, Maintenance will monitor and recheck for holes.		7/18/18

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K 372	Continued From page 11 amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed penetrations in the following smoke barriers; 1. The 2008 addition along the activities room at the ceiling line around the roof panels. 2. The barrier along the pine cove lounge, the annular space around 5 conduits above the ceiling tile. This deficient condition was confirmed by the Maintenance Supervisor.	K 372			
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift and verify the transmission of the fire alarm signal as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient	K 712	Fire drills added to the PM scheduler system. Transmitting night shift drills will be added the following day to the procedure.		7/25/18

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K 712	Continued From page 12 practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 documentation review revealed there was no record of the transmission of the fire alarm signal the day after the night shift drills during the 1st & 2nd quarter of 2018 and no record of a drill being performed on the 2nd shift of the 2nd quarter in 2018. This deficient condition was confirmed by the Maintenance Supervisor.	K 712			
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced	K 753			7/23/18

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K 753	Continued From page 13 by: Based on observation and staff interview the facility failed to restrict highly flammable furnishings as required by the Life Safety Code (NFPA 101) 2012 edition sections 10.3.5 & A 10.3.5 This deficient practice could provide easy ignition of a fire and spread smoke and flame throughout the smoke compartment. This could affect 30 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed the entrance door to resident room 37 was covered by about 75% with pictures and drawings. This deficient condition was confirmed by the Maintenance Supervisor.	K 753	the decorations were removed by Bertha Hartung, RN, Long Term Care Director after consulting with the resident. Bertha will monitor doors for decorations ongoing. The admission meeting will include instructions to families about decorations on doors.		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and	K 901	The Risk assessment was provided via e-mail to Bob Baumann on 6/27/2018		6/27/18

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K 901	Continued From page 14 current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 75 of 75 residents, as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 documentation review revealed there was no record of a risk assessment per NFPA 99. This deficient condition was confirmed by the Maintenance Supervisor.	K 901			
K 909 SS=D	Gas and Vacuum Piped Systems - Information an CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Information and Warning Signs Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 909			7/15/18
			The oxygen pipe at the control valve was		

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

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K 909	Continued From page 15 facility failed to follow the installation procedures for gas piping according to NFPA 99 (12) section 5.1.11.1.1. This deficient practice could allow an accidental stop in the flow of oxygen. This could affect 36 of the 75 residents. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed the oxygen pipe at the control valve location for the Pine Villa wing was not labeled. This deficient condition was confirmed by the Maintenance Supervisor.	K 909	labeled by Dave Primus, maintenance.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		7/25/18	

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K 914	Continued From page 16 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 75 of 75 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 documentation review revealed there was no record of inspection for the receptacles in resident care areas at the time of survey. This deficient condition was confirmed by the Maintenance Supervisor.	K 914	Annual testing was set up in the PM system. Testing will be completed annually. Dave Primus, maintenance to monitor.		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920			7/17/18

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K 920	Continued From page 17 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2.4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect 1 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed two power strips "daisy chained" in the nurses office in the Pine Villa wing and a 3 way multi plug adapter being used in resident room 65. This deficient conditions was confirmed by the Maintenance Supervisor.	K 920	Both power strips were removed and replaced with a longer, hospital grade cord. Dave Primus, maintenance to monitor.		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923			7/23/18

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K 923	Continued From page 18 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to label oxygen storage rooms in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.3.4.1. This deficient practice could affect an undetermined	K 923	Door was labeled with appropriate signage. Completed by Dave Primus, maintenance.		

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K 923	Continued From page 19 amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 06/26/2018 observations revealed the oxygen storage room in the memory care wing was not labeled. This deficient conditions was confirmed by the Maintenance Supervisor.	K 923			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 16, 2018

Mr. Gerry Gilbertson, Administrator
CentraCare Health System - Melrose Pine Villa CC
525 West Main Street
Melrose, MN 56352

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5396027

Dear Mr. Gilbertson:

The above facility was surveyed on June 25, 2018 through June 28, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 only a suggestion 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 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.

July 16, 2018

Page 2

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.

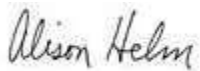
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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 Brenda Fischer, Unit Supervisor at brenda.fischer@state.mn.us or (320) 223-7338.

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
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/28/2018
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE F			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 attached Minnesota	2 000			

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/25/18

Minnesota Department of Health

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 6/25/18, to 6/28/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively investigate an incident from the bath chair for 1 of 1 residents (R28), who stated the tub chair broke while bathing. Findings include: R28's annual Minimum Data Set (MDS) assessment dated 4/19/18, indicated R28 had intact cognition and received extensive assistance to complete activities of daily living (ADL's) including transferring and dressing. R28's care plan, also indicated a self care deficit related to functional limitations related to history of a fractured humerus (the long bone in the upper arm) and arthritis. The care plan dated 3/22/16,	2 830	Corrected	7/26/18

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2 830	Continued From page 3 directed staff to provide assistance with transfer assistance and bathing. On 6/28/18, at 9:10 a.m. R28 stated she had received a bath on 6/27/18, by staff. When she was assisted out of the tub, the chair broke and she was on the floor. R28 stated "It was hard to get me up from the floor." On 6/28/18, at 9:20 a.m. the tub room on Lilac Lane was observed with NA-D. It was an Apollo tub which opened on the end. The tub chair and base attached to the end of the tub and then the chair was released from the base and glided on rails on either side of the tub. The base was released and the end of the tub was closed. Following a bath the tub was drained the door at the end of the tub was opened and the tub chair base was locked to the end of the tub. The seat was glided on the rails over the tub chair base and was locked into place. The resident could then be transferred from the tub chair to a wheelchair. NA-D stated she assisted R28's with her bath in the Lilac Lane tub room on 6/27/18, at approximately 7:50 a.m. NA-D stated after finishing R28's bath NA-D glided the seat on the rails towards the tub chair base. NA-D stated "Something happened. The whole thing moved", indicating the portion of the chair R28 was seated on lifted off the rails and slid back on the track system into the tub. NA-D demonstrated this movement on the Apollo tub on Lilac Lane and the black plastic portion of the seat tilted forward and lifted off of the seat frame. NA-D stated with the movement of the base of the seat forward R28 was unable to gain her balance and NA-D assisted R28 onto the moveable chair base (without the seat section), placed the base	2 830			

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2 830	Continued From page 4 against the wall so she was able to summon help. NA-D did not identify R28 was placed the floor. NA-D stated staff responded and R28 was assessed for injuries. R28 was free from injuries and assisted to complete dressing and transfer into her wheelchair. NA-D stated an unidentified staff member later informed her the tub was broken and "they found a screw on the floor". On 6/28/18, at 10:36 a.m. NA-D stated she had not received any further training or instruction regarding tub use and transfer equipment. On 6/28/18, at 9:50 a.m. the director of maintenance (DM) and maintenance assistant (M)-A stated they were unaware of any incident involving the tub transfer system on Lilac Lane with R28. M-A stated monthly tub maintenance was performed, following manufacturers recommendations. M-A stated when notified by staff with any incidents involving equipment maintenance would evaluate the equipment function to determine need for repair and if it could remain in use. M-A stated he was contacted on 6/27/18, of the tub transfer system not releasing on the tub on Lilac Lane and did fix a piece on the foot lever would not allow the chair to release. However, was not made aware of the incident with R28. M-A observed a piece underneath had busted off, and a nut which had come off. On 06/28/18, at 10:57 a.m. RN-A stated R28 was lowered to the floor after her bath because part of the chair had fallen away when staff were assisting R28 with a transfer out of the tub. RN-A stated R28 was assessed for injuries and vital signs were checked R28 denied any injuries and hitting her head. R28 was assisted by four staff members into her wheelchair. RN-A stated the	2 830		

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 tub chair was placed back on the track of the tub and seemed to be working properly.; however did not notify the maintenance department of the incident for further inspection. RN-A stated he did not complete any follow up education with NA-A after the incident. RN-A stated the Interdisciplinary Team (IDT) reviewed the incident later in the morning, however, there was no documentation about the incident. On 6/28/18, at 11:17 a.m. LPN-A stated she assisted R28 following her being lowered to the floor prior to RN-A's arrival. LPN-A stated no follow up was completed with the maintenance department at the time as it was felt to be an operator error. LPN-A stated following the next bath in the Lilac Lane tub room staff experienced problems with the transfer system and maintenance was contacted for follow up but had not advised him of the previous incident with the tub transfer system. R28's electronic incident report dated 6/27/18, at 10:19 a.m. completed by RN-A indicated R28 was lowered to the floor at 8:00 a.m. "After the tub seat attachment fell off." The incident report did not include any investigation into the cause of the seat detachment or interventions the facility initiated. On 6/28/18, at 12:01 p.m. the director of nursing (DON) stated following an incident it would be her expectation the charge nurse would evaluate the situation which included assessing for injuries and determine the cause of incident. This process should include evaluation of the equipment, transfer assistance provided, and any training of staff as needed. The DON stated she had been informed of the incident and no concerns were identified regarding user error.	2 830		

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2 830	Continued From page 6 Additionally, the DON stated there was no evidence the chair was malfunctioning. The DON stated there would be evaluation of the event at the daily interdisciplinary team meeting which was held daily at 9:00 a.m. The DON stated formal documentation was not completed for these meetings. On 6/28/18, at 1:45 p.m. RN-B stated she was aware of the incident and it was felt to be operator error. A facility policy for investigation of incidents was requested and not received. A request was made for NA-D training documentation for use of the tub but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review policies and procedures for fall investigations. The DON or designee, could audit fall investigations to ensure proper steps and procedures were implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920			7/26/18

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2 920	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral cares were offered or provided for 1 of 1 residents (R8) in the sample who was dependent on staff for assistance with activities of daily living (ADL's). Findings include: R8's quarterly Minimum Data Set (MDS) dated 3/15/18, indicated she had Alzheimers disease, was cognitively impaired and needed extensive assistance with ADL's. R8's care plan revised on 2/4/18, indicated for personal hygiene an intervention to assist of one to brush teeth after each meal. R8's Kardex (report sheet for nursing assistant giving instructions on cares) indicated to brush teeth after each meal. During interview 6/25/18, at 2:43 a.m. family member (FM)-A stated they wanted R8's teeth brushed after lunch which the facility does not complete. FM-A stated they have told the staff several times and sometimes find food in her mouth when they come to visit in the afternoon. During observation 6/27/18, at 12:20 p.m. nursing assistant (NA)-B was observed to wheel R8 in her wheelchair to her room and placed in front of the television. At 12:30 p.m. NA-A and NA-B were observed to use a EZ-Stand (a lift to help transfer) and place R8 into bed. NA-A and NA-B provided peri-care and then lowered the bed covered her up and left the room. No oral cares were provided as FM-A had requested. During interview 6/27/18, registered nurse (RN)-A	2 920	Corrected	

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2 920	Continued From page 8 stated R8's teeth should be brushed after each meal according to her care plan. RN-A stated this is on her Kardex but he will be adding a task on the computer so the NA's know oral cares must be completed after each meal. A facility policy revised 4/2018, indicated nursing staff will provide all residents with mouth care to maintain or improve oral hygiene. The policy directed staff to wash hands gather supplies assist the resident with oral hygiene and offer water for rinsing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents oral care needs are met. The DON or designee could educate all appropriate staff on the policies and procedures and audit oral care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently review and analyze their collected infection control data	21375	Corrected		7/10/18

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21375	Continued From page 9 for potential patterns of infection in the facility, including signs/symptoms of infections not treated with an antibiotic, to prevent the spread of communicable disease and infections. This practice had the potential to affect all 72 residents who currently resided in the facility. In addition, the facility failed to ensure housekeeping staff appropriately disinfected a room for 1 of 1 residents (R25) who was on enteric precautions for C-diff (Clostridium difficile, a highly contagious, spore-forming bacterium which can cause severe diarrhea). This had the potential to affect all 23 residents who resided on Lilac Lane. Findings include: INFECTION CONTROL DATA REVIEW AND ANALYSIS: The facility Resident Illness Symptoms Tracking Logs and Infection Analysis forms from January 2018 thru June 2018 were reviewed. Infection control data was presented on two different documents. One of the "Resident Illness Symptom Tracking Logs" document exclusively line-listed residents receiving antibiotic treatment for infections. A second "Resident Illness Symptoms Tracking Log" line-listed residents with various symptoms, or incidents that may be infection related, such as loose stools, altered mental status, cough, skin abrasion after a fall, and included all residents whether or not they were receiving an antibiotic. Data collected on tracking logs included: resident name, room and location, onset date of the symptom, indicated if the infection was facility acquired or not, a culture date if applicable, symptoms, source of infection, any predisposing factors, the organism identified, the antibiotic intervention, and dated cleared.	21375			

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21375	Continued From page 10 Another document, Monthly Infection Analysis, identified the number or frequency of: resident symptoms by nursing home unit (North, South, West, Villa Court, Pine Haven and total); resident repeat symptoms by infection type within 30 days; Employee illness reporting by symptom by type (fever, vomiting, diarrhea, skin, eye-conjunctivitis, influenza, respiratory, C-diff [Clostridium Difficile], headache, or other) and number of staff ill; and sources of infection (including respiratory, urinary, eye, ear, skin, wound, gastro-intestinal, or other). The bottom of the page included space to Identify trends/action Plan. Review of the collected data from January 2018 through June 2018 identified the following: January 2018 Infection Analysis identified included: -no repeat resident infection past 30 days; -organisms identified: 1 proteus; 2 staph epidermidis; 1 corynebacterium; -11 identified sources of infections: 5 respiratory; 4 urinary tract; 1 eye; and 1 skin. - 34 resident symptoms identified, sorted by source of infection, including 10 respiratory, 5 urinary tract, 1 skin, 1 wound 1 eye, and 1 skin infection; -12 long-term care staff ill, with symptoms including fever, vomiting, diarrhea, influenza, respiratory, headache and other unidentified - 62 total resident symptoms identified by source: 19 respiratory; 2 urinary tract; 1 eye; 7 skin; 16 gastro-intestinal; 17 other, unidentified; and as identified by nursing home location: 8 North; 6 South; 5 West; 14 Villa Court; and 29 (Pine) Haven. In the "Identify trends/action Plan" section	21375		

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21375	Continued From page 11 identified; "Staff and resident symptoms had no trends identified." There was no further narrative summary, analysis or identification of trends from surveillance data collected for residents who had symptoms of potential infections, but were not receiving any antibiotic therapy treatment. The February 2018 Infection Analysis identified: -11 Health-Care Associated Infections (HAI or in-house acquired), and no (0) community acquired resident infections; -no repeat resident infection past 30 days; -3 total organisms identified: 1 proteus; 2 staph epidermidis; 1 corynebacterium; -11 total identified sources of infections: 5 respiratory; 4 urinary tract; 1 eye; and 1 skin; and as identified by nursing home location: 1 North; 1 South; 1 West; 8 Villa Court; and 0 (Pine) Haven. -No residents on isolation; -34 total resident symptoms identified by location: 2 North; 5 south; 6 West; 8 Villa Court; 16 Pine Haven; -34 resident symptoms identified by source of infection: 10 respiratory, 5 urinary tract, 1 skin, 1 wound; 5 respiratory; and 12 other unidentified; -12 long-term care staff ill, with symptoms (frequency) including: fever (6), vomiting (3), diarrhea (3), influenza (6), respiratory (6), headache (6) and other unidentified (3). In the "Identify trends/action Plan" section was the following: "Employee tested positive for Influenza. Pine Haven residents exposed, no positive influenza. Majority of illness and illness by symptoms was from resp (respiratory) source. Pine Haven residents exposed to influenza B. No resident tested positive for influenza. No trends noted." There was no further summary or	21375			

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21375	Continued From page 12 analysis. The March 2018 Infection Analysis identified: -(11) Health-Care Associated Infections (HAI or in-house acquired), and (1) community acquired resident infections; -no repeat resident infection past 30 days; -(6) total organisms identified: C-difficile; (1) Enterococcus; (3) Klebsiella; and (1) corynebacterium; -(11) total identified sources of infections: (2) respiratory; (6) urinary tract; (1) eye; (2) gastro-intestinal; -(11) total infections as identified by nursing home location: (0) North; (4) South; (3) West; (1) Villa Court; and (3) Pine Haven; -(1) resident on isolation in south unit; -(48) total resident symptoms identified by location: (1) North; (9) South; (7) West; (9) Villa Court; and (22) Pine Haven; -(48) resident symptoms identified by source of infection: (16) respiratory; (2) urinary tract; (10) skin; (1) wound; (8) gastro-intestinal; and (11) other unidentified; -(4) long-term care staff ill, with symptoms (frequency) including: fever (1); eye-conjunctivitis (1); headache (1); and other unidentified (3). In the "Identify trends/action Plan" section was the following: "Exposure to influenza from staff x (times) 2, no resident influenza diagnosis so far this season. Majority of illness and symptoms of illness from respiratory source. Exposed to influenza with no resident testing positive. C diff (Clostridium Difficile) isolation. 2 residents in the same unit were tested for C-Diff and were both negative. There was no further summary or analysis for March 2018.	21375			

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21375	Continued From page 13 There was no Monthly Infection Analysis for April or May 2018. When interviewed on 6/28/18, at 10:28 a.m., registered nurse (RN)-D stated she was responsible and in charge of the infection control program, in conjunction with the infection control committee. RN-D stated she had been in charge since September of 2017, and admitted was not completely familiar with the expectations of infection control program for long term care. RN-C stated we did a good job of collecting data, but they could do a better, more thorough job of analysis and summarizing of what the data "showed or did not show." RN-D stated the analysis "was lacking." RN-D cited an example and talked about the facility's "uneventful" flu season, and recalled how a staff member passing medications on a unit went home sick, then subsequently was diagnosed with influenza B. RN-D stated the staff started on Tamiflu, then we monitored the residents' symptoms and vital signs for 7 days, and we had no outbreaks. RN-D stated her monthly infection control report had no documentation about how the facility responded to the situation, and what action was taken to mitigate the spread flu. RN-D stated when looking for trends, she looked for type, location, frequency, same types of bugs and treatments and antibiotics used, and possible staff connections, but "was not documented" in any analysis. RN-D stated the summary reports had the numbers, but did not have the "why" explaining RN-D stated if that were part of the monthly summary, "we'd have evidence" that we looked at what were doing. RN-D stated she had not completed monthly summaries of infection reports for April 2018 or May 2018.	21375			

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21375	Continued From page 14 A facility policy, Infection Prevention and Control Plan-Long Term Care, last revised 11/2017, indicated as its purpose to establish a comprehensive Infection Control and Prevention Plan to reduce the risks of nosocomial/Healthcare Acquired Infections (HAIs) and to provide a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases in residents, staff, visitors, volunteer, and other individuals providing services under a contractual agreement. Under the responsibilities section, the policy indicated the infection preventionist will maintain records of incidents related to infections and communicable diseases, and analyze epidemiological data, evaluate effectiveness of prevention and control strategies. DISINFECTION of RESIDENT ROOM: R25's quarterly Minimum Data Set (MDS) dated 4/12/18, identified R25 had moderate cognitive impairments and required extensive assistance with toileting. Further, R25 was always continent of bowel. During observation on 5/25/18, at 2:08 p.m. R25 had a cart outside the room with gloves and masks. On top of the cart was a container of Sani Cloth Bleach Germicidal Wipes. R25's door had a sign directing staff and visitors R25 was on enteric precautions. The sign included direction to always glove, gown and to disinfect the environment and equipment using bleach. R25's lab results dated 5/31/18, identified R25 had C-Diff R25's progress note(s) identified the following:	21375		

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21375	Continued From page 15 -5/31/18, R25 lab results were positive for C-Diff and was placed on precautions. -6/27/18, R25 had formed stools the last three days and was removed from precautions. During interview on 6/26/18, at 3:23 p.m. nursing assistant (NA)-C stated the nursing staff always wear gloves and gowns when providing personal cares, including toileting to R25. R25 had been incontinent of stool with the C-Diff infection; however, it was contained in her brief. On 6/27/18, at 7:31 a.m. housekeeper (H)-A stated she cleaned all the rooms on Lilac Lane and uses the standard disinfectant Virex (general disinfectant that does not kill C-Diff spores) on all the rooms including R25's. H-A stated she wore gloves and a gown when cleaning R25's room. She cleaned R25's bathroom daily including the toilet and counters with the Virex disinfectant. She cleaned the floors with the standard floor cleaner Stride to wash the bathroom and living area floors. Each resident room was cleaned with a clean separate mop head as well as a clean separate mop head for each bathroom and living area. H-A stated she tried to clean R25's room last, but did not always clean it last. She brought the supplies in from her cart and returned them to her cart after cleaning R25's room. She tried not to set the supplies down in the room "if she could help it." H-A's cart was observed at the time, there was a spray bottle of Virex cleaner and clean rags. There were no bleach products on the cart. On the top of the cart was soapy water H-A stated she used for mopping the floors. She stated a clean mop head went into the water to wash the floor and didn't place a dirty mop head into the water bin.	21375			

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21375	Continued From page 16 During interview on 6/27/18, at 9:49 a.m. environmental services coordinator (ESC) stated when a resident had C-Diff it needed to be disinfected with bleach products according to the contact time. After coming off the precautions the curtains were washed and all services were disinfected with Sani Cloth Bleach Germicidal wipes. If a resident has C-Diff the floors were to be cleaned with 1 part bleach to 10 parts water. The Virex disinfectant spray and Stride floor cleaning solution was not effective at killing the C-Diff bacteria. During interview on 6/27/18, at 9:24 a.m. H-B stated when cleaning rooms where the resident had C-Diff she wore gloves and a gown. She used the Quat disinfecting cleaner to clean the bathrooms and used Crossbow cleaner to clean the floors. She cleaned all residents rooms the same and did not use and special products when cleaning rooms of residents with C-Diff. She cleaned the rooms in the order she came to them and did not clean rooms with infection control precautions last. During follow up interview on 6/27/18, at 12:56 p.m. ESC stated a couple of the housekeeping staff approached her on how the should be cleaning a room when the resident had C-Diff. She educated them they needed to be using bleach products. There was supposed to be information on how to clean rooms on a kardex ring on the housekeeping carts that instructed the housekeepers on how to clean rooms depending on the bacteria or virus , but they were not on the housekeeping carts. During interview on 6/28/18, at 9:51 a.m. environmental service manager (ESM) stated the	21375		

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21375	Continued From page 17 staff were trained on hire and annually on how to properly clean rooms including when a resident had C-Diff. She stated the training needed to be re-enforced every time a resident was placed on precautions so the staff were reminded on the proper cleaning expectations and had the supplies to clean with. ESM reported there were 23 residents who resided in the Lilac unit. During interview on 6/28/18, at 10:59 a.m .the director of nursing (DON) stated if R25's room was not disinfected properly it placed other residents, staff and visitors at risk of contracting C-Diff as it was highly contagious. The Centers for Disease Control Guidelines for Environmental Infection Control in Health-Care Facilities dated 2003 identified. "The recommended approach to environmental infection control with respect to C. difficile is meticulous cleaning followed by disinfection using hydrochlorite-based germicides as appropriate." The facility policy Clostridium Difficile and Patients with Unformed Stool revised 8/17, identified enteric precautions would be used for all residents with a C-Diff infection. Use of a bleach based disinfecting agent would be used for all environmental cleaning. The undated Virex II manufacturer instructions identified it was effective against blood born pathogens; however, it was not effective at killing C-Diff. The undated Quat 256 manufacturer instructions did not identify it was effective against C-Diff. The undated Stride manufacturer instructions did not identify it was effective against C-Diff.	21375			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and that policies are appropriately implemented. The DON could inservice staff regarding proper infection control measures are implemented. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. The environmental services manager (EMS) could review policies and procedures ensure housekeeping staff know what is expected for cleaning a room with isolation precautions. The EMS could complete audits to ensure appropriate cleaning solutions are used. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535			7/26/18

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21535	Continued From page 19 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a physician face to face visit was completed every 14 days for an "as needed" (PRN) antipsychotic medication for 1 of 1 (R65) resident who was prescribed PRN antipsychotic medication. Findings include: R65's quarterly Minimum Data Set (MDS) assessment dated 5/24/18, indicated R65 had moderate cognitive impairment and experienced delusions (an abrupt change in the brain that causes mental confusion and emotional disruption). R65's behaviors included; physical aggression towards others, other behaviors not directed towards others, and daily verbal aggression towards others and rejection of cares. The MDS identified diagnoses of dementia and depression. R65 was identified as having a terminal diagnosis with life expectancy of less than six months. R65 had a physician's order for Haloperidol	21535	Corrected	

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21535	Continued From page 20 Lactate Concentrate (an antipsychotic drug) 2 milligrams (mg) per milliliter (ml). Staff to give 0.5 ml (1 mg) by mouth every six hours PRN for agitation or delirium; for yelling, hitting, attempting to self transfer, moving arms and legs. The order was originally placed on 5/24/18, with a discontinuation date of 6/20/18. The order was renewed on 6/20/18, with a discontinuation date of 6/18/19 (363 days after order date). The medication administration record from 6/1/18, to 6/26/18, identified Haloperidol Lactate Concentrate was not administered. On 6/27/18, at approximately 1:10 p.m. RN-A stated the order for Haldol previously had a stop date of 6/20/18. RN-A stated it was difficult to complete the renewal periods with shortened end dates and physician follow up. RN-A stated they had previously extended a PRN Ativan (an antianxiety medication) end date and asked the physician to extend the order in the same manner. On 6/27/18, at 1:30 p.m. the director of nursing (DON) stated the facility policy for renewal of PRN antipsychotic medications was for the resident to be evaluated in- person by the physician every 14 days. The DON stated the order should not have been extended beyond the 14 days. A facility policy Psychotropic Medication Management-Long Term care last revised 4/2018, indicated PRN orders for anti-psychotic medications are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication.	21535			

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21535	Continued From page 21 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure as needed antipsychotic medication prescriptions receive a face to face visit with the physician for justification of use every 14 days. The DON or designee could audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535			