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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1PJN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**

2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 07/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Heath
Enforcement Specialist 09/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5616

On May 21, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections were required. The facility has been given the opportunity to correct before remedies would be imposed. An FSES was completed to verify substantial compliance of the life safety code deficiencies. Refer to the CMS 2567 for both health and life safety code. Along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245616

September 1, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

Dear Ms. Lisell:

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 June 13, 2014 the above facility is certified for:

20 Skilled Nursing Facility/Nursing Facility Beds

20 Nursing Facility I Beds

Your facility's Medicare approved area consists of all 20 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 22, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

RE: Project Number S5616006

Dear Ms. Lisell:

On June 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 26, 2014 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 May 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2014, effective June 13, 2014 and therefore remedies outlined in our letter to you dated June 6, 2014, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245616	A. Building B. Wing	7/15/2014

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	06/13/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	06/05/2014	ID Prefix F0441 Reg. # 483.65 LSC	06/05/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By LB/KFD	Date: 06/06/2014	Signature of Surveyor: 28035	Date: 07/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/21/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245616	02 - GREENBUSH MANOR	6/26/2014

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	05/21/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	06/06/2014	27200	06/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/21/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 1PJN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 06/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5616

On May 21, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections were required. The facility has been given the opportunity to correct before remedies would be imposed. Refer to the CMS 2567 for both health and life safety code. Along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

An FSES was conducted at the facility to detereming substantial compliance of life safety code deficiency cited at K25. Refer to the CMS 2786T for details of the FSES.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 6, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

RE: Project Number S5616006

Dear Ms. Lisell:

On May 21, 2014, 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. In addition, at the time of the May 21, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 21, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 June 30, 2014, 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 June 30, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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 August 21, 2014 (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 November 21, 2014 (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
Division of Compliance Monitoring
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R12, R10) in the Cedar Boulevard dining room received timely assistance to eat for 1 of 1 meal observation in the Rosewood Neighborhood. Findings include: R12 did not receive timely staff assistance to finish eating her breakfast meal.	F 312	R10 & R12, care plans and nursing assistant registered (NAR) and homemaker (HMKR) assignments updated to reflect current need for feeding assistance according to MDS information. For all residents, education has been provided at staff meetings on June 5, 2014 at 1430 and 2130 ensuring that residents who need assistance for po intake as determined by MDS assessments and care plans are receiving	6/13/14

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

Electronically Signed | 06/13/2014

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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	245616	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

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F 312	Continued From page 1 R12's quarterly Minimum Data Set (MDS) dated 3/2/14, indicated R12 was diagnosed with cerebral vascular accident (stroke), dementia and depression. The MDS also indicated had impaired cognition and required extensive assistance of one staff to eat. R12's undated, current care plan indicated R12 received a pureed diet, required supervision and set up with meals and directed staff to provide encouragement and cueing for eating. On 5/21/14, at 7:10 a.m. R12 was observed to be wheeled to the dining room table. -At 7:27 a.m. R12 received breakfast which included hot cereal (Malt-O-Meal) and pureed waffles. -At 7:57 a.m. R12 was observed eating small bites of her hot cereal. -At 8:06 a.m. the cereal bowl was noted to be almost empty and at that time homemaker (HM)-B came out of the kitchen and asked R12 how she was doing. HM-B stated she would put the bowl of waffles in front of her so R12 could eat them. -At 8:10 a.m. R12 was observed to hold a spoon in her right hand and gently stir the waffles, but had not taken a bite. R12 was observed to put the spoon down and pick the bowl up with both hands then put it down and proceeded to fidget with the bowl and spoon. -At 8:17 a.m. R12 had not yet taken a bite of the waffles. She was observed to move her two	F 312	appropriate assistance. The NAR and Homemaker assignment sheets were updated to reflect the level of assistance required. Director of Nursing or designee will audit compliance per observation audits 2 times weekly x 4 weeks to ensure compliance. Results of audits will be brought to QA/PI meetings for further evaluation.	

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F 312	Continued From page 2 glasses of beverages around but did not take a drink. -At 8:26 a.m. licensed practical nurse (LPN)- A sat down next to R12 and physically assisted her with eating the waffles. LPN-A continued to assist R12 with the waffles until 8:37 a.m. at which time R12 was observed to consume the entire bowl of the pureed waffles with LPN-A's assistance. The director of nursing (DON) was also sitting at the table assisting another resident and verbally encouraged R12 to drink her beverages. R12 did not drink any of her fluids and was taken to her room at 8:45 a.m. and transferred to bed. R10 did not receive timely staff assistance to eat the breakfast meal for 55 minutes after the meal was served to her. Staff did not offer to reheat the food prior to feeding R10. R10's quarterly MDS dated 2/15/14, indicated R10 was diagnosed with dementia and anemia. The MDS also indicated R10 was cognitively impaired and required total to extensive staff assistance to eat. R10's Nutritional Assessment dated 5/12/14, indicated R10 continued to eat in the dining room, fed self after set up and required encouragement and cues. R10's current, undated, care plan indicated R10 received a pureed diet, required supervision and set up with meals and directed staff to provide verbal and manual cues throughout the meal.	F 312		

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F 312	Continued From page 3	F 312		

On 5/2/14, at 7:30 a.m. R10 was observed seated in her wheelchair at the dining room table. R10 had been served breakfast which consisted of hot cereal (Malt-O-Meal) and pureed waffles.

-At 7:45 a.m. R10 was observed to take a bite of her cereal and then put the spoon down. R10 was observed fiddling with her clothing protector and did not attempt to take another bite of food or a drink of her beverages.

-At 8:16 a.m. R10 reached for a glass of apple juice and was observed to drink approximately 70% of the juice.

-At 8:25 a.m. HM-B was heard to verbally encourage R10 to eat and when R10 did not respond, HM-B obtained a chair and sat down next to R10 and proceeded to physically assist her to eat. HM-B continued to assist R10 with eating until 8:32 a.m.

-At 8:33 a.m. the DON was observed to sit down next to R10 and physically assist her to eat the hot cereal and pureed waffles. R10's food was observed to sit on the table, for 55 minutes without R10 receiving assistance to eat it. No staff were observed to offer to warm up the food prior to assisting R10 to eat it.

On 5/21/14, at 11:27 a.m. the DON stated R12 and R10 should not have been served their hot food until a staff person was available to verbally encourage or physically assist them to eat.

On 5/21/14 at 1:55 p.m. HM-B confirmed R12 and R10's hot breakfast food had sat on the table for a long period of time and it was not reheated

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F 312	Continued From page 4 prior to eating it. Although the residents ate their food with assistance, HM-B stated she would not have reheated the food but would have just replaced it with fresh, hot food from the steam table. A policy related to eating assistance was requested and none was provided.	F 312		
F 323 SS=D	. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure seated, wheeled, walkers were utilized appropriately in order to minimize the risk for falls and / or injury for 2 of 2 residents (R16, R33) observed to unsafely utilize the seated walkers for transportation. Findings include: R16 was observed unsafely transported down a hallway via a seated, wheeled, walker. R16's quarterly Minimum Data Set (MDS) dated	F 323	For all residents, education has been provided at staff meetings held June 5, 2014 at 1430 and 2130, by posted notes in nurses station and on weekly posted information sheet in break room that no resident should be transported while resident sitting on seated walker. Residents may sit on seat to rest only. Director of Nursing or designee will audit compliance per observation audits 2 times weekly x 4 weeks. Results of audits will be brought to QA/PI meetings for further evaluation.	6/5/14

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3/17/14, indicated R16 was diagnosed with dementia, anxiety and had a history of falls. The MDS also indicated R16 had moderate cognitive impairment, required limited staff assistance for transfers and ambulation and was independent with locomotion.

On 5/21/14, at 7:15 a.m. R16 was observed to ambulate to the dining room utilizing a seated, wheeled, walker. NA-A accompanied R16 as she walked.

On 5/21/14, at 8:36 a.m. homemaker (HM)-A was observed to assist R16 to ambulate from the east Edgewood dining room to the west Edgewood dining room. R16 stated she was tired and wanted to sit down. At this time, HM-A was observed to assist R16 to sit on the walker seat. HM-A then placed her hands on the handles of the walker and with R16 seated on the walker, proceeded to push R16 backwards down the hall from the dining room to R16's room.

On 5/21/14, at 11:42 a.m. registered nurse (RN)-B stated R16 tired very quickly while ambulating due to a chronic heart conditions. She stated staff were to encourage R16 to rest to ensure she does not wear herself out. RN-B confirmed she was aware staff members wheeled R16 backwards in the walker while seated on the walker seat for short distances but verified the walkers were not to be used in this manner.

A copy of a manufactures guidelines for the use of a wheeled walker were requested and none were provided.

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F 323	Continued From page 6	F 323		

On 5/21/14, at 6:45 a.m. R33 was observed to be wheeled backwards by nursing assistant (NA) -C down the hallway in the Rosewood neighborhood while seated on a four wheeled seated walker.

R33's quarterly MDS dated 5/6/13, indicated R33 was diagnosed with anemia, dementia, anxiety, macular degeneration and had a history of falls. The MDS also indicated R33 required limited to extensive assistance of one staff for ambulation in the hallway and locomotion on the unit.

R33's current, undated, care plan indicated R33 ambulated with a wheeled walker with supervision in the hallway, required set up help only for walking in the corridor and may need rest stops. The care plan also indicated R33 was a risk for falls, became dizzy with positional changes, walked with a cane and utilized a seated walker for longer distances.

On 5/21/14, R33 was observed to be wheeled to the dining room table then stood up and transferred self into a dining room chair. At 6:50 a.m. R33 was observed seated at the table waiting for her breakfast and was briefly interviewed. R33 asked "how did I get here?" She was informed that a nursing assistant helped her to the table. R33 stated I feel a little funny and confused.

At 7:41 a.m. R33 was observed to independently

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F 323	Continued From page 7 eat her breakfast without difficulty. At this time, NA-D asked R33 if she was ready to go back to her room. R33 proceeded to independently stand up and sit down on the seat of the wheeled, seated walker. NA-D was observed to push R33, while seated on the walker, backwards down to the end of the hallway to her room where she was taken into the bathroom. At 7:50 a.m. NA-D stated R33 was feeling a little shaky today so they gave her a ride to her room. On 5/21/14, at 11:33 a.m. the director of nursing (DON) was asked if staff should be rolling residents down the hallway on the rolling walker. The DON shook her head, stated no, and then added the wheeled, seated, walkers were not made for wheeling residents. On 5/21/14, at 1:40 p.m. NA-D stated R33 was wheeled down the hallway while seated on the walker frequently for breakfast because she was shaky in the morning. NA-D stated R33 did not have a wheelchair. A copy of a manufactures guidelines for the use of a wheeled walker was requested and not provided.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		6/5/14

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F 441	Continued From page 8 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures where followed when providing glucose monitoring for 1 of 2 observations for resident (R8) who utilized the	F 441	For all residents, education was provided at nursing staff meetings held June 5, 2014 at 1430 and 2130 regarding the need to clean glucometers with appropriate wipes after each use.	

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F 441	Continued From page 9 community glucometer (device utilized for monitoring blood sugars). This practice had the potential to affect 7 of 7 residents (R2, R7, R8, R17, R19, R25, R32) who required blood sugar monitoring. Findings include: On 5/19/14, at 5:18 p.m. licensed practical nurse (LPN)-B was observed to perform a blood glucose check on R8. Immediately following R8's blood glucose check, LPN-B was observed placing the glucometer back in its case and returning the case to the medication room. LPN-B did not clean the glucometer after it had been used to check R8's blood glucose. LPN-B confirmed the glucometer was a community glucometer for the Edgewood neighborhood and was utilized on two residents (R7, R8) regularly to monitor their blood glucose. LPN-B verified the facility practice for cleaning the glucometer was a daily cleaning with a sani-cloth by the night staff. On 5/20/14, at 9:46 a.m. LPN-C confirmed she had not routinely cleaned the glucometer after each resident use. LPN-C stated if the glucometer got soiled with blood, she would use an alcohol wipe and wipe it down. However, she thought the primary cleaning of the glucometers was done by the night staff when they recalibrated the glucometers. LPN-C confirmed the glucometer was a community glucometer for the Rosewood neighborhood and was utilized on five residents (R2, R17, R19, R25, R32) to monitor their blood glucose. On 5/20/14, at 3:10 p.m. the director of nursing (DON) confirmed the facility did utilize community glucometers in the neighborhoods. Her	F 441	Additionally, laminated signs have been placed on all glucometers stating need to clean after each use. All newly hired nurses complete glucometer training which includes the need for cleaning after each use. Director of Nursing or designee will audit compliance per observation audits 2 times weekly x 4 weeks to ensure compliance. Results of audits will be brought to QA/PI meetings for further evaluation.	

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F 441	Continued From page 10 expectation and the facility policy was for them to be cleaned with the appropriate cleaning cloth between each resident use. The facility's Precision-Xceed-Pro Blood Glucose System policy and procedure dated 2/10, directed staff to clean and disinfect the device after each use. Recommended solutions included: Sani-Cloth HB.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. At the time of this survey, LifeCare Greenbush Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2014

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@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.

LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building.

The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the

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K 000	Continued From page 2 Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 39 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread	K 025	LifeCare Greenbush Manor had a passing score after a Fire Safety Evaluation System (FSES) survey on 5/21/14, conducted by the State Fire Marshal.	5/21/14

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**05/21/2014**

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K 025	Continued From page 3 throughout the facility in the event of a fire which could affect all 40 residents, staff and visitors. Findings include: On facility tour between 9:30 PM to 2:30 PM on 05/21/2014, it was observed that the smoke barrier walls do not extend thought the attic space above the ceiling. This condition is not covered by the NFPA 101 (00) 8-3.2 exceptions and do not meet the requirement for a smoke barrier wall. These deficient practices were confirmed by the Maintenance Supervisor (BD).	K 025	Brett Dallager, Maintenance Supervisor, will be responsible for maintaining the ongoing compliance with the conditions necessary to maintain a passing FSES score.	

Electronically submitted
June 6, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5616006

Dear Ms. Lisell:

The above facility was surveyed on May 19, 2014 through May 21, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00578N	A. BUILDING: _____ B. WING _____	05/21/2014

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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 is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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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 5/19/14, 5/20/14, and 5/21/14, 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.	2 000	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 MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF 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 ensure seated, wheeled, walkers were utilized appropriately in order to minimize the risk for falls and / or injury for 2 of 2 residents (R16, R33) observed to unsafely utilize the seated walker for transportation. Findings include: R16 was observed unsafely transported down a hallway via a seated, wheeled, walker. R16's quarterly Minimum Data Set (MDS) dated	2 830	Corrected	6/5/14

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2 830	Continued From page 3 3/17/14, indicated R16 was diagnosed with dementia, anxiety and had a history of falls. The MDS also indicated R16 had moderate cognitive impairment, required limited staff assistance for transfers and ambulation and was independent with locomotion. On 5/21/14, at 7:15 a.m. R16 was observed to ambulate to the dining room utilizing a seated, wheeled, walker. NA-A accompanied R16 as she walked. On 5/21/14, at 8:36 a.m. homemaker (HM)-A was observed to assist R16 to ambulate from the east Edgewood dining room to the west Edgewood dining room. R16 stated she was tired and wanted to sit down. At this time, HM-A was observed to assist R16 to sit on the walker seat. HM-A then placed her hands on the handles of the walker and with R16 seated on the walker, proceeded to push R16 backwards down the hall from the dining room to R16's room. On 5/21/14, at 11:42 a.m. registered nurse (RN)-B stated R16 tired very quickly while ambulating due to a chronic heart conditions. She stated staff were to encourage R16 to rest to ensure she does not wear herself out. RN-B confirmed she was aware staff members wheeled R16 backwards in the walker while seated on the walker seat for short distances but verified the walkers were not to be used in this manner. A copy of a manufactures guidelines for the use of a wheeled walker were requested and none were provided.	2 830		

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2 830	Continued From page 4 On 5/21/14, at 6:45 a.m. R33 was observed to be wheeled backwards by nursing assistant (NA) -C down the hallway in the Rosewood neighborhood while sitting on a four wheeled seated walker. R33's quarterly MDS dated 5/6/13, indicated R33 was diagnosed with anemia, dementia, anxiety, macular degeneration and had a history of falls. The MDS also indicated R33 required limited to extensive assistance of one staff for ambulation in the hallway and locomotion on the unit. R33's current, undated, care plan indicated R33 ambulated with a wheeled walker with supervision in the hallway, required set up help only for walking in the corridor and may need rest stops. The care plan also indicated R33 was a risk for falls, became dizzy with positional changes, walked with a cane and utilized a seated walker for longer distances. On 5/21/14, R33 was observed to be wheeled to the dining room table then stood up and transferred self into a dining room chair. At 6:50 a.m. R33 was observed seated at the table waiting for her breakfast and was briefly interviewed. R33 asked "how did I get here?" She was informed that a nursing assistant helped her to the table. R33 stated I feel a little funny and confused. At 7:41 a.m. R33 was observed to independently eat her breakfast without difficulty. At this time,	2 830		

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2 830	Continued From page 5 NA-D asked R33 if she was ready to go back to her room. R33 proceeded to independently stand up and sit down on the seat of the wheeled, seated walker. NA-D was observed to push R33, while seated on the walker, backwards down to the end of the hallway to her room where she was taken into the bathroom. At 7:50 a.m. NA-D stated R33 was feeling a little shaky today so they gave her a ride to her room. On 5/21/14, at 11:33 a.m. the director of nursing (DON) was asked if staff should be rolling residents down the hallway on the rolling walker. The DON shook her head, stated no, and then added the wheeled, seated, walkers were not made for wheeling residents. On 5/21/14, at 1:40 p.m. NA-D stated R33 was wheeled down the hallway while seated on the walker frequently for breakfast because she was shaky in the morning. NA-D stated R33 did not have a wheelchair. A copy of a manufactures guidelines for the use of a wheeled walker was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could provide education to staff to address the importance of appropriate usage of adaptive equipment. The quality assurance committee could establish a system to audit assist devices to ensure	2 830		

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2 830	Continued From page 6 compliance. 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R12, R10) in the Cedar Boulevard dining room received timely assistance to eat for 1 of 1 meal observation in the Rosewood Neighborhood. Findings include: R12 did not receive timely staff assistance to finish eating her breakfast meal. R12's quarterly Minimum Data Set (MDS) dated 3/2/14, indicated R12 was diagnosed with cerebral vascular accident (stroke), dementia and depression. The MDS also indicated had impaired cognition and required extensive assistance of one staff to eat. R12's undated, current care plan indicated R12	2 920	Corrected	6/5/14

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2 920	Continued From page 7 received a pureed diet, required supervision and set up with meals and directed staff to provide encouragement and cueing for eating. On 5/21/14, at 7:10 a.m. R12 was observed to be wheeled to the dining room table. -At 7:27 a.m. R12 received breakfast which included hot cereal (Malt-O-Meal) and pureed waffles. -At 7:57 a.m. R12 was observed eating small bites of her hot cereal. -At 8:06 a.m. the cereal bowl was noted to be almost empty and at that time homemaker (HM)-B came out of the kitchen and asked R12 how she was doing. HM-B stated she would put the bowl of waffles in front of her so R12 could eat them. -At 8:10 a.m. R12 was observed to hold a spoon in her right hand and gently stir the waffles, but had not taken a bite. R12 was observed to put the spoon down and pick the bowl up with both hands then put it down and proceeded to fidget with the bowl and spoon. -At 8:17 a.m. R12 had not yet taken a bite of the waffles. She was observed to move her two glasses of beverages around but did not take a drink. -At 8:26 a.m. licensed practical nurse (LPN)- A sat down next to R12 and physically assisted her with eating the waffles. LPN-A continued to assist R12 with the waffles until 8:37 a.m. at which time R12 was observed to consume the entire bowl of the pureed waffles with LPN-A's assistance. The director of nursing (DON) was also sitting at the	2 920		

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2 920	Continued From page 8 table assisting another resident and verbally encouraged R12 to drink her beverages. R12 did not drink any of her fluids and was taken to her room at 8:45 a.m. and transferred to bed. R10 did not receive timely staff assistance to eat the breakfast meal for 55 minutes after the meal was served to her. Staff did not offer to reheat the food prior to feeding R10. R10's quarterly MDS dated 2/15/14, indicated R10 was diagnosed with dementia and anemia. The MDS also indicated R10 was cognitively impaired and required total to extensive staff assistance to eat. R12's Nutritional Assessment dated 5/12/14, indicated R10 continued to eat in the dining room, fed self after set up and required encouragement and cues. R12's current, undated, care plan indicated R12 received a pureed diet, required supervision and set up with meals and directed staff to provide verbal and manual cues throughout the meal. On 5/2/14, at 7:30 a.m. R10 was observed seated in her wheelchair at the dining room table. R10 had been served breakfast which consisted of hot cereal (Malt-O-Meal) and pureed waffles. -At 7:45 a.m. R10 was observed to take a bite of her cereal and then put the spoon down. R10 was observed fiddling with her clothing protector and did not attempt to take another bite of food or a drink of her beverages.	2 920		

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2 920	Continued From page 9 -At 8:16 a.m. R10 reached for a glass of apple juice and was observed to drink approximately 70% of the juice. -At 8:25 a.m. HM-B was heard to verbally encourage R10 to eat and when R10 did not respond, HM-B obtained a chair and sat down next to R10 and proceeded to physically assist her to eat. HM-B continued to assist R10 with eating until 8:32 a.m. -At 8:33 a.m. the DON was observed to sit down next to R10 and physically assist her to eat the hot cereal and pureed waffles. R10's food was observed to sit on the table, for 55 minutes without R10 receiving assistance to eat it. No staff were observed to offer to warm up the food prior to assisting R10 to eat it. On 5/21/14, at 11:27 a.m. the DON stated R12 and R10 should not have been served their hot food until a staff person was available to verbally encourage or physically assist them to eat. On 5/21/14 at 1:55 p.m. HM-B confirmed R12 and R10's hot breakfast food had sat on the table for a long period of time and it was not reheated prior to eating it. Although the residents ate their food with assistance, HM-B stated she would not have reheated the food but would have just replaced it with fresh, hot food from the steam table. A policy for assisting residents with eating was requested and none was provided. SUGGESTED METHOD OF CORRECTION:	2 920		

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2 920	Continued From page 10 The director of nursing or designee could provide education to staff to ensure residents who require physical asisstance to eat are provided such assistance. The quality assurance committee could establish a system to audit the provision of eating assitance to esnure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		6/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00578N	A. BUILDING: _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued From page 11 Based on interview and document review, the facility failed to ensure 1 of 5 (DON) new employees were provided a two-step tuberculin skin test (TST) according to the facility's guidelines. Findings include: The director of nursing's (DON) hire date was 1/6/2014. The DON's tuberculin skin test documentation indicated she had received step one of the TST on 12/2/13. This TST was read on 12/4/2013, with a "o" induration reading. The DON received the second step TST on 1/21/14, which was 27 days beyond the one to three weeks outlined on the facility's Tuberculin skin test (TST) form. On 5/21/2014, at 9:10 a.m. the DON confirmed the time frame from the step one and step two TST was greater than three weeks. The facility' Employee Health Policy revised 3/12, specified all new employees were required to be screened for TB and complete a two-step TST. Step one was to be completed prior to the employee starting employment and step two was to be completed one to three weeks after the first test. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could provide education to staff to address the importance of tuberculosis monitoring. The quality assurance committee could establish a system to audit tuberculosis testing to ensure compliance.	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21426	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		