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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 280A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**
2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **07/31/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
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, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Post Certification Revisits (PCR) were completed by the Departments of Health and Public Safety and found all deficiencies corrected, effective July 15, 2014. The facility is again requesting a waiver F458 and based on submitted documentation, the waiver has been approved. Effective July 15, 2014, the facility is certified for 65 skilled nurinsg facility beds.

17. SURVEYOR SIGNATURE
Tammy Williams, HFE NEII
Date : 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 09/15/2014 (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
07/27/1989
(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
08/06/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5537

August 12, 2014

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

Dear Mr. Knoll:

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 July 15, 2014 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

Your request for waiver of F458 has been approved based on the submitted documentation.

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
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Protecting, Maintaining and Improving the Health of Minnesotans

August 12, 2014

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537025

Dear Mr.Knoll:

On June 19, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On July 31, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 21, 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 June 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2014, effective July 15, 2014 and therefore remedies outlined in our letter to you dated June 19, 2014, will not be imposed.

Your request for a waiver involving the deficiency cited under F458 at the time of the June 5, 2014 standard has been approved.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5537r14

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
245537	A. Building B. Wing	7/31/2014

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **07/15/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/15/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/15/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/15/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	08/12/2014	32603	07/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/5/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245537	A. Building B. Wing 01 - 01 - 1960 BUILDING AND ADDITIONS	7/21/2014

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 06/05/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GA/mm	Date: 08/12/2014	Signature of Surveyor: 32603	Date: 07/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/4/2014	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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245537	A. Building B. Wing **02 - 02 - 2004 ADDITIONS**	7/21/2014

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **06/05/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	08/12/2014	22373	07/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/4/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 280A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **06/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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
X 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Christina Martinson, HFE NEII — 07/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/05/2014 (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
07/27/1989
(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
(L33)

DETERMINATION APPROVAL

CCN: 24-5537

On June 5, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

The facility has again submitted documentation requesting waiver of deficiency cited at F458 (Rooms Size Waiver). The request has been previously approved. Refer to the provider's letter dated July 2, 2014 along with the health CMS 2567 including the plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1522

June 19, 2014

Ms. Cindy Iverson, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537025

Dear Ms. Iverson:

On June 5, 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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;

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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

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 July 15, 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 July 15, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 5, 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 December 5, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

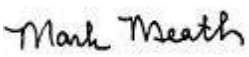
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax

Enclosure

cc: Licensing and Certification File 5537s14.rtf

Minnewaska Community Health Services
a community of services grounded in faith

July 2, 2014

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Dear Ms. Anderson:

Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey completed by the Minnesota Department of Health and Public Safety on June 2, 2014. The waiver request is in response to the following Federal Deficiency:

1. F 458 483.70 (d)(1)(ii) Bedrooms Measure at least 100 Sq. Feet for one bed, private bedrooms.

A waiver has been previously reviewed and approved at the Minnesota Department of Health.

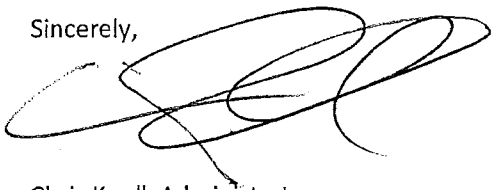
A Wing rooms: 24,25,26,27,28,29,30,31,32,33,34,35 and 36

The facility recognizes that the square footage in the A wing for the private one bed rooms noted are between 95.68 to 96.07 square feet and will work to address the comments/concerns noted by residents in the deficiency.

A previous remodeling and expansion of the toileting rooms on the "A" wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver.

If you have any questions or concerns, please feel free to contact me.

Sincerely,



Chris Knoll, Administrator
Minnewaska Community Health Services
Phone: (320) 239-2217 Ext. 7144 Email: cknoll@mchs-healthcare.org

Minnewaska Community Health Services

a community of services grounded in faith

July 17, 2014

Addendum to Plan of Correction F – 314

Residents who have been identified at moderate to high risk for pressure ulcers will be reviewed to determine our skin assessments are accurate and up to date. At that time MLH will ensure our interventions are appropriate and implemented correctly.

Chris Knoll,

Administrator

Minnewaska Community Health Services

7/21/14

605 Main St PO Box 40 | Starbuck, MN 56381 | mchs-healthcare.org

Minnewaska Therapy Services 320.239.7122

Minnewaska Home Care 320.239.7259

Holly Ridge Manor Assisted Living 320.239.4775

Minnewaska Lutheran Home 320.239.2217

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(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. 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 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	This plan and response to survey finding from 6/2/2014 through 6/5/2014. The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provision of State and Federal Law. Without waiving the foregoing statement, the facility states that with respect to the following:	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164		

7/2/14 See addendum to POC

RECEIVED
JUL 07 2014
MN Dept of Health
Fergus Falls

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-2-14

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

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure specialized medical services remained confidential for 1 of 1 residents (R6) who received hospice services. Findings included: During an observation on 6/3/13, at 3:30 p.m. R6's personal medical chart was on stationary shelving behind the nurses station along with the other resident charts for the A and B wing. R6's chart was in view of all who stopped at the desk. The large blue 3 ring binder displayed R6's full name and medical doctors name on the spine along with a yellow number 1 sticker that had " call Knute Nelson Hospice FIRST" and then the phone number "320-759-1270." The yellow sticker identified R6 to be the one resident receiving hospice services. During an observation on 6/4/14, at 9:00 a.m. R6's medical chart labeled with R6's name remained on the stationary shelving located behind the A and B wing nurses station. The yellow sticker identifying R6 received hospice services remained on the medical chart. During an interview on 6/4/14, at 9:08 a.m. registered nurse (RN)A confirmed stationary shelving behind the nurses desk which held the resident charts for A and B wing, were in view of	F 164	F – 164 It is the policy of Minnewaska Lutheran Home (MLH) to treat all resident information, whether medical, financial, or social in nature, on a confidential basis. The Director of Nursing or her designee is responsible to maintain an environment in which no signs are posted in resident's rooms or in staff work areas that are able to be seen by other residents and/or visitors that contain confidential, clinical, or personal information. Measures that have been put into place to ensure compliance include: 1. Because numerous Hospice organizations provide services within the facility, the Director of Nursing or her designee have assessed residents' room and charts for posted information that would indicate that the residents were receiving services from a Hospice organization. The affected Hospice organization has	

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F 164	Continued From page 2 all residents and visitors to read. RN-A confirmed the binding of the medical charts identified each resident by name and R6 had been identified to receive hospice services . RN-A confirmed the usual facility procedure for private documentation, wound not typically be in sight of others. RN-A confirmed the facility staff should have moved the sticker to a location of the chart that would not be in view of others. During an interview on 6/5/14, at 9:20 a.m. the director of nursing (DON) confirmed the facility staff are not to have resident private information visible to others. The undated facility policy titled Policy on Resident Privacy and Confidentiality, identified the purpose to ensure that each resident has the right to privacy and confidentiality of personal and clinical records.	F 164	been notified of the breach of confidentiality caused by posting their information on the back of the resident's chart. The Hospice sticker for resident R6 was removed from the back of the chart and placed on the front cover where it would not be visible in the work area. 2. Information will be provided to all Hospice organizations offering services within the facility R/T where information can be posted in regards to the services that they are providing to the resident. Staff education will be provided during the "All Staff In-service" on July 14th, 2014 addressing the Confidentiality of Information policy in which there are no signs posted with confidential information about the residents. Staff not receiving education on that day will be provided with education throughout the week with the final education being provided on July 18th, 2014.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan related to repositioning for 1 of 1 residents (R6) identified with current pressure ulcers. Findings include:	F 282		

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F 282	Continued From page 3 R6's care plan revised on 5/15/14, identified R6 had a stage 3, pressure ulcer on the coccyx, a blister on the right heel, and areas on the left foot. The care plan interventions indicated that R6 required extensive assistance of 2 staff for bed mobility, extensive assistance with transfers, and a mechanical standing lift. The care plan included interventions which included a pressure reduction device in chair, APM on bed, and to encourage repositioning every two hours as needed. During observations on 6/4/14, from 7:10 a.m. until 10:06 a.m. R6 was observed at 7:10 a.m. seated in a wheel chair, with a blue quilted heel boot on the right foot, resting on the foot pedal of the wheel chair. At 8:27 a.m. R6 was observed to remain seated in the wheel chair with the right foot in the same position on the foot pedal as he ate the breakfast meal in the dining room. At 9:00 a.m. a family member approached R6 in the dining room, wheeled him towards his room, entered briefly and then proceeded to assist R6 outside the front entrance of the facility. At 9:05 a.m. R6 was observed outside near the entrance to the facility, seated in the wheelchair with his feet resting on the wheelchair pedals. R6's wife was seated near R6, at the entrance to the facility. R6 was observed to remain in the same position until 10:06 a.m., when R6 was assisted to his room and to be repositioned. R6 was observed to have remained in the same position for 2 hours and 56 minutes, without having been offered or encouraged to change positions. During an interview on 6/4/14, at 9:53 a.m. nursing assistant (NA)-B confirmed R6 had been assisted into the wheel chair at approximately	F 282	3. Environmental audits will be completed weekly by the Director of Nursing or her designee x 6 weeks focusing on breaches in resident's confidentiality through posting of resident information. The results of the audits will be reviewed at the quarterly QA meeting to be held in September and will proceed according to the recommendations of that committee. Date in compliance: (07/15/2014) F – 282 It is the policy of Minnewaska Lutheran Home (MLH) that a comprehensive care plan that includes	

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F 282	Continued From page 4 7:00 a.m. and had not been offered and/or assisted to be repositioned since. NA-B confirmed the care plan directed R6 to be repositioned every 2 hours and further stated "but we try to get to him sooner." Following the interview with NA-B, R6 was assisted from the wheel chair with a mechanical standing lift at 10:06 a.m. with assistance of NA-B and NA-A. During an interview on 6/4/14, at 10:10 a.m. registered nurse (RN)-A confirmed R6's current care plan directed staff to follow a two hour repositioning schedule and that R6 had current pressure ulcers. RN-A confirmed the expectation of staff was to follow the care plan at all times, including when a resident sat outside the facility. The facility policy titled Care Plans-Comprehensive, reviewed 5/3/12, identified the careplan is developed and maintained in order to meet each resident's medical, nursing, mental and psychological needs.	F 282	measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. The Director of Nursing or her designee is responsible to ensure that the resident is being provided services by qualified staff in accordance with the resident's written plan of care. Because each resident has different needs, each resident's completed care plan is placed in their chart and accessible to staff. The Director of Nursing or her designee is responsible for developing the nurse's aide's daily assignment sheet from the care plan. The nursing assistants are responsible for reporting any changes in the resident's condition. Changes in the resident's condition must be reported to the RN/Case Manager so that a review of the resident's assessment and care plan can be made. Measures that have been put into place to ensure compliance include:	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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F 314	Continued From page 5 by: Based on observation, interview and document review, the facility failed to reassess, develop and implement interventions to prevent the development of, or promote healing of, pressure ulcers for 1 of 1 resident (R6) reviewed who had current pressure ulcers. This resulted in actual harm for R6 who acquired two pressure ulcers while in the facility, one of which progressed to a Stage 3 pressure ulcer, (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). Findings include: Although R6 had developed a pressure ulcer to the coccyx on 5/10/14, and had subsequently developed another pressure ulcer on the heel, the facility did not reassess, or implement interventions to prevent further skin breakdown, which caused actual harm for R6. R6's significant change Minimum Data Set (MDS) dated 5/4/14, identified R6 had diagnoses which included heart failure, diabetes and atrial fibrillation. The MDS identified R6 had severe cognitive impairment, required extensive assistance with bed mobility, transferring, toileting, did not ambulate and was incontinent of bowel and bladder. Further, the MDS identified R6 was at risk of development of pressure ulcers, but did not have any pressure ulcers at that time. Review of R6's Care Area Assessment (CAA) dated 5/4/14, identified R6 transferred with use of a mechanical lift and assist of two staff, seldom moved in chair or bed, was at moderate risk for	F 314	1. All changes in resident's orders and levels of care are to be entered into the Temporary Plan of Care (POC) as they occur. A daily review of new orders will be completed by the Case Managers to ensure that they have been entered into the resident's POC. 2. Staff education will be completed by July 14th, 2014 regarding staff's responsibility in following the resident's plan of care in providing resident care including repositioning. Also, they will be educated on their responsibility in reporting changes in resident's condition to the charge nurse and/or case manager. Staff not receiving education on that day will be provided with education throughout the week with the final education being provided on July 18th, 2014. 3. Repositioning audits will completed on 10% of the residents weekly by the Director of Nursing or her designee. Results of the audits will be reviewed at the quarterly QA meeting held in September, 2014 and will proceed according to the recommendations of that committee. Date in compliance: (07/15/2014)	

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F 314	Continued From page 6 pressure ulcer development due to diagnosis, ulcers present at this time, immobility, medication, edema, incontinence and poor nutrition. The CAA identified R6 had an alternating pressure mattress (APM) on the bed and a pressure reducing cushion in wheelchair. Although the CAA identified an ulcer, the MDS only identified R6 as at risk. Review of the facility's form, Minnewaska Lutheran Home Tissue Tolerance Testing dated 3/14/14, identified for both sitting in a chair and lying, R6 could tolerate a 2 hour repositioning program and "reposition every 2 hours" as interventions. No further pressure distribution assessment was provided. Even though R6 had developed a pressure ulcer after 3/14/14, no reassessment had been done to determine whether the every 2 hour repositioning schedule was still appropriate for R6. R6's care plan revised on 5/15/14, identified R6 had a stage 3, pressure ulcer on the coccyx, a blister on the right heel, and areas on the left foot. The care plan interventions indicated that R6 required extensive assistance of 2 staff for bed mobility, extensive assistance with transfers, and a mechanical standing lift. The care plan also included interventions for a pressure reduction device in chair, APM on bed, to encourage repositioning every two hours as needed, to follow wound protocol as needed, to complete a "Tissue Tolerance test quarterly and as needed," and to notify physician of significant changes in the skin integrity. Review of a clinical record note dated 5/10/14, identified R6 had developed a "new ulcer" on the coccyx, identified as a stage 3 pressure ulcer.	F 314	F – 314 It is the policy of MLH that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable The Director of Nursing or her designee is responsible to ensure that residents who are identified as high risk for pressure ulcer development are receiving the necessary cares and treatment required, and care planned with interventions to prevent the development of pressure ulcers. A review of MLH policy on "Prevention of Pressure Ulcers" and "Skin Care Policy" was reviewed and updated. Reviewed repositioning protocol with current nursing staff on A/B wing where Resident R6 resides. Completed Skin Risk/Braden Assessment on 6/24/14 for resident R6 which indicates that resident is a moderate risk for pressure ulcer development. Also, completed a Tissue Tolerance Testing assessment on 6/25/14 which indicates that	

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F 314	Continued From page 7 According to the documentation, the pressure ulcer measured 3 centimeters (cm) by 1.5 cm with a scant amount of clear drainage, and had 50% yellow sough and 50% pink granulation tissue in the wound bed. The note identified the area was washed with wound cleanser and covered with an Allevyn dressing. The dressing was to be changed every five days. The note also indicated R6 "has APM mattress." Review of the facility's, Minnewaska Lutheran Home Physician Communication form dated 5/10/14, revealed R6 had been identified with a blister/eschar on right heel, and an open area on the coccyx. The communication form indicated facility staff had requested orders for application of Betadine solution to the blister on the heel followed by an Allevyn dressing and blue foam boot, and an Allevyn dressing to the coccyx area. Review of the clinical record note dated 5/28/14 identified R6 had developed a large dark brown/black fluid filled area DTI (deep tissue injury) on the right heel measuring 4.4 cm by 4 cm. The note indicated the fluid filled area had drained, was dry and had 100% stable black eschar. The note also indicated the surrounding tissue was pink and soft with dry dead skin from where the previous blister had been, and indicated a blue foam boot was to be worn for protection at all times with heels floated while in the recliner and bed. The note identified a stage 3 pressure ulcer remained on the coccyx with a small amount of serosanguinous (thin,bloody) drainage, measured 0.5 cm by 0.7 cm, which showed slow improvement. During observations on 6/4/14, from 7:10 a.m. until 10:06 a.m. R6 was observed at 7:10 a.m.	F 314	resident can tolerate a q 2 hr. repositioning schedule both sitting and lying. Interventions for resident's care include utilizing the APM mattress when in bed. Reposition q 2 hrs. when up in chair. Offering Arginade 8 oz BID to aid in wound healing. Noted on 6/11/2014, Stage 3 area on coccyx has healed. Area on (Rt.) heel is stable with continued slow improvement noted. Interventions in place include washing area daily with wound cleanser and paint with Betadine. Cover heel with an Alleyvn foam heel protector and to wear a blue foam boot at all times for protection, and to float heels in recliner and in bed. Measures that have been put into place to ensure compliance include:	

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F 314	Continued From page 8 seated in a wheel chair, with a blue quilted heel boot on the right foot, resting on the foot pedal of the wheel chair. At 8:27 a.m. R6 was observed to remain seated in the wheel chair with the right foot in the same position on the foot pedal as he ate the breakfast meal in the dining room. At 9:00 a.m. a family member approached R6 in the dining room, wheeled him towards his room, entered briefly and then proceeded to assist R6 outside the front entrance of the facility. At 9:05 a.m. R6 was observed outside near the entrance to the facility, seated in the wheelchair with his feet resting on the wheelchair pedals. R6's wife was seated near R6, at the entrance to the facility. R6 was observed to remain in the same position until 10:06 a.m., when R6 was assisted to his room and to be repositioned. R6 was observed to have remained in the same position for 2 hours and 56 minutes, without having been offered or encouraged to change positions. During an interview on 6/4/14, at 9:53 a.m. nursing assistant (NA)-B confirmed R6 had been assisted into the wheel chair at approximately 7:00 a.m. and had not been offered and/or assisted to be repositioned since. NA-B confirmed the care plan directed R6 to be repositioned every 2 hours and further stated "but we try to get to him sooner." Following the interview with NA-B, R6 was assisted from the wheel chair with a mechanical standing lift at 10:06 a.m. with assistance of NA-B and NA-A. During an interview on 6/4/14, at 10:10 a.m. registered nurse (RN)-A confirmed R6's current care plan directed staff to follow a two hour repositioning schedule and that R6 had current pressure ulcers. RN-A confirmed the expectation of staff was to follow the care plan at all times,	F 314	1. All residents at MLH will have a Skin Risk/Braden Assessment and a Tissue Tolerance Testing Assessment completed upon admission, quarterly, with Significant Change MDS, and PRN. Interventions will be put in place immediately upon completion of the assessments. Interventions will be placed in resident's Plan of Care and staff will be informed of changes at shift change through report, through nursing communication, and per communication boards in all report rooms. 2. Weekly with each resident's bath, a skin assessment and documentation will be completed to ensure awareness in changes in all resident's skin conditions. Bath aides and licensed staff will be educated on the importance of assessing changes in skin condition immediately. Documentation and interventions are to start immediately upon discovery of changes in skin condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(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 314	Continued From page 9 including when a resident sat outside the facility. During an observation with RN-B on 6/4/14 at 1:08 p.m., R6 was observed to have an unstageable pressure ulcer on the right heel and pressure ulcers on the coccyx. The heel area was observed to have black eschar, and measured 3.9 centimeters (cm) by 3.6 cm. The coccyx area had an Allevyn dressing (an adhesive foam dressing) in place, however the entire coccyx area was dusky pink in color. The open area on the coccyx measured 0.1 cm by 0.3 cm. RN-B verified R6 had 2 pressure ulcers, one on the coccyx and an unstageable ulcer on the right heel. RN-B confirmed a new intervention had been put in place including use of a larger Allevyn dressing to cover the entire area of the coccyx in an attempt to prevent further pressure ulcers. During an interview on 6/4/14, at 1:21 p.m. the hospice RN confirmed R6 had a current pressure ulcer and indicated it was concerning that R6 had not been repositioned for approximately 3 hours. During an interview on 6/5/14, at 9:20 a.m. the director of nursing (DON) confirmed R6's current care plan and also confirmed staff were directed to follow the care plan for resident cares. The facility policy titled Skin Care policy, revised 8/24/09, was reviewed. The policy indicated a comprehensive assessment would be completed routinely (admission, quarterly, significant change), and as needed. The policy indicated an assessment would include the identification of risk factors, risk assessment tools of a Braden Scale (tool for predicting the development of pressure ulcers), and a Tissue Tolerance	F 314	3. Education will be provided to all nursing staff at the All Staff In-service on July 14th, 2014 the in-service will include facility policies on "Prevention of Pressure Ulcers" and "Pressure Ulcer Treatment." 4. Random audits will be completed on 10% of the resident population weekly, ensuring that skin issues have been identified, treatments have been initiated, and documentation is occurring. The results of these audits will be reviewed at the QA Meeting in September of 2014 and will proceed per recommendation of this committee. Date in compliance: (07/15/2014)	

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F 314	Continued From page 10 Assessment (tool to evaluate the need for redistribution of pressure). The policy indicated analysis of the comprehensive assessment would include the development of individualized interventions for residents. The facility procedure titled Prevention of Pressure Ulcers revised 4/5/13, was reviewed. The procedure indicated the usual cause of pressure ulcers as, "when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area which destroys the tissues." The procedure also identified the most common site of a pressure ulcer as where the bone is near the surface of the body, and listed various locations which included the backbone and heels. The procedure directed preventative actions which included routine skin care and "change position at least every 2 hours."	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356	F – 356 It is the policy of MLH that the Nursing Staff hours will be posted on a daily basis with the number of licensed and unlicensed nursing personnel directly responsible for resident care in a prominent location accessible to residents and visitors. The Director of Nursing or her designee is responsible to ensure that the nurse staffing information is posted and readily accessible to residents and visitors. A review of MLH policy on "Posting Daily Nursing Staff Schedule" was done with no changes made to the policy. The policy instructs the document to be posted in a prominent location that is accessible to residents and visitors and is in a clear and readable format. It is noted that there are several other documents hanging in that same area.	

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F 356	Continued From page 11 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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 ensure the required nurse staff posting information was readily accessible in the facility to all residents and visitors. This had the potential to affect all 64 residents residing in the facility, and all visitors. Findings include: On 6/2/2014, 12:45 p.m. on initial tour of the facility the required nurse staffing information was observed hanging on the wall of the main hallway into the facility tacked to a strip of cork board. However, the required staff posting information was covered up by other forms in individual plastic sleeve protectors, which were also attached to the cork board. The four other forms laid on top of the required staff posting. The required staff posting was unable to be seen unless the other forms were moved to the side. In	F 356	The "Nursing Staff Schedule" could easily be covered up by the other documents. Measures that have been put into place to ensure compliance includes: 1. The document will be placed in a manner at which it is visible to residents in wheelchairs as well as visitors. Twenty four hours of staffing information will be maintained in a single location. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months. 2. Education will be provided to the staff responsible for posting nurse staffing levels to assure that they are displayed appropriately and maintained for the designated length of time. 3. Audits will be completed daily x30 days by the Administrator during the Administrators walking rounds or his designee to ensure proper placement of the document. The results of the audits will be reviewed at the quarterly QA meeting to be held in September and will proceed according to the recommendations of that committee.	

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F 356	Continued From page 12 addition, the facility had not posted a notification as to where the required staff posting was located. On 6/5/2014, 8:30 a.m. the required nurse staffing information was noted to be in the same location as upon initial tour, unable to be seen without moving the other papers from on top of the posting. On 6/5/2014, at 9:45 a.m. the director of nursing (DON) confirmed placement of posting on the wall and also confirmed that the posted nursing information was not readily accessible to residents or visitors in current location due to other postings blocking the information from view. Review of the undated facility policy titled, Posting Daily Nursing Staff Schedule included instructions for displaying the information in a prominent location (accessible to residents and visitors).	F 356	Date in compliance: (07/15/2014)	
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the single resident rooms on the A-wing of the facility had at least 100 feet of usable floor space for 13 of 15 rooms. This affected 13 of the 13 residents (R17, R18, R32, R46, R40, R41, R49, R62, R68, R70, R73, R82, R88) who resided in the rooms.	F 458	F – 458 Waiver requested: A-wing rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36 are 95.68 to 96.07 square foot of usable floor space. Formally complying bedrooms were reduced in area to accommodate expanded toilet rooms. A previous similar waiver was requested and approved. Letter is attached.	

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F 458	Continued From page 13 Findings include: During initial tour of the facility on 6/2/14, at 12:44 p.m., the resident rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35,and 36, in the A-wing of the facility appeared small. When interviewed on 6/4/14, at 1:56 p.m., facility environmental services staff (ES)-B provided an architectural floor plan of the rooms on A-wing and verified that each resident room in that wing of the facility had 95.68-96.07 square feet of usable floor space. When interviewed on 6/4/14, at 1:33 p.m., the facility environmental services director (ESD) confirmed the single rooms on A-wing were less than the required 100 square feet of usable floor space. ESD stated he would be applying for a waiver for the resident rooms. When interviewed on 6/3/14, at 3:28 p.m., R32 stated the room had a " penned up " feeling. R32 stated he had not asked to move to a larger room. When interviewed on 6/4/14, at 2:00 p.m., R46 stated the room was "too crowded". R47's bed was placed against the longest wall under the window in the room. A small dresser was placed at the foot of the bed with a television on top. R47 was seated in a wheel chair which faced the end of the bed and television. There were approximately three feet from the doorway to R47's chair when it was up against the bedside. There was very little room left on the floor to turn R47's wheel chair around in the room. When interviewed on 6/4/14 at 4:43 p.m., R82	F 458		

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F 458	Continued From page 14 stated the room was too small to have visitors. There was a bed up against the opposite wall from the doorway to the room and a small dresser next to the head of the bed. There was just enough room to turn around in a wheel chair to face the door and exit. When interviewed, R17, R18, R40, R41, R49, R62, R68, R70, R73, and R88, who resided in the rooms voiced no concerns. When interviewed on 6/4/14, at 8:38 a.m., nursing assistant (NA)-B indicated there was no difficulty in providing care for the residents in A-wing related to the size of the rooms. During observation, on all days of the survey, 6/2/14, 6/3/14, 6/4/14, and 6/5/14, there was no evidence of problems with provision of resident care. The residents were able to access the bathrooms, decorate their rooms and had access to common areas throughout the facility. A letter was provided from the Minnesota Department of Health, dated 6/13/13 which indicated a waiver had been approved for the smaller resident rooms.	F 458		

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

F5537022

PRINTED: 06/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING 01 - 01 - 1960 BUILDING AND ADDITIONS B. WING _____	06/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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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 4, 2014. At the time of this survey, Building 01 of Minnewaska Community Health Services Nursing Home was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok FS 7-16-14 RECEIVED JUL 11 2014 OF PUBLIC SAFETY MARSHAL DIVISION	

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

TITLE: Admin

(X6) DATE: 7-2-14

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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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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K 000	Continued From page 1 By eMail 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. Building 01 of Minnewaska Community Health Services Nursing Home is a one-story building with no basement, and is fully fire sprinkler protected throughout. The original 1960 building along with the 1968 and 1972 additions were determined to be of Type II(111) construction. The 1988 and 1996 building additions were determined to be of Type V(111) construction. The 2000 building addition was 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 65 beds and had a census of 62 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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K 144 SS=F	Continued From page 2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 65 of 65 residents. FINDINGS INCLUDE: On 06/04/2014 at 12:20 PM, during a review of the monthly inspection and testing log of the emergency generator for February, March, April and May of 2014, no documentation could be provided verifying the genset had been either: 1). Exercised at not less than 30% of the EPS nameplate rating, or; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the manufacturer, or; 3). Had a 2-hour load bank test performed within the previous year. This finding was confirmed with the	K 144	K – 144 MLH has a diesel fired generator. To meet requirements at N.F.P.A. 110 (1999) sec 6-4. We have installed a pyrometer and will record temperatures of 650 degrees per engine manufactures ratings. Recording will be monitored by E.S.D. Date in Compliance (06/05/2014)	

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MINNEWASKA COMMUNITY HEALTH SERVICES	505 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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K 144	Continued From page 3 environmental services director.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING 02 - 02 - 2004 ADDITIONS B. WING _____	06/04/2014

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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 4, 2014. At the time of this survey, Building 02 of Minnewaska Community Health Services Nursing Home was found not to be 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 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok JB 7-16-14 RECEIVED JUL 11 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Admin.	7-2-14

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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(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
K 000	Continued From page 1 By eMail 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. Building 02 of Minnewaska Community Health Services Nursing Home consists of the 2004 building addition, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(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 65 beds and had a census of 62 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING 02 - 02 - 2004 ADDITIONS B. WING _____	06/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 65 of 65 residents. FINDINGS INCLUDE: On 06/04/2014 at 12:20 PM, during a review of the monthly inspection and testing log of the emergency generator for February, March, April and May of 2014, no documentation could be provided verifying the genset had been either: 1). Exercised at not less than 30% of the EPS nameplate rating, or; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the manufacturer, or; 3). Had a 2-hour load bank test performed within the previous year. This finding was confirmed with the environmental services director.	K 144	K – 144 MLH has a diesel fired generator. To meet requirements at N.F.P.A. 110 (1999) sec 6-4. We have installed a pyrometer and will record temperatures of 650 degrees per engine manufactures ratings. Recording will be monitored by E.S.D. Date in Compliance (06/05/2014)	