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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2C43

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00636

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245253**

2.STATE VENDOR OR MEDICAID NO.
(L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC**
(L4) **200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

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) **10/01/2013**

6. DATE OF SURVEY **04/27/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Brenda Fischer, Unit Supervisor 04/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/08/2015 (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
09/01/1987
(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.
00000
(L31)

30. REMARKS
Posted 06/04/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245253
May 8, 2015

Ms. Annette Greely, Administrator
Centracare Health Paynesville Koronis Manor Cc
200 First Street West
Paynesville, Minnesota 56362

Dear Ms. Greely:

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 May 15, 2015 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 8, 2015

Ms. Annette Greely, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, Minnesota 56362

RE: Project Number S5253025

Dear Ms. Greely:

On March 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 13, 2015 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 March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 15, 2015 and therefore remedies outlined in our letter to you dated March 20, 2015, 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245253	A. Building B. Wing	4/27/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/15/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **04/15/2015**	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	BF/KJ	05/08/2015	10562	04/27/2015
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
3/5/2015			

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
245253	A. Building B. Wing 01 - MAIN BUILDING 01	4/13/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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 K0056	Correction Completed 03/20/2015	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 PS/KJ	Date: 05/08/2015	Signature of Surveyor: 34764	Date: 04/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/4/2015		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: 2C43

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00636

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2.STATE VENDOR OR MEDICAID NO.
(L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC**
(L4) **200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

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) **10/01/2013**

6. DATE OF SURVEY **03/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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
	52			
(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 :
Mardelle Trettel, HFE NE II 04/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(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.
00000
(L31)

30. REMARKS
Posted 04/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1390
March 20, 2015

Ms. Annette Greely, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, Minnesota 56362

RE: Project Number S5253025

Dear Ms. Greely:

On March 5, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 19, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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. 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 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 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 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 June 5, 2015 (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 September 5, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

CENTRACARE Health
Paynesville

Koronis Manor
Addendum to Plan of Correction
April 15, 2015

F157D. Facility administrator modified Admission and Transfer Policy to notify the resident, resident's legal representative and family of all new roommates assigned or room transfers as they occur. Social Service will document family/resident notification in chart. Director of Nursing (DON) will audit monthly that documentation is compliant with policy. All information concerning notification of resident/family of room changes is presented to the Quality Assurance Committee every month by the Quality Assurance nurse coordinator.

F241D. Charge nurse will be responsible to refresh staff understanding of "dining with dignity and without interruption" and then to observe compliance intervals throughout the month. All incidents of non-compliance will be addressed at the time of the incident and rate of non-compliance will be presented at each Quality Assurance Committee by the Quality Assurance nurse coordinator.

F280D. A list of all residents utilizing lap belts will be reviewed by the charge nurse with staff at change of shift. Twice a month, a random audit of belt release compliance will be conducted. All incidents of non-compliance will be addressed at the time of the incident and rate of non-compliance will be presented at each Quality Assurance Committee by the Quality Assurance nurse coordinator. Since March 9, 2015, we have no lap belts in use here at Koronis Manor.

F323D. A random weekly audit will be conducted by the charge nurse in March and April 2015 and then monthly until July 2015 to assure that slings/harnesses match the stand manufacturer. All incidents of non-compliance will be addressed at the time of the incident and rate of non-compliance will be presented at each Quality Assurance Committee by the Quality Assurance nurse coordinator. Once budget allows, all stands and slings will be replaced by MedCare products and we will discontinue this audit because this potential non-compliance will be eliminated and the issue will be closed.

Annette Greely — 4-15-15

Annette Greely — Date

4/17/15 accepted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING _____ B. WING _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

(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	RECEIVED APR 06 2015 MN Dept of Health St.Cloud	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A. Social Services staff have been re-educated to alert both family and resident of all room transfers and room-mate changes at the time they occur. Social Services staff agree to notify family via a telephone call at the time the decision to make the change is made. In addition, Social Services staff will alert all pertinent staff of any change in the resident's location. B. The Admission and Transfer Policy has been modified to highlight the requirement to notify the resident, resident's legal representative and family of all new roommates assigned or room transfers as they occur. For room changes, the Room	

4/7/15 Dev reviewed BT

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

Annette Greeg MS LNHA — Director of Senior Services — 4/1/15

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.

Dominic C. Milloy — Administrator/CEO — 4/2/15

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	245253	A. BUILDING _____ B. WING _____	03/05/2015

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to notify the family regarding a roommate change for 1 of 1 residents (R56) reviewed with cognitive impairment, and whom had a new roommate. Findings include: R56's significant change Minimum Data Set (MDS), dated 12/10/14, identified R56 had severe cognitive impairment, and it was "very important" to have her family involved in her care. During interview on 3/3/15, at 1:00 p.m. family member (FM)-A stated he was the person who was typically notified of changes in R56's care. Further, R56 had several roommate changes in the past couple months, and staff did not update him with those changes stating, "It would be nice to know that." When interviewed on 3/5/15, at 12:29 p.m. licensed practical nurse (LPN)-A stated R56 has had two different roommates, with the current roommate admitting just a few days prior. Further, the facility's licensed social worker (LSW) was responsible for notifying residents and families regarding room and roommate changes.	F 157	Change Notification Form will be completed and placed in the medical record. C. Since March 10, 2015, all new admissions and room transfers have followed this process and residents and families have been notified via telephone. D. Social Services staff will document room changes, follow-up's and any discussion with residents or family members concerning these changes in the medical record. E. Final responsibility for compliance with modified Transfer Notice Policy remains with the Director of Social Services. Corrective action is to be completed by April 15, 2015.	

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F 157	Continued From page 2 During interview on 3/5/15, at 1:06 p.m. LSW-A stated she was responsible for notifying residents and families about room and roommate changes, and her typical practice was to notify the resident just prior to the roommates admission. R56 had been told on Friday (2/27/15) that she (R56) would be getting a new roommate over the weekend. Further, LSW-A stated she did not notify any family members, despite R56's severe cognitive impairment, regarding a roommate change, "I always knew I had to tell the residents, and that's what I did." A facility LTC (Long Term Care) Interdisciplinary Care Team policy, dated 6/2014, identified a procedure which included, "The Social Worker will serve as the coordinator of any admissions, transfers/room changes, or discharges...", in which the LSW would, "Notify the resident, their roommate, and any responsible party of the decision."			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 4 residents (R44) observed who required staff assistance for eating.	F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY A. All nursing assistants were instructed to continue to assist with meals without interruption until the resident is finished eating. If the staff is requested to assist with another resident's care, the staff has been instructed to request fellow staff members to continue with the current resident's meal until the staff member can return to that table.	

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F 241	Continued From page 3 Findings include: R44's diagnoses, as indicated in the annual Minimum Data Set (MDS) dated 1/8/2015, identified R44 had dementia and Parkinson's Disease, had severe cognitive impairment, and required extensive assistance of 1-2 persons for all activities of daily living (ADLs), including eating. During observation on 3/4/2015, at 12:03 p.m. nursing assistant (NA)-D was pushing R44 into the dining room in her wheelchair, while R44 was dozing off for the noon meal. NA-D told R44 about the noon menu, placed a clothing protector around R44's chest, and then exited the room to assist other residents into the dining area. At 12:13 p.m., R44, was asleep with her chin on her chest. At 12:23 p.m., three other residents who were seated at the table with R44 were served their meals. NA-C, who was seated opposite R44 at the same table, began assisting the residents nearest her. At 12:26 p.m., R44's meal tray was brought to the table, and NA-D sat down to the right of R44, who was asleep. NA-D began to talk and gently massaged her arm to attempt to wake her. NA-D continued to talk to R44, whose eyes were closed and chin still touching her chest, placed a spoon in her hand, and encouraged her to begin eating. R44 nodded to NA-D's words with her eyes closed. NA-D offered R44 a bite of food from another spoon, and R44 took a small bite with her eyes closed. At 12:27 p.m., NA-D suddenly stood up and left the dining room. R44 continued to doze off with her spoon in her hand, and did not attempt to feed herself, nor was provided assistance from staff to eat from 12:28 p.m. until 12:37 p.m. (9 minutes). NA-C, who was seated at the same table, neither	F 241	All staff has been instructed that it is inappropriate to leave a resident in the middle of a meal for 10 minutes or more and staff should be made available to fill in if assistance is interrupted. B. Staff has been instructed that all residents requiring assistance during meals should not be left alone to serve themselves and fellow staff need to be alerted and agree to continue with meal assistance when staff is called away. C. The staff will attend a new education module entitled "Dining with Dementia" to re-educate on the appropriate process of serving and assisting residents with dementia at the Koronis Manor Care Center. D. Charge Nurses will re-address the concept of appropriate coverage for each meal with staff at the start of each meal time in the dining room. Staff assisting in the dining room will agree to promptly cover for any staff person called away to assist with cares during meal time. E. Final responsibility for compliance with the resident's	

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F 241	Continued From page 4 provided R44 assistance nor offered encouragement to eat, but rather continued to assist the two residents nearest her. At 12:37 p.m., NA-D returned to the dining room and began feeding R44 her meal. NA-D remained with R44 in the dining room, assisting her to eat, until 1:00 p.m. In an interview on 3/4/2015, at 1:07 p.m. nursing assistant (NA)-D stated she left the table because she had been "called to help with a transfer", and left R44 unattended. During an interview on 3/5/2015, at 10:33 a.m. registered nurse (RN)-A stated NA's should not leave the resident while helping them to eat, and they should be able to finish their meals "without interruption." In an interview on 3/5/2015 at 1:27 p.m., the director of nursing (DON) stated she "fully agreed with the charge nurse", that it was not dignified for any residents meal time to be interrupted. A facility policy entitled "Resident Bill of Rights," undated, in the "Quality of Life" section, under dignity, indicated the following: "The facility must, with courtesy, promote and care for you in a manner and environment that maintains or enhances your dignity and respect, in full recognition of your individuality."	F 241	corrective action plan at meal time remains with the Director of Nursing. Corrective action is to be completed by April 15, 2015.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP A. The Charge Nurse reviewed the care plan for compre-hensiveness, accuracy and needs of this one resident	

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F 280	Continued From page 5 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise and update the plan of care for 1 of 1 residents (R44), who utilized a lap belt. Findings include: R44's diagnoses, identified in the annual Minimum Data Set (MDS) dated 1/8/2015, identified R44 had dementia, Parkinson's disease, had severe cognitive impairment, and required extensive assistance with activities of daily living (ADL). The care area assessment (CAA), dated 1/20/2015, indicated R44 utilized a lap belt, due to inability to safely transfer without staff assistance, and having no insight as to safety. The CAA identified medical symptoms for use of the lap belt, which included gait disturbance, history of falls, and Parkinson's		(R44). The Charge Nurse then met with all unit staff across all shifts to detail the policy of removing the lap belt during meals for resident comfort. The Charge Nurse then placed specific tasks and directions on the C.N.A.'s task charting requirements for them to implement, follow and chart on while providing care for the resident. B. At this time, R44 was the only resident utilizing a lap belt, so no other residents were affected. However, in the future, the Charge Nurse will alert staff at the change of shift of all residents utilizing a lap belt, that it should be removed during meal time and that their care plan reflects that a lap belt is in use and should be removed during meals. C, A list of all residents utilizing lap belts and the release timing cycle for each resident will be posted and reviewed at each shift change; currently there are no lap belts in use at the Koronis Manor Care Center. D. Once lap belts are implemented, a mini-audit will be conducted for release schedule	

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F 280	Continued From page 6 disease. The CAA further indicated, "The lap restraint is removed q2H [every 2 hours] and at meals." R44's care plan, revised on 1/22/2015, directed staff to "apply lap belt with in chair and release Q [every] 2 hours for repositioning. Check every 30 minutes for safety while using restraint." The care plan lacked specific direction that R44's lap belt was to be removed during meal times, even though the CAA identified to remove it at meals. During continuous observation on 3/4/2015, from 12:03 p.m. until 1:00 p.m. (57 minutes), R44 was seated in her wheelchair with the lap belt in place. R44 was served and assisted with her meal, finishing her meal at 1:00 p.m. During this time, the lap belt remained in place and staff made no attempts to remove it. In an interview on 3/4/2015, at 1:07 p.m. NA-D stated she was "not aware" that R44's lap belt was to be released during meal times. During an interview on 3/5/2015, at 10:30 a.m. registered nurse (RN)-A stated R44's lap belt should have been removed during meal time as identified in the quarterly assessments. Although R44's lap belt was identified to be removed during meal time in her assessments, their was no indication this was added to R44's care plan. A facility care plan policy was requested, but none provided.	F280	compliance every two weeks. E. Final responsibility for compliance with the resident's care plan and release of the lap belt during meals remains with the Director of Nursing. Corrective action is to be completed by April 15, 2015.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	

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F 323	Continued From page 7 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 1 of 1 residents (R31) observed during transfers was comprehensively assessed for safe transfers using the MedCare brand stand (mechanical device that uses a harness to stand someone) with an EZ Way harness, which the EZ Way manufacturer had not recommended to use with other mechanical stand brands. This had the potential to affect an additional 4 residents (R28, R10, R44, and R68) residing on the North Unit who used MedCare and EZ Way stands/harnesses interchangeably for resident transfers. Findings include: R31's quarterly Minimum Data Set (MDS), dated 1/2/15, identified R31 had intact cognition, and required extensive assistance of two staff to complete transfers. R31's care plan, dated 4/16/14, identified R31 was at risk for falls, and required, "Transfer: Ext [extensive] Assist of 1-2 and EZ Stand." During observation of care on 3/4/15, at 7:06 a.m. nursing assistant (NA)-A entered R31's room with	F 323	A. MedCare advertises and sells a universal sling that can be used on any loop stand. The universal MedCare sling was purchased and utilized on both the MedCare and EZ Way stands currently in place within the facility. The surveyor noted the Med-Care universal sling being used on an EZ stand. The immediate corrective action was to notify all staff that the universal MedCare sling was not to be considered a universal sling because EZ stands did not recognize the universal sling as safe in operation on the EZ stands. Effective immediately, the staff was instructed by the Director of Nursing that MedCare slings were to be used only on MedCare stands. Each stand is now labeled as either MedCare or EZ Way and only matching slings are to be used on that stand. B. All residents designated as requiring use of stand for transfer have a note on the care plan to use only the sling harness that matches the stand being used to transfer. C. In the short term, the Director of Nursing sent a	

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F 323	Continued From page 8 a MedCare mechanical stand which had two different colored harnesses (A blue harness, developed by MedCare along with a green harness, developed by EZ Way, Inc.) on top of the device, placing it in front of R31 who was seated in her wheelchair. NA-A removed the EZ Way brand harness from the top of the MedCare stand, placed it behind R31 and secured the it to the stand using two cloth loops on the harness. R31 was stood up from her wheelchair and assisted into the restroom with the mechanical stand. At 7:09 a.m. R31 was assisted to stand, using the same stand and harness, and seated back in her wheelchair. NA-A detached the EZ Way harness from the MedCare stand, placed it back on top of the device, and placed it back in the hallway for further use with other residents at 7:14 a.m.. During review of R31's medical record, indicated there was no assessment to determine if R31 was safe to transfer with a MedCare mechanical stand and EZ Way harness. When interviewed on 3/4/15, at 12:59 p.m. registered nurse (RN)-A stated the residents are not assessed for safety when interchanging the mechanical stands and harnesses. Further RN-A stated, "I don't see a problem." Review of the EZ Way Stand Operator's Instruction manual, dated 3/11/09, identified, "EZ Way harnesses are made specifically for EZ Way stands. For the safety of the patient and caregiver, only EZ Way harnesses should be used with EZ Way stands." Review of the MedCare Products Operation Manual, dated 2014, identified, "MedCare slings	F 323	written device to all staff notifying them that the MedCare universal sling was not to be used as a universal sling at the Koronis Manor Care Center. All staff are aware that sling/harness equipment is to match the stand being used to transfer. In the long term, as budget permits, the facility will eliminate EZ stands and products from the facility and replace them with Med-Care universal products and stands which will eliminate the opportunity to have this deficiency being issued in the future. D. An audit of staff compliance to slings matching the stand will be conducted weekly in March and April 2015 and monthly until July 2015 or until EZ stands/products are removed from the facility, leaving only one manufacturer in the facility. E. Final responsibility for compliance with the "one stand and matching slings/ harnesses" directive remains with the Director of Nursing. Corrective action is to be completed by April 15, 2015.	

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and belts have been specifically designed and tested for use with lifts and stands manufactured by MedCare Products, Inc. and any other lift with a 4 point hanger bar loop system." There was no indication if another manufacturer's harnesses could safely be used with their mechanical stands.

During interview on 3/4/15, at 9:06 a.m. licensed practical nurse (LPN)-A stated some residents have a preference for a certain harness because of comfort, however EZ Way harnesses should only be used with EZ Way mechanical stands, "I believe so."

When interviewed on 3/4/15, at 9:14 a.m. NA-C held up both harnesses side by side, and stated the EZ Way harness had two attachment points, while the MedCare harness had three attachment points. Further, the staff had been told all harnesses are interchangeable, and could be used with either brand of mechanical stand.

During interview on 3/4/15, at 7:26 a.m. nursing assistant (NA)-A stated she had been told the harnesses could be used interchangeably, and were not specific to each manufacturers product. She further stated the North Unit had four residents (R28, R10, R44 and R68) who used MedCare and EZ Way stands/harnesses for resident transfers.

R28's quarterly MDS, dated 1/22/15, identified R28 had short and long term memory problems, and required extensive assistance from two staff to complete transfers. R28's care plan, dated 4/17/14, identified she was at risk for falls, needed assistance with activities of daily living (ADLs) and required, "Transfer: EZ Stand and

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F 323	Continued From page 10	F 323		

assist of 1-2." During review of R28's medical record, no assessment was located to determine if R28 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety.

R10's quarterly MDS, dated 11/19/14, identified R10 had moderate cognitive impairment, and required extensive assistance of one staff to complete transfers. R10's care plan, dated 2/2/15, identified she was at risk for falls, needed extensive assistance from staff for ADLs, and required, "Transfer: EZ-Stand with 1 assist." During review of R10's medical record, no assessment was located to determine if R10 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety.

R44's annual MDS, dated 1/8/15, identified R44 had short and long term memory problems, and required extensive assistance of two staff to complete transfers. R44's care plan, dated 4/30/14, identified she was at risk for falls, and required, "Transfer: EZ Stand with 1, or 2 person stand pivot, Extensive Assist of 1-2." During review of R44's medical record, no assessment was located to determine if R44 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety.

R68's initial care plan, dated 2/28/15, identified R68 was "forgetful", at risk for falls, and required assistance to transfer using the EZ Stand and assistance of one staff. During review of R68's medical record, no assessment was located to determine if R68 was safe to transfer with a

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	245253	A. BUILDING _____ B. WING _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

(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 323	Continued From page 11	F 323		

MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety.

During a subsequent observation on 3/5/15, at 8:48 a.m. three EZ Way mechanical stands, and a single MedCare mechanical stand were in the hallway of the North Unit and available for use to transfer residents. The MedCare stand had two harnesses sitting on top for use, a MedCare harness and a EZ Way harness. In addition, a EZ Way lift had two harnesses sitting on top for use, a MedCare harness and a EZ Way harness.

During interview on 3/4/15, at 9:21 a.m. an EZ Way representative stated the MedCare company often tells people the harnesses are universal, however EZ Way does not agree. The EZ Way harnesses are tested with EZ Way mechanical stands, and the products are not able to be used on other manufacturer's mechanical stands, "We tell people, use our slings [harnesses] on our lift."

When interviewed on 3/5/15, at 2:06 p.m. the director of nursing (DON) stated the MedCare mechanical stands were purchased in early 2014, and MedCare indicated the stands and harnesses were universal and interchangeable. Further, no residents had been assessed for safety with using the equipment against EZ Way manufacturer guidelines, but that manufacturer guidelines should be followed.

During interview on 3/6/15, at 11:07 a.m. a MedCare representative stated he was unsure why EZ Way would say their products are not able to be used with MedCare stands, but felt the products were universal, "I have no idea why they would say that." Further, the facility was still

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F 323	Continued From page 12 responsible to ensure the resident was safe during the transfer, "They should be assessing if the transfer is done safe." A facility supplied memo from MedCare, dated 1/1/14, identified, "MedCare's patient lift slings are manufactured as "universal slings." Further, "It is imperative that caregivers operating patient lifts receive proper training for the application of each sling with each type of lift it is used." The memo lacked any indication if it was safe to use a EZ Way sling with a MedCare lift. A facility E/Z Stand policy, dated 12/2014, identified a purpose of, "Provide staff with procedural guidelines for the safe use and care of the E/Z stand." However, the policy lacked any direction for assessment of resident safety using the mechanical stands and harnesses, nor if the different manufacturer's products were interchangeable. There was no indication that facility had comprehensively assessed the use of an MedCare brand stand (mechanical device that uses a harness to stand someone) with an EZ Way harness, eventhough on 3/6/15, at 11:07 a.m. a MedCare representative stated, "They [the facility] should be assessing if the transfer is done safe," eventhough the EZ Way manufacturer had not recommended to use their harnesses with any other mechanical stand brands.	F 323		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A. The Quality Assurance Policy requires at least a quarterly	

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F 520	Continued From page 13 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. This had the potential to affect all 51 residents whom resided in the facility, staff, and visitors. Findings include: Review of the CENTRACARE Health Paynesville Quality Assurance meeting attendance logs from 1/14/14 to 2/2/15 identified the facility QAA committee met nine times in 2014. The medical	F 520	meeting with all required personnel to be present on a quarterly basis. The Quality Assurance Coordinator has scheduled and completed a 1Q15 meeting with appropriate personnel in both February and March 2015 and will continue to hold appropriate timed and attended meetings in 2Q, 3Q, and 4Q 2015. B. The Quality Assurance Coordinator has sent out the projected meeting invitations for 2Q, 3Q, and 4Q 2015 meetings. The Director of Nursing has spoken to the Medical Director concerning the requirement to have his presence at each of the next three scheduled quarterly meetings. C. The Quality Assurance Coordinator has scheduled the remaining 2015 quarterly meetings for the Quality Assurance Committee. We have altered the process to assure appropriate attendance. If the meeting is scheduled and all required personnel are not in attendance, the meeting will be re-scheduled each day for seven business days	

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F 520	Continued From page 14 director attended the 1/14/14, 4/14/14, 10/13/14, and 11/25/14 meetings. The medical director did not attend the QAA meeting from May through September 2014, a period of five months between QAA meetings which exceeded the quarterly requirement. During interview on 3/5/15, at 3:20 p.m. the director of nursing (DON) stated that quality assurance meetings are held monthly with the exception of June and December. In addition, the DON stated, we missed the August 2014 meeting due to staff being out on leave of absence and vacations. The DON stated, "We missed it." The facilities policy Quality Management System dated 4/3/06, indicated "The Quality Committee will review, at least quarterly, the overall PAHCS (Paynesville Area Health Care System) Quality Process Improvement Plan." The policy did not identify who needed to be in attendance at the quarterly meetings.	F 520	until all staff are able to attend. If personnel cannot attend, the Quality Assurance Coordinator will move the meeting to the second month in that quarter. The required personnel are aware they are responsible to be in attendance as required for at least one Quality Assurance Committee Meeting per quarter. D. The Quality Assurance Coordinator will inform the Koronis Manor Care Center Administrator that the quarterly attendance criteria have been met at 10 days prior to the quarter end and if quarterly criteria are not met, a meeting will be called immediately. E. Final responsibility for compliance with the Quality Assurance Meeting requirements remains with the Administrator. Corrective action is to be completed by April 15, 2015.	

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

F5253024

PRINTED: 03/20/2015
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
	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/04/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Paynesville Area Health Care System - Koronis Manor 01 Main Building 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 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 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.	K 000	POC ok 4-6-15 RECEIVED APR 6 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 4-19-15
Exit: 3-5-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annette Greeg, MS, LNHA — TITLE: Director Senior Services — (X6) DATE: 4/1/15

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.

Donna C. Miley — Administrator/CEO — 4/2/15

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Paynesville Area Health Care System - Koronis Manor was constructed at 4 different times. The original building was constructed in 1965, is 1-story and was determined to be of Type II(000) construction. In 1969 an addition was added to the main building, Type II (000) no basement. In 1989 a 1-story addition with no basement was constructed and was determined to be of Type II(000). In 2000 a Southwest addition was added with partial basement housing only mechanical equipment. Type V (111) The building is divided into 3 smoke compartments by 30 minute and 2-hour fire barriers. Fully sprinkler protected with a manual fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 52 beds and had a census of 51 at the time of the survey. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one	K 000		

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K 000	Continued From page 2 building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in accordance with NFPA 13 Standard for the Installation of Sprinkler System 1999 edition section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively impact all the residents, visitors and staff. Findings include: Observations during the facility tour on March 4, 2015, between 9:15 AM and 11:45 AM, revealed that storage in the following areas were within 18 inches of the sprinkler heads within the rooms;	K 056	NFPA 101 LIFE SAFETY CODE STANDARD Staff relocated all resident items stored above their clothing on the shelf in each resident's closet. Maintenance removed the upper shelf in each closet in every room. All closets now have the required 18 inches of clearance of the sprinkler heads within the rooms. Final responsibility for compliance with this corrective action plan for life safety code sprinkler clearance remains with the Director of Nursing. Corrective action has been completed on March 20, 2015.	

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K 056	Continued From page 3 1) Patient rooms 192, 195, 199, 210 and 225. The Facilities Management Manager (FC) and Facilities Safety Manager (MM) verified these findings during the facility tour.	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1390
March 20, 2015

Ms. Annette Greely, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, Minnesota 56362

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5253025

Dear Ms.. Greely:

The above facility was surveyed on March 2, 2015 through March 5, 2015 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00636	A. BUILDING: _____ B. WING _____	03/05/2015

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CENTRACARE HEALTH PAYNESVILLE KORONIS MAI	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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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: On 3/2/15, 3/3/15, 3/4/15, and 3/5/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	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 Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000	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 which 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.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		

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2 570	Continued From page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise and update the plan of care for 1 of 1 residents (R44), who utilized a lap belt. Findings include: R44's diagnoses, identified in the annual Minimum Data Set (MDS) dated 1/8/2015, identified R44 had dementia, Parkinson's disease, had severe cognitive impairment, and required extensive assistance with activities of daily living (ADL). The care area assessment (CAA), dated 1/20/2015, indicated R44 utilized a lap belt, due to inability to safely transfer without staff assistance, and having no insight as to safety. The CAA identified medical symptoms for use of the lap belt, which included gait disturbance, history of falls, and Parkinson's disease. The CAA further indicated, "The lap restraint is removed q2H [every 2 hours] and at meals." R44's care plan, revised on 1/22/2015, directed staff to "apply lap belt with in chair and release Q [every] 2 hours for repositioning. Check every 30 minutes for safety while using restraint." The care plan lacked specific direction that R44's lap belt was to be removed during meal times, even though the CAA identified to remove it at meals. During continuous observation on 3/4/2015, from	2 570		

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CENTRACARE HEALTH PAYNESVILLE KORONIS MAI	200 FIRST STREET WEST PAYNESVILLE, MN 56362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 3 12:03 p.m. until 1:00 p.m. (57 minutes), R44 was seated in her wheelchair with the lap belt in place. R44 was served and assisted with her meal, finishing her meal at 1:00 p.m. During this time, the lap belt remained in place and staff made no attempts to remove it. In an interview on 3/4/2015, at 1:07 p.m. NA-D stated she was "not aware" that R44's lap belt was to be released during meal times. During an interview on 3/5/2015, at 10:30 a.m. registered nurse (RN)-A stated R44's lap belt should have been removed during meal time as identified in the quarterly assessments. Although R44's lap belt was identified to be removed during meal time in her assessments, their was no indication this was added to R44's care plan. A facility care plan policy was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		

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2 830	Continued From page 4 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 1 of 1 residents (R31) observed during transfers was comprehensively assessed for safe transfers using the MedCare brand stand (mechanical device that uses a harness to stand someone) with an EZ Way harness, which the EZ Way manufacturer had not recommended to use with other mechanical stand brands. This had the potential to affect an additional 4 residents (R28, R10, R44, and R68) residing on the North Unit who used MedCare and EZ Way stands/harnesses interchangeably for resident transfers. Findings include: R31's quarterly Minimum Data Set (MDS), dated 1/2/15, identified R31 had intact cognition, and required extensive assistance of two staff to complete transfers. R31's care plan, dated 4/16/14, identified R31 was at risk for falls, and	2 830		

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2 830	Continued From page 5	2 830		

required, "Transfer: Ext [extensive] Assist of 1-2 and EZ Stand."

During observation of care on 3/4/15, at 7:06 a.m. nursing assistant (NA)-A entered R31's room with a MedCare mechanical stand which had two different colored harnesses (A blue harness, developed by MedCare along with a green harness, developed by EZ Way, Inc.) on top of the device, placing it in front of R31 who was seated in her wheelchair. NA-A removed the EZ Way brand harness from the top of the MedCare stand, placed it behind R31 and secured the it to the stand using two cloth loops on the harness. R31 was stood up from her wheelchair and assisted into the restroom with the mechanical stand. At 7:09 a.m. R31 was assisted to stand, using the same stand and harness, and seated back in her wheelchair. NA-A detached the EZ Way harness from the MedCare stand, placed it back on top of the device, and placed it back in the hallway for further use with other residents at 7:14 a.m..

During review of R31's medical record, indicated there was no assessment to determine if R31 was safe to transfer with a MedCare mechnical stand and EZ Way harness.

When interviewed on 3/4/15, at 12:59 p.m. registered nurse (RN)-A stated the residents are not assessed for safety when interchanging the mechanical stands and harnesses. Further RN-A stated, "I don't see a problem."

Review of the EZ Way Stand Operator's Instruction manual, dated 3/11/09, identified, "EZ Way harnesses are made specifically for EZ Way stands. For the safety of the patient and caregiver, only EZ Way harnesses should be

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2 830	Continued From page 6 used with EZ Way stands." Review of the MedCare Products Operation Manual, dated 2014, identified, "MedCare slings and belts have been specifically designed and tested for use with lifts and stands manufactured by MedCare Products, Inc. and any other lift with a 4 point hanger bar loop system." There was no indication if another manufacturer's harnesses could safely be used with their mechanical stands. During interview on 3/4/15, at 9:06 a.m. licensed practical nurse (LPN)-A stated some residents have a preference for a certain harness because of comfort, however EZ Way harnesses should only be used with EZ Way mechanical stands, "I believe so." When interviewed on 3/4/15, at 9:14 a.m. NA-C held up both harnesses side by side, and stated the EZ Way harness had two attachment points, while the MedCare harness had three attachment points. Further, the staff had been told all harnesses are interchangeable, and could be used with either brand of mechanical stand. During interview on 3/4/15, at 7:26 a.m. nursing assistant (NA)-A stated she had been told the harnesses could be used interchangeably, and were not specific to each manufacturers product. She further stated the North Unit had four residents (R28, R10, R44 and R68) who used MedCare and EZ Way stands/harnesses for resident transfers. R28's quarterly MDS, dated 1/22/15, identified R28 had short and long term memory problems, and required extensive assistance from two staff to complete transfers. R28's care plan, dated	2 830		

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2 830	Continued From page 7 4/17/14, identified she was at risk for falls, needed assistance with activities of daily living (ADLs) and required, "Transfer: EZ Stand and assist of 1-2." During review of R28's medical record, no assessment was located to determine if R28 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety. R10's quarterly MDS, dated 11/19/14, identified R10 had moderate cognitive impairment, and required extensive assistance of one staff to complete transfers. R10's care plan, dated 2/2/15, identified she was at risk for falls, needed extensive assistance from staff for ADLs, and required, "Transfer: EZ-Stand with 1 assist." During review of R10's medical record, no assessment was located to determine if R10 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety. R44's annual MDS, dated 1/8/15, identified R44 had short and long term memory problems, and required extensive assistance of two staff to complete transfers. R44's care plan, dated 4/30/14, identified she was at risk for falls, and required, "Transfer: EZ Stand with 1, or 2 person stand pivot, Extensive Assist of 1-2." During review of R44's medical record, no assessment was located to determine if R44 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety. R68's initial care plan, dated 2/28/15, identified R68 was "forgetful", at risk for falls, and required assistance to transfer using the EZ Stand and assistance of one staff. During review of R68's	2 830		

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2 830	Continued From page 8	2 830		

medical record, no assessment was located to determine if R68 was safe to transfer with a MedCare mechanical stand and EZ Way harness, which the EZ Way manufacturer had not recommended for safety.

During a subsequent observation on 3/5/15, at 8:48 a.m. three EZ Way mechanical stands, and a single MedCare mechanical stand were in the hallway of the North Unit and available for use to transfer residents. The MedCare stand had two harnesses sitting on top for use, a MedCare harness and a EZ Way harness. In addition, a EZ Way lift had two harnesses sitting on top for use, a MedCare harness and a EZ Way harness.

During interview on 3/4/15, at 9:21 a.m. an EZ Way representative stated the MedCare company often tells people the harnesses are universal, however EZ Way does not agree. The EZ Way harnesses are tested with EZ Way mechanical stands, and the products are not able to be used on other manufacturer's mechanical stands, "We tell people, use our slings [harnesses] on our lift."

When interviewed on 3/5/15, at 2:06 p.m. the director of nursing (DON) stated the MedCare mechanical stands were purchased in early 2014, and MedCare indicated the stands and harnesses were universal and interchangeable. Further, no residents had been assessed for safety with using the equipment against EZ Way manufacturer guidelines, but that manufacturer guidelines should be followed.

During interview on 3/6/15, at 11:07 a.m. a MedCare representative stated he was unsure why EZ Way would say their products are not able to be used with MedCare stands, but felt the products were universal, "I have no idea why they

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2 830	Continued From page 9 would say that." Further, the facility was still responsible to ensure the resident was safe during the transfer, "They should be assessing if the transfer is done safe." A facility supplied memo from MedCare, dated 1/1/14, identified, "MedCare's patient lift slings are manufactured as "universal slings." Further, "It is imperative that caregivers operating patient lifts receive proper training for the application of each sling with each type of lift it is used." The memo lacked any indication if it was safe to use a EZ Way sling with a MedCare lift. A facility E/Z Stand policy, dated 12/2014, identified a purpose of, "Provide staff with procedural guidelines for the safe use and care of the E/Z stand." However, the policy lacked any direction for assessment of resident safety using the mechanical stands and harnesses, nor if the different manufacturer's products were interchangeable. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies regarding the proper use of a mechanical lift for transfers. They could educate staff, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		

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21805	Continued From page 10 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 4 residents (R44) observed who required staff assistance for eating. Findings include: R44's diagnoses, as indicated in the annual Minimum Data Set (MDS) dated 1/8/2015, identified R44 had dementia and Parkinson's Disease, had severe cognitive impairment, and required extensive assistance of 1-2 persons for all activities of daily living (ADLs), including eating. During observation on 3/4/2015, at 12:03 p.m. nursing assistant (NA)-D was pushing R44 into the dining room in her wheelchair, while R44 was dozing off for the noon meal. NA-D told R44 about the noon menu, placed a clothing protector around R44's chest, and then exited the room to assist other residents into the dining area. At 12:13 p.m., R44, was asleep with her chin on her chest. At 12:23 p.m., three other residents who were seated at the table with R44 were served their meals. NA-C, who was seated opposite R44 at the same table, began assisting the residents nearest her. At 12:26 p.m., R44's meal tray was brought to the table, and NA-D sat down to the right of R44, who was asleep. NA-D began to talk and gently massaged her arm to attempt to wake her. NA-D continued to talk to R44, whose eyes were closed and chin still touching her	21805		

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21805	Continued From page 11	21805		

chest, placed a spoon in her hand, and encouraged her to begin eating. R44 nodded to NA-D's words with her eyes closed. NA-D offered R44 a bite of food from another spoon, and R44 took a small bite with her eyes closed. At 12:27 p.m., NA-D suddenly stood up and left the dining room. R44 continued to doze off with her spoon in her hand, and did not attempt to feed herself, nor was provided assistance from staff to eat from 12:28 p.m. until 12:37 p.m. (9 minutes). NA-C, who was seated at the same table, neither provided R44 assistance nor offered encouragement to eat, but rather continued to assist the two residents nearest her. At 12:37 p.m., NA-D returned to the dining room and began feeding R44 her meal. NA-D remained with R44 in the dining room, assisting her to eat, until 1:00 p.m.

In an interview on 3/4/2015, at 1:07 p.m. nursing assistant (NA)-D stated she left the table because she had been "called to help with a transfer", and left R44 unattended.

During an interview on 3/5/2015, at 10:33 a.m. registered nurse (RN)-A stated NA's should not leave the resident while helping them to eat, and they should be able to finish their meals "without interruption."

In an interview on 3/5/2015 at 1:27 p.m., the director of nursing (DON) stated she "fully agreed with the charge nurse", that it was not dignified for any residents meal time to be interrupted.

A facility policy entitled "Resident Bill of Rights," undated, in the "Quality of Life" section, under dignity, indicated the following: "The facility must, with courtesy, promote and care for you in a manner and environment that maintains or

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21805	Continued From page 12 enhances your dignity and respect, in full recognition of your individuality." SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		