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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2MK4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00467

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245356**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230080000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MCINTOSH SENIOR LIVING**
(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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) **09/24/2009**

6. DATE OF SURVEY **05/21/2018** (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 **45** (L18)
13.Total Certified Beds **45** (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
	45			
(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 :
Lyla Burkman, Unit Supervisor 05/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/25/2018 (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
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245356 May 25, 2018

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, MN 56556

Dear Ms. Knutson:

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 April 26, 2018 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2018

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, MN 56556

RE: Project Number S5356032

Dear Ms. Knutson:

On April 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 21, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 3, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 5, 2018, effective April 26, 2018 and therefore remedies outlined in our letter to you dated April 17, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2MK4

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(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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

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(L9) **09/24/2009**

6. DATE OF SURVEY **04/05/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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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) :

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NE-II 05/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/04/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2018

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, MN 56556

RE: Project Number S5356032

Dear Ms. Knutson:

On April 5, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 15, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 15, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____	04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/2/18, through 4/5/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/2/18 through 4/5/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		4/23/18

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

Electronically Signed | 04/26/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____	04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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 761	Continued From page 1 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure insulin vials for a personal insulin pen included a pharmacy label for 1 of 1 residents (R17) observed to receive insulin injection. In addition, the facility failed to ensure narcotic medications were controlled and stored in a manner to ensure limited access in order to prevent drug diversion. Findings include: R17's physician's orders signed 3/7/18, directed staff to administer subcutaneous via pen, Humalog (insulin used to control blood sugar) 4 units with lunch and supper, 5 units with breakfast. On 4/3/18, at 5:18 p.m. registered nurse (RN)-C	F 761	R17 was the only resident that was affected by this deficient practice and all the other residents requiring insulin were using disposable insulin pens with pharmacy labels intact. The unmarked hinged box located in the med cart in question had a faded name label on the outside that was still legible, however, on 4/06/18 an new label with darker print was placed on the hinged box. The insulin pen and cap for R17 was then labeled with her name and the insulin cartridge with her medication was labeled with her name and a sticker with "direction change see emar" was placed on the pen for nursing to refer to the emar for insulin orders. This pen for R17 will be used until current supply is gone, then resident will switch to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____	04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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 761	Continued From page 2 removed an insulin pen from an unmarked hinged box which was located in the medication cart. The pen was inscribed "Free sample" and Lilly company (manufacturer). The cartridge (which holds the insulin) contained the manufacturer's inscription identifying the medication name. Neither the pen nor the cartridge contained a pharmacy label which identified resident name, medication, and dosage to administer. RN-C confirmed the pen was not labeled with R17's name and stated it is a very unique pen that family supplied. RN-C also acknowledged that the insulin cartridge did not contain a label that identified it was intended for R17, or the prescribed dose. On 04/05/18, at 11:53 a.m. director of nursing (DON) acknowledged that R17's insulin was not labeled and indicated they had tried in the past but the labels fell off. The DON expected the pharmacy to label the individual vials for R17. During telephone interview with consulting pharmacist on 4/6/18, at 1:35 p.m. she acknowledged that there should be labeling on insulin cartridges. The facility policy was requested and not received. On 4/15/18 at 9:00 a.m. during medication storage and review of medication destruction, licensed practical nurse (LPN)-A indicated that any narcotic medication that was discontinued was to be put in the director of nursing (DON) office in a locked file cabinet. LPN-A proceeded to walk to the DON's office door which was noted to be left all the way open with the DON not present. Upon entering the unlocked DON's office, LPN-A	F 761	disposable pen which will be labeled by pharmacy with name and directions. To prevent this from occurring again we have reviewed and updated policies and education given to staff on 4/23/18 of our policy and procedures in having all medications labeled appropriately. The DON/Chg nurse will audit daily to ensure pen is marked appropriately until current supply of insulin cartridges are gone and disposable pen received. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018. All residents found were potentially affected by our deficient practice, however facility has had not drug diversion problems. on 4/8/18 a locked box was purchased to lock all narcotics due to be destroyed by nurse and pharmacy. the locked box will be then in a locked filed cabinet in the DON's office to meet the double lock requirements. Policies and procedures were update. Education given to staff on 4/23/18 of our policy and procedures. The Administrator will audit to ensure the double locked regulation for narcotics is being followed 2x's a week for 2 months. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018.	

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	245356	A. BUILDING _____ B. WING _____	04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 3	F 761		

retrieved keys from the unlocked top drawer of the DON's desk, and unlocked a long file cabinet drawer which contained medications which LPN-A stated needed to be destroyed with the pharmacist. LPN-A then indicated the narcotics in the drawer were not tracked or counted until destruction with the pharmacist, which was usually monthly. LPN-A verified there was no log sheet to identify which narcotics were supposed to be in the drawer and that information was tracked in the narcotic count books on each of the three medication carts. LPN-A stated that, to her knowledge, only she, (maybe one other nurse), and the DON accessed the file cabinet. LPN-A verified the DON's door was not always closed and locked when unoccupied. LPN-A verified narcotics needed to be double locked. LPN-A stated she had worked at the facility for 5 years in which this had been the process and there had been no discrepancy with counts or facility diversion that she was aware of.

On 4/5/18, at 11:51 a.m. DON acknowledged narcotics were locked in a file drawer in her office and verified the door was not always locked when she was out of the office, and to her knowledge there had not been any discrepancy with counts or facility diversion. DON acknowledged that narcotics should have been double locked as required.

During telephone interview on 4/6/18, at 1:35 p.m. consultant pharmacist verified that narcotics should have been double locked and confirmed the medications were only under single lock when the office door was left open.

A Storage of Medications and Narcotics in Med Room policy dated 10/29/15, indicated

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F 761	Continued From page 4 medications put on hold/discontinued would be stored in a designated basket in locked med room/or locked cabinet in the DON's office until destruction by a registered nurse. A Counting of Narcotics policy dated 10/29/15, indicated when a schedule II, III, IV, V drug needed to be destroyed, medication was taken out of the locked med cart, counted by two licensed staff and placed in DON's office in a locked file cabinet awaiting destruction with Pharmacy.	F 761		

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	245356	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/03/2018**

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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey McIntosh Senior Living was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Healthcare Facilities Code (NFPA 99)

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2018

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency McIntosh Senior Living is a 1-story building without a basement. The building was built in 1983 and was determined to be Type V (111) construction. The facility is separated into 4 smoke compartments by 1-hour fire barriers. The facility is completely sprinkler protected with standard response sprinkler heads, which are installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke detection and smoke detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 45 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect	K 321	All residents residing at the facility were potentially affected by our deficient practice. On 4/4/18 maintenance department installed a self closure on the door leading into the maintenance office/storage room. This will ensure that	4/4/18

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K 321	Continued From page 3 the quick and efficient exiting for an undetermined amount of staff . Findings include: On the facility tour between 9:00 am to 12:00 pm on 04/03/18 observations and staff interview revealed the door maintenance office/storage room did not self close. This deficient conditions was confirmed by the Maintenance Supervisor.	K 321	the door will be shut at all times for safety of the residents, visitors and staff. To ensure that the door is always closed, Administrator will audit the door for one month 2x's per week. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018.	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period as per NFPA 101 2012 edition section 9.6.1.6. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 45 residents as well as an undetermined number of staff, and visitors.	K 346	On 4/19/18 the policy and procedure for the fire alarm system out of service was updated to reflect the proper and current contact information. The deficient practice affected all residents residing and future residents at MSL. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018.	4/19/18

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K 346	Continued From page 4 Findings include: On the facility tour between 9:00 am to 12:00 pm on 04/03/2018 review of the records revealed the Fire Alarm System out of service policy did not contain the did not contain current contact information. This deficient condition was confirmed by Maintenance Supervisor.	K 346		
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for ten or more hours in a 24 hour period as per NFPA 25. This deficient practice could affect the facility's ability for early response and notification	K 354	On 4/19/18 the policy and procedure for the fire alarm system out of service was updated to reflect the proper and current contact information. The deficient practice affected all residents residing and future residents at MSL. This will then be reviewed and discussed at the next Quality Assurance Committee meeting	4/19/18

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K 354	Continued From page 5 of a fire and would affect the safety of all 45 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On the facility tour between 9:00 am to 12:00 pm on 04/03/2018 review of the records revealed the Fire Sprinkler System out of service policy did not contain the verbiage when out of service for more than 10 hours in a 24 hour period and it did not contain current contact information. This deficient condition was confirmed by the Maintenance Supervisor.	K 354	scheduled for May 2018.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		4/23/18

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K 363	Continued From page 6 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide six corridor doors with a means suitable for resisting the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 35 of the 45 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:00 pm on 04/03/2018 observations and staff interview revealed resident rooms 105, 107, 108, 109, 112, 113 did not fit tight in the frame. This deficient condition was confirmed by the facility Maintenance Supervisor.	K 363	The facility has been in contact with a company to replace the resident room doors 105, 107, 108, 109, 112, 113. The company stated that new door jams may also need to be installed with the new door. New doors take a minimum of 6 weeks for delivery and we are requesting an extension waiver to allow the facility more time to be in compliance with NFPA 101 corridor doors. This will also be discussed and reviewed in the next Quality Assurance Committee meeting in May 2018.	

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct fire drills under varied conditions on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 45 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:00 pm on 04/03/2018 documentation review and staff interview revealed review revealed the fire drills on two shifts were not conducted under varying conditions. This deficient condition was confirmed by the Maintenance Supervisor.	K 712	All residents residing at McIntosh Facility Living facility were affected by this deficient practice. On 4/19/18, a yearly guide has been developed with each month and varied times the fire drill should be conducted to ensure the facility is following the required Life Safety Code 19.7.1.4 to 19.7.1.7. The Administrator will audit monthly for the next 4 months. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018.	4/19/18

Electronically delivered
April 17, 2018

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, MN 56556

Re: State Nursing Home Licensing Orders - Project Number S5356032

Dear Ms. Knutson:

The above facility was surveyed on April 2, 2018 through April 5, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00467	A. BUILDING: _____ B. WING _____	04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00467	A. BUILDING: _____ B. WING _____	04/05/2018

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/2/18-4/5/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21615	All residents found were potentially	4/23/18

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21615	Continued From page 2 review, the facility failed to ensure narcotic medications were controlled and stored in a manner to ensure limited access in order to prevent drug diversion. Findings include: On 4/15/18 at 9:00 a.m. during medication storage and review of medication destruction, licensed practical nurse (LPN)-A indicated that any narcotic medication that was discontinued was to be put in the director of nursing (DON) office in a locked file cabinet. LPN-A proceeded to walk to the DON's office door which was noted to be left all the way open with the DON not present. Upon entering the unlocked DON's office, LPN-A retrieved keys from the unlocked top drawer of the DON's desk, and unlocked a long file cabinet drawer which contained medications which LPN-A stated needed to be destroyed with the pharmacist. LPN-A then indicated the narcotics in the drawer were not tracked or counted until destruction with the pharmacist, which was usually monthly. LPN-A verified there was no log sheet to identify which narcotics were supposed to be in the drawer and that information was tracked in the narcotic count books on each of the three medication carts. LPN-A stated that, to her knowledge, only she, (maybe one other nurse), and the DON accessed the file cabinet. LPN-A verified the DON's door was not always closed and locked when unoccupied. LPN-A verified narcotics needed to be double locked. LPN-A stated she had worked at the facility for 5 years in which this had been the process and there had been no discrepancy with counts or facility diversion that she was aware of. On 4/5/18, at 11:51 a.m. DON acknowledged narcotics were locked in a file drawer in her office	21615	affected by our deficient practice, however facility has had not drug diversion problems. on 4/8/18 a locked box was purchased to lock all narcotics due to be destroyed by nurse and pharmacy. the locked box will be then in a locked filed cabinet in the DON's office to meet the double lock requirements. Policies and procedures were update. Education given to staff on 4/23/18 of our policy and procedures. The Administrator will audit to ensure the double locked regulation for narcotics is being followed 2x's a week for 2 months. This will then be reviewed and discussed at the next Quality Assurance Committee meeting scheduled for May 2018.	

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21615	Continued From page 3 and verified the door was not always locked when she was out of the office, and to her knowledge there had not been any discrepancy with counts or facility diversion. DON acknowledged that narcotics should have been double locked as required. During telephone interview on 4/6/18, at 1:35 p.m. consultant pharmacist verified that narcotics should have been double locked and confirmed the medications were only under single lock when the office door was left open. A Storage of Medications and Narcotics in Med Room policy dated 10/29/15, indicated medications put on hold/discontinued would be stored in a designated basket in locked med room/or locked cabinet in the DON's office until destruction by a registered nurse. A Counting of Narcotics policy dated 10/29/15, indicated when a schedule II, III, IV, V drug needed to be destroyed, medication was taken out of the locked med cart, counted by two licensed staff and placed in DON's office in a locked file cabinet awaiting destruction with Pharmacy. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policy and procedures related the narcotic storage requirements. The DON or designee could educate staff on the requirements and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		

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21620	Continued From page 4	21620		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure insulin vials for a personal insulin pen included a pharmacy label for 1 of 1 residents (R17) observed to receive insulin injection. Findings include: R17's physician's orders signed 3/7/18, directed staff to administer subcutaneous via pen, Humalog (insulin used to control blood sugar) 4 units with lunch and supper, 5 units with breakfast. On 4/3/18, at 5:18 p.m. registered nurse (RN)-C removed an insulin pen from an unmarked hinged box which was located in the medication cart. The pen was inscribed "Free sample" and Lilly company (manufacturer). The cartridge (which holds the insulin) contained the manufacturer's inscription identifying the medication name. Neither the pen nor the cartridge contained a pharmacy label which identified resident name, medication, and dosage to administer. RN-C confirmed the pen was not labeled with R17's name and stated it is a very unique pen that family supplied. RN-C also acknowledged that the insulin cartridge did not contain a label that identified it was intended for R17, or the prescribed dose.	21620	R17 was the only resident that was affected by this deficient practice and all the other residents requiring insulin were using disposable insulin pens with pharmacy labels intact. The unmarked hinged box located in the med cart in question had a faded name label on the outside that was still legible, however, on 4/06/18 an new label with darker print was placed on the hinged box. The insulin pen and cap for R17 was then labeled with her name and the insulin cartridge with her medication was labeled with her name and a sticker with "direction change see emar" was placed on the pen for nursing to refer to the emar for insulin orders. This pen for R17 will be used until current supply is gone, then resident will switch to disposable pen which will be labeled by pharmacy with name and directions. To prevent this from occurring again we have reviewed and updated policies and education given to staff on 4/23/18 of our policy and procedures in having all medications labeled appropriately. The DON/Chg nurse will audit daily to ensure pen is marked appropriately until current supply of insulin cartridges are gone and disposable pen received. This will then be reviewed and discussed at the next Quality Assurance Committee meeting	4/23/18

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21620	Continued From page 5 On 04/05/18, at 11:53 a.m. director of nursing (DON) acknowledged that R17's insulin was not labeled and indicated they had tried in the past but the labels fell off. The DON expected the pharmacy to label the individual vials for R17. During telephone interview with consulting pharmacist on 4/6/18, at 1:35 p.m. she acknowledged that there should be labeling on insulin cartridges. The facility policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related medication labeling requirements. The DON or designee could educate nursing staff and develop a monitoring system to ensure compliance. Time Period For Correction: Twenty-one (21) days	21620	scheduled for May 2018.	