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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 2S25

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**
2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA SENIOR LIVING**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/26/2015** (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 **51** (L18)

13.Total Certified Beds **51** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Michele McFarland, HFE NE II 09/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/03/2015 (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 :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245536

September 3, 2015

Ms. Julie Vettleson, Administrator
Green Lea Senior Living
115 North Lyndale, RR 2 Box 49
Mabel, Minnesota 55954

Dear Ms. Vettleson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 19, 2015 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 3, 2015

Ms. Julie Vettleson, Administrator
Green Lea Senior Living
115 North Lyndale, RR 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536024

Dear Ms. Vettleson:

On July 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 2, 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 July 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2015, effective August 19, 2015 and therefore remedies outlined in our letter to you dated July 24, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245536	A. Building B. Wing	8/26/2015

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **08/19/2015**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/19/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/19/2015**
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	GPN/kfd	09/03/2015	31217	08/26/2015
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
7/10/2015			

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 A. Building B. Wing	(Y3) Date of Revisit
245536	01 - MAIN BUILDING 01	9/2/2015

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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 K0050	Correction Completed 08/10/2015	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/03/2015	25822	09/02/2015
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
7/9/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2S25

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**
2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA SENIOR LIVING**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/10/2015** (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 **51** (L18)

13.Total Certified Beds **51** (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
	51			
(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 :
Gail Sorensen, HFE NE II 08/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/14/2015 (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 :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 24, 2015

Ms. Julie Vettleson, Administrator
Green Lea Senior Living
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536024

Dear Ms. Vettleson:

On July 10, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 19, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 10, 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 January 10, 2016 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		8/19/15

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

Electronically Signed | 08/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice on a timely manner prior to termination of Medicare skilled services for 1 of 3 residents (R41) reviewed for liability notice and beneficiary appeal rights. Findings include: R41 was admitted to the facility on 2-11-15 according to the admission form, and currently resided at the facility. A Notice of Medicare Provider Non-Coverage indicated R41's skilled services would end effective 3-8-15. The facility provided the Skilled Nursing Facility Determination of continued stay and The Notice of Medicare Non-Coverage on 3-7-15, which was less than two days before Medicare skilled	F 156	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R41 was provided with a continuation of stay notice. 2. All residents will recieve an advance copy of Notice of Medicare Non-Coverage	

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F 156	Continued From page 3 services would be terminated. On 7/08/2015 at 2:32 p.m. the director of nursing (DON) acknowledged based on the facility documentation of the Medicare denial notices provided to R41, a one day notice was provided before R41's Medicare skilled services were terminated. The DON acknowledged the resident should have been given more than one day notice per regulation for the denial notice. On 7-8-15 at 3:13 p.m. registered nurse (RN)-A verified R41 used 24 days of Medicare skilled services from 2-11-15 to 3-7-15. Review of the Form Instructions for the Notice of Medicare Non-Coverage dated 12/31/11 read, "A Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services not later than two days before the termination of services ..."	F 156	no later than 2 days before the termination of service. 3. The facility tracking system for Medicare coverage determination has been revised. 4. The DNS/Designee will audit resident's medical record to ensure proper notification of Medicare services has been provided. The data collected will be reviewed/discussed at the Monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. 5. Responsible for Monitoring: DNS/Designee 6. Compltedion Date: 08/19/2015	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 274		8/19/15

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F 274	Continued From page 4 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a significant change Minimum Data Set (MDS) assessment for 1 of 1 resident (R14). Findings Include: R14 admitted to the facility on 5/15/15 with primary diagnoses that included: closed fracture of C2 vertebra [neck], closed fracture of malar and maxillary bones (face). Admission MDS dated 5/22/15 indicated R14 required an extensive one person physical assist for bed mobility, transfer, walking in room and locomotion on and off the unit. On 7/8/15 4:00 p.m. and 7/9/15 7:27 a.m. R14 was observed to be independently ambulating with a four wheeled walker in the hallway and in her room. On 07/10/15 at 11:21 a.m. certified occupational therapist assistant, (COTA)-A was asked about R14's therapy status and said, "We had her on supervised transfers in her room. She got better with her walker and she did make good progress, initially she needed a lot of help and she regained quickly. She was independent in her room as of 6/12/15 she was stand by assist for toilet transfers." COTA-A verified R14 completed therapy on 6/12/15.	F 274	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R14 has had a comphrensive assessment completed. Care plan has been revised to reflect current levels of care. 2. All residents care plans have been reviewed and revised as needed to reflect current cares. 3. RN responsible for completion of MDS has received re-education regarding significant change requirements. 4. Nurisng staff will receive re-education on significant change on abilites.	

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F 274	Continued From page 5 On 07/10/2015 at 11:27 a.m. nursing assistant (NA)-A was asked about the assistance she provides R14 and said, "In the a.m. you can set up everything. She gets herself dressed. She transfers well by herself. We stand by. Her abilities have gone up over the past month." On 07/10/2015 at 11:31 a.m. registered nurse (RN)-A, who completes the MDS, was asked when she would be prompted to complete another MDS for R14 said, "At the IDT [interdisciplinary team] meeting we would discuss. I don't know why it was not done." RN-A verified the IDT meeting occurred daily and the MDS should have been completed when resident completed therapy. Nursing Assistant Plan of Care, dated 7/7/15, indicated R14 was independent with bed mobility, transfers, repositioning, locomotion in room and on the unit.	F 274	5. DNS/Designee will audit 2 resident medical records for 4 weeks than 1x weekly for 4 weeks for significant change. The data collected will be reviewed/discussed at the monthly Quality Improvement meeings for further evaluation, inteventions and ongoing audits. 6. Responsible for Monitoring: DNS 7. Completeion Date: 08/19/2015	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		8/19/15

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F 278	Continued From page 6 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an Minimum Data Set (MDS)was accurately coded in the area of functional range of motion of 2 of 4 residents (R10, R47) reviewed for range of motion (ROM). Findings include: R10 had been observed on 07/08/15, at 8:58 a.m. R10 completed breakfast meal independently, stood up and ambulated out of the dining room area with no assistive device. Gait was noted to be slow and steady with a right sided lean. R10 was admitted to the facility on 10/1/10 according to the facility's admission record and had diagnoses that included but was not limited to congestive heart failure, Parkinson's, difficulty in walking, and generalized muscle weakness. R10's MDS dated 6/1/15 indicated R10 required extensive assist of one staff for activities of daily living (ADLs) of bed mobility, walking, dressing, toileting, and personal hygiene. The MDS further indicated a functional range of motion impairment	F 278	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R10 the MDS has been modified. Care Plan reviewed and revised. 2. R47 MDS was modified, receivng Hospice care and is no longer in the facility. 3. RN responsible for MDS completion	

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F 278	Continued From page 7 for both upper extremities and both lower extremities that would interfere with daily functions or placed the resident at risk for injury. During an interview on 07/09/15, at 7:36 a.m. registered nurse (RN)-A stated the MDS was incorrectly coded, R10 did not have limitations with functional mobility. RN-A stated the MDS should have been coded " no impairment. " R47 was admitted to the facility on 5/12/15 according to the facility's admission record with diagnoses that included but was not limited to chronic airway obstructive disorder, chronic pulmonary heart disease, malaise and fatigue, and depressive disorder. R47's MDS dated 6/1/15 indicated R47 required extensive assist of one staff for ADLs of toileting and transfers and required extensive assist of one staff member for bed mobility, dressing, and personal hygiene. The MDS also indicated R47 had a functional range of motion impairment of one upper extremity and one lower extremity that would interfere with daily functions or placed the resident at risk for injury. During an interview on 7/9/15, at 2:09 p.m. RN-B stated she did not realize to code functional range of motion impairment on the MDS, the impairment had to interfere with activities of daily living or put the resident in danger which it did not for R47.	F 278	has received re-education regarding functional range of motion. 4. Nursing staff will recieve re-education on functional range of motion. 5. The DNS/Designee will audit 2 residents' medical records 2 times per week for 4 weeks and the 1x weekly for 4 weeks to ensure that all functional range of motion is accurately reflected. The data collected will be reviewed/discussed at the monthly Quality Improvment meetings for further evaluation, interventions, and ongoing audits. 6. Responsibel for Monitoring; DNS/Designee 7. Completion Date: 08/19/2015	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		8/19/15

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F 279	Continued From page 8 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan that included interventions for impaired skin integrity and risk for pressure ulcers for 1 of 3 residents (R47) reviewed for non-pressure related skin issues. Findings include: R47 had been observed on 7/7/15, at 2:16 p.m. and noted a skin lesion on the upper right deltoid area that was approximately 3.0 centimeters (cm) in diameter. The skin in this area appeared dry and irritated. R47 stated it did not itch and it was from a fall. R47 was admitted to the facility on 5/12/15 according to the facility admission record and had diagnoses that included but were not limited to chronic airway obstruction disease (COPD), pulmonary heart disease, and malaise and fatigue. R47's facility admission assessment dated	F 279	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R47 was receiving hospice care and is no longer in the facility. 2. RN responsible for completion of the MDS recieved re-education on development of comphrehensive care plan.	

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F 279	Continued From page 9 5/12/15 indicated resident had various areas of ecchymosis (bruising) related venipuncture. It was not evident in the record a care plan was developed or initiated for the monitoring and treatment of the bruises. R47's admission Minimum Data Set (MDS) dated 5/19/15 indicated R47 required extensive assist from one staff member for bed mobility and extensive assistance from two staff members for transfers. The MDS further indicated a formal assessment/tool and a clinical assessment were used to determine R47 was at risk for pressure ulcers. A pressure ulcer Care Area Assessment (CAA) was triggered as a result of the MDS coding. It was not evident in the record a care plan had been developed for the risk for impaired skin integrity or the risk for pressure ulcers as indicated by the MDS. A Body Audit dated 5/25/15 read, "bruising on both upper extremities from blood/IV's prior to admission, small bruising on both shins r/t [related to] fall at home." It was not evident in the care plan the developed for the bruising on the bilateral shins. R47's significant change MDS dated 6/1/15 indicated a formal assessment/tool and a clinical assessment were used to determine R47 was at risk for pressure ulcers. A pressure ulcer CAA was triggered as a result of the MDS coding. The CAA indicated risk for pressure ulcers had been included in the care plan. The CAA summary dated 6/8/15 read, "Skin integrity is good at this time except bruising on her buttocks r/t [related to] an implant for urinary incontinence and a LN [licensed nurse] completes a body audit to identify any issues. It was not evident in R47 ' s record the buttock bruising mentioned in the CAA on 6/8/15 was comprehensively assessed or monitored to	F 279	3. All residents receive a comphrehensive skin assessment upon admission, quarterly and with a significant change. 4. Nursing staff willl recieve re-education on documentation requirments of impaired skin and revision of the care plan. 5. Facility will provide re-education to all Hospice agencies regarding integration and revision of care plans. 6. The DNS/Designee will audit 2 residents' medical records 2 times per week for 4 weeks and the 1 time weekly for 4 weeks to ensure interventions for impaired skin intefrity are present. The data collected will be reviewed/dsicussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. 7. Responsible for Monitoring: DNS/Designee 8. Completion Date: 08/19/2015	

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F 279	Continued From page 10	F 279		

include exact location, measurements, and overall appearance. Furthermore, there was no evidence to suggest the implant that caused the bruising was identified in the care plan nor was the risk for pressure ulcers identified in the CAA was ever care planned.
A progress note on 6/2/15 indicated R47 had a fall and sustained a skin tear that measured 5.0 centimeters (cm) by 3.5 cm. The progress note did not contain the location, treatment applied, or an ongoing treatment plan. The location of the skin tear was not identified until 6/3/15 in a progress note; note indicated location was right arm. Exact location on the right arm was not identified.
A hospice progress note dated 6/4/15 indicated presence of skin tear and " severe bruising " on right side. The note failed to identify location of bruising on right side and measurements. There was no further mention of the severe bruising on the right side and it was not evident in the record a plan of care was initiated.
A hospice progress note on 7/2/15 indicated R47 had a red bottom. It was not evident in the record a plan of care was developed to include interventions for care and prevention of further breakdown.
A Body Audit on 7/6/15 indicated a new area of impaired skin integrity, the note read, " fissure in buttock crease, barrier cream applied ..." A comprehensive assessment that would include measurements, general appearance, causative factors, plan for treatment and ongoing prevention was not evident in record nor included on R47 ' s care plan.
A hospice visit note on 7/6/15 identified R47 had a slit in the coccyx from turning. Although immediate interventions were put into place that included turning and repositioning every two

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F 279	Continued From page 11 hours, it was not evident interventions to address the skin slit had been added to the care plan. During an interview on 7/7/15, at 7:08 p.m. hospice RN (HRN) stated an initial care plan should have been developed for skin integrity on admit to hospice, stated she had not visualized the breakdown on the R47's coccyx, stated she had not communicated the change in skin condition to the physician, and stated a care plan should have been initiated to reflect the impaired skin integrity on the coccyx. During a subsequent interview on 7/8/15, at 3:20 p.m. HRN stated development of the care plan was a collaborative effort between facility and hospice agency, "I am not sure who updates the care plan in the facility." In addition HRN explained if a hospice nurse needed to change or update the care plan as a result of a visit, " We are allowed 5-7 days to send the changes to the facility." To the question, "What happens during the 5-7 days the care plan is not updated?" HRN responded, "We explain the changes and the facility updates their care plan." During an interview on 7/8/15, at 9:45 a.m. the facility RN consultant (RNC) verified the absence of ongoing care planning for the skin integrity issues. RNC stated skin integrity issues and risks should have been care planned. Facility policy pertaining to development of care plans was requested and not received.	F 279		
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 changes in care and treatment.	F 280		8/19/15

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F 280	Continued From page 12 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 the plan of care after a change in bladder status for 1 of 1 resident (R28) reviewed for incontinence. Findings include: R28 had been observed on 7/7/15 at 2:14 p.m., 7/8/15 at 9:03 a.m. R28's room was noted to have a strong urine odor. During an interview on 7/8/15, at 9:33 a.m. housekeeper (HSKP)-A stated R28 urinates on the floor. During an interview on 7/9/15, at 7:57 a.m. nursing assistant (NA)-C (in the presence of registered nurse (RN)-A) stated she occasionally worked on the night shift. NA-C stated R28 is checked and changed every 2 hours. NA-C stated R28 is not woken-up to use the restroom and was not ambulated to the restroom at night because he would refuse and become agitated. NA-C further stated R28 would often urinate on	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R28 Care Plan and nursing assistant care sheet have been reviewed and revised to reflect current bladder status and refusal of cares. 2. All resident care plans have been reviewed and revised to refect current	

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F 280	Continued From page 13 the floor after the staff left his room at night. RN-A confirmed R28's behaviors with toileting on the night shift. During an interview on 7/10/15, at 10:21 a.m. NA-A stated R28 "is toileted every two hours and as often as he asks, he is usually continent and knows when he needs to go. Some days he can make it and other days he can't." NA-A further explained R28 did have a behavior of urinating on the floor and refused to use the bathroom on night shifts. NA-A stated the behavior of urinating on the floor and refusing to be toileted occurs at least once per week mainly on the night shift however had witnessed it right away in the morning. NA-A stated the resident tended to have more urine output at night than during the day. R28 was admitted to the facility on 5/31/13 according to the facility admission record with diagnoses that included dementia with urinary incontinence, behavioral disturbance, delusional disorder, anxiety, difficulty with walking, and muscle weakness. R28's annual Minimum Data Set (MDS) dated 5/18/15 indicated resident required limited assistance from one staff member for transfers and extensive assistance from one staff member for toileting. The MDS further indicated R28 was not on a toileting program, frequently incontinent of urine, and used a diuretic medication. The assessment triggered a urinary incontinence Care Assessment Area (CAA) that read, " ...does leak urine and is often unable to feel sensation or need to use bathroom, he is more incontinent at night. He is checked, changed, and toileted every three hours day and night and whenever he asks to go ..." R28's bladder Continence Evaluation dated 5/18/15 indicated frequency on average toileting needed a day while awake had been eight times,	F 280	resident care needs. 3. Licensed staff will recieve re-education on reviewing and revision of the Care Plan. 4. The DNS/Designee will audit 2 resident care plans per week for 4 weeks and then 1 resdients care plan per week for 4 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, intervention, and ongoing audits. 5. Responsible for Monitoring: DNS/Designee 6. Completetion Date: 08/19/2015	

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F 280	Continued From page 14	F 280		

was incontinent more than once per day, amount of incontinence would cause wetness to outer layer of clothing, was not always aware when wet, and had dribbling after urination. The assessment indicated a 3 day voiding diary had been completed.
R28's electronic care plan provided by the facility on 7/9/15 included R28 required assist of one for toileting, often leaked urine, often did not feel sensation to use restroom, and had urinary urgency. The care plan further directed staff of the toileting program of " Check and change every three hours day and night and when he asks to go. He attempts self-toileting and self-transfers during the day ..."
The care plan did not reflect the assessed need for toileting indicated on the Continence Evaluation which indicated the resident voided 8 times per day while awake. Every three hours as indicated on the care plan would not be sufficient to ensure highest level of bladder function and continence. Furthermore the care plan did not address nor mention R28's behaviors of refusal of toileting or urinating on the floor per staff interview.
R28's nursing assistant care sheet provided by the facility on 7/9/15 indicated occasional incontinence. This contradicted the MDS assessment of frequently incontinent. The care assessment also instructed aide staff to toilet every two hours which contradicted the CAA and the toileting program of every three hours as outlined in the care plan.
During an interview on 7/9/10 RN-A indicated she had completed the Continence Evaluation and MDS. RN-A verified the care plan did not correspond with the assessment.
Facility policy Bowel and Bladder Evaluation dated November 2010 instructs staff to gather

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F 280	Continued From page 15 information pertaining to the incontinence through monitoring, personal preferences, medical and physical assessments. The policy directs staff to use the information to complete the MDS and develop an individualized plan of care. In addition the policy included what the care plan should include, " The individualized resident plan of care is made part of the nursing assistant care plan and should be specific including any incontinence product used, preferred toileting schedule (including times/frequency), assistance needed and any other personal information necessary to care appropriately for the individual."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive care plan that included a plan of care for impaired skin integrity and failed to ensure ongoing monitoring of impaired skin integrity for 1 of (R47) reviewed for pressure and non-pressure related skin injuries. Findings include: Initial observation of R47 on 7/7/15, at 2:16 p.m. revealed a skin lesion on the upper right deltoid	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the	8/19/15

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F 309	Continued From page 16 area that was approximately 3.0 centimeters (cm) in diameter. The skin in this area appeared dry and irritated. R47 stated it did not itch and it was from a fall. Further investigation revealed the facility failed to develop an initial care plan pertaining to overall skin integrity condition and risks on admission, multiple impaired skin integrity issues since the time of admission that were not comprehensively assessed, monitored, or care planned. R47 was admitted to the facility on 5/12/15 according to the facility admission record and had diagnoses that included but were not limited to chronic airway obstruction disease (COPD), pulmonary heart disease, and malaise and fatigue. R47's admission Minimum Data Set (MDS) dated 5/19/15 indicated R47 required extensive assist from one staff member for bed mobility and extensive assistance from two staff members for transfers. The MDS further indicated a formal assessment/tool and a clinical assessment were used to determine R47 was at risk for pressure ulcers. A pressure ulcer Care Area Assessment (CAA) was triggered as a result of the MDS coding. R47's facility admission assessment dated 5/12/15 included the following: resident was able to reposition independently, and had various areas of ecchymosis (bruising) related venipuncture. The assessment did not include exact location of bruises, physical description, or measurements of bruises. R47's Comprehensive Positioning and Skin Assessment dated 5/12/15 included a Braden Scale (tool to determine risk for pressure ulcers) risk score of 21 indicating no risk for pressure ulcers. Interventions to minimize risk included "	F 309	facility states that with respect to: 1. R47 was recieving hospice care and is no longer in the facility. 2. RN responsible for completion of the MDS received re-education on developemnt of comphrehnesive care plan. 3. All resident care plans have been reviewed and revised to reflect current cares. 4. All residents recieve a comphrehensive skin assessment upon admission. 5. Nursing staff will recieve re-education on documention requirements of impaired skin, revision of the care plan and notificaton of MD and family. 6. Facilty will provide re-education to all contracted Hospice agencies reqarding integration and revision of care plans. 7. The DNS/Designee will audit 2 residents' medical record 2 times per week for 4 weeks and then 1 weekly for 4 weeks to ensure interventions for impaired skin are present. The data collected will be reviewed/discussed at the monthly Quality Imporvment meeting for further evalaution, inteventions, and ongoing audits. 8. Responsible for Monitoring: DNS/Designee	

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F 309	Continued From page 17 position according to individual needs, inspect skin daily, use mild soap and water during bathing, and maintain head of bed at 30-40 degrees. The assessment further identified, " skin fragile due to chronic steroid use for COPD. Bruises on upper extremities from venipuncture in hospital. The assessment gave direction to monitor skin daily with cares. Neither the Admission assessment nor Comprehensive assessment included exact location of bruises, physical description, or measurements of the bruises. Furthermore it was not evident in the medical record a temporary care plan was established for the monitoring and care of the bruises. A Body Audit dated 5/25/15 read, "bruising on both upper extremities from blood/IV's prior to admission, small bruising on both shins r/t [related to] fall at home." Again, no exact location, measurements, general description of bruises was included in the assessment and this was the first mention of bruising on bilateral shins. R47 was admitted to a hospice service on 5/26/15. The hospice Comprehensive assessment or hospice Interdisciplinary Plan of Care Update did not identify risks for impaired skin integrity or risk for pressure ulcers; subsequently a care plan that would minimize or reduce the risk was not developed. The comprehensive assessment also did not include mention of bruises that had been documented by facility staff on the same day (5/26/15). R47's significant change MDS dated 6/1/15 indicated a formal assessment/tool and a clinical assessment were used to determine R47 was at risk for pressure ulcers. A pressure ulcer CAA was triggered as a result of the MDS coding. The CAA indicated risk for pressure ulcers had been included in the care plan. The CAA summary	F 309	9. Date of Completion: 08/19/2015	

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F 309	Continued From page 18 dated 6/8/15 read, "Skin integrity is good at this time except bruising on her buttocks r/t [related to] an implant for urinary incontinence and a LN [licensed nurse] completes a body audit to identify any issues. It was not evident in the medical record the buttock bruising mentioned in the CAA on 6/8/15 was comprehensively assessed or monitored to include exact location, measurements, and overall appearance. Furthermore, there was no evidence to suggest the implant that caused the bruising was identified in the care plan nor was the risk for pressure ulcers identified in the CAA was ever care planned. On 6/1/15 two Comprehensive Skin and Positioning Evaluations were completed. One evaluation indicated a Braden Scale Score of 15 and the other a score of 16. The interventions to decrease the risk of pressure ulcers continued to remain unchanged despite the identification of bruising on the buttock where skin would be weak and vulnerable to pressure ulcers. A corresponding summary note indicated R47's level of assistance was dependent. At a dependent level of assistance R47 would not have been able to independently reposition. A summary progress note dated 6/1/15 read, "turning and repositioning guidance intervention/plan of care assessment completed. Braden score low to medium risk. High risk factors are reduced or removed." It was not evident in R47 ' s care plan interventions including a positioning program was initiated even though documentation indicated R47 was dependent on staff for assistance. A progress note on 6/2/15 indicated R47 had a fall and sustained a skin tear that measured 5.0 centimeters (cm) by 3.5 cm. The progress note did not contain the location, treatment applied, or	F 309		

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F 309	Continued From page 19 an ongoing treatment plan. The location of the skin tear was not identified until 6/3/15 in a progress note; note indicated location was right arm. Exact location on the right arm was not identified. It was not evident in R47 ' s record a temporary care plan was initiated for the skin tear. Hospice clinical notes from 6/2/15 through 6/30/15 indicated care plans were reviewed with each visit and indicated skin integrity was an ongoing problem however, it was not evident in R47 ' s record a care plan for impaired skin integrity was developed. A Body Audit on 6/3/15 indicated presence of multiple dark purple bruises on arms and small bruise to buttock. The body audit did not mention the skin tear. A hospice progress note dated 6/4/15 indicated presence of skin tear and "severe bruising " on right side. The note failed to identify location of bruising on right side and measurements. There was no further mention of the severe bruising on the right side and it was not evident in the medical record a plan of care was initiated. A Body Audit on 6/8/15 included mention of bruises on arms and skin tear. Although the audit indicated dressing changes had been done daily, it did not include dressing type. The evaluation also lacked a comprehensive assessment of the skin tear. Body Audits from 6/15/15, 6/22/15, 6/29/15 continued to mention areas that had been previously identified, however lacked a comprehensive reassessment and evaluation of the areas. A hospice progress note on 7/2/15 indicated simply R47 had a red bottom. It was not evident in R47 ' s record interventions were developed and put into place to prevent further breakdown	F 309		

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F 309	Continued From page 20	F 309		

and monitoring of the area was performed.
A Body Audit on 7/6/15 indicated a new area of impaired skin integrity, the note read " fissure in buttock crease, barrier cream applied ... " A comprehensive assessment that would include measurements, general appearance, causative factors, plan for treatment and ongoing prevention was not evident in the medical record. Furthermore, it was not evident a care plan was developed. In addition, it was not evident in the medical record the physician or family member were notified of the change in condition. An observation of the coccyx on 7/8/15, at 1:00 p.m. with the director of nursing (DON) present, revealed a thin slit in the skin almost the length of the coccyx. Slit was superficial, surrounding skin did not appear macerated or moist. DON stated the skin breakdown was a result of moisture from incontinent garments.
A hospice visit note on 7/6/15 identified R47 had a slit in the coccyx from turning. Although immediate interventions were put into place that finally included turning and repositioning every two hours, it was not evident in R47 ' s care plan had been developed.
During an interview on 7/7/15, at 7:08 p.m. hospice RN (HRN) stated an initial care plan should have been developed for skin integrity on admit to hospice, stated she had not visualized the breakdown on the R47 ' s coccyx, stated she had not communicated the change in skin condition to the physician, and stated a care plan should have been initiated to reflect the impaired skin integrity on the coccyx. During a subsequent interview on 7/8/15, at 3:20 p.m. HRN stated development of the care plan was a collaborative effort between facility and hospice agency, "I am not sure who updates the care plan in the facility". In addition HRN explained if a hospice nurse

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F 309	Continued From page 21 needed to change or update the care plan as a result of a visit, "we are allowed 5-7 days to send the changes to the facility." To the question, "What happens during the 5-7 days the care plan is not updated?" HRN responded, "We explain the changes and the facility updates the physical care plan." During an interview on 7/8/15, at 9:45 a.m. the facility RN consultant (RNC) stated, the nurse practitioner had not been contacted regarding the wound on coccyx and was notified on 7/8/15. When asked about the conflicts in daily documentation pertaining to the presence of bruises. RNC stated it's a result of poor nursing assessments and poor or incomplete documentation and monitoring. RNC stated measurements should have been obtained and recorded, RNC verified the absence of ongoing care planning for the skin integrity issues. RNC stated skin integrity issues and risks should have been care planned. During an interview on 7/10/15, at 8:18 a.m. licensed practical nurse (LPN)-A explained when a change in skin integrity was noted the physician and family members are notified, investigation is supposed to be done, and measurements are documented in a progress note and body audit, the impaired skin integrity is then checked daily until healed. LPN-A stated bruises are measured upon discovery and measured again if they get larger. LPN-A stated skin tears are measured weekly. During an interview on 7/10/15, at 9:36 a.m. RN-B stated skin impairments were documented on a weekly wound document and weekly body audit, the documentation should reflect location, size, and color. Daily wound monitoring is supposed to be done. RN-B stated bruises were measured weekly.	F 309		

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F 309	Continued From page 22 Facility policy Comprehensive Skin and Positioning Evaluation last reviewed June 2015 directed staff on documentation requirements that included, "The daily wound monitoring form will be completed for all residents on a daily basis that have any alterations in skin integrity until is resolved." The daily wound monitoring form was not evident in the medical record. In addition this policy does not reflect current standards of prevention, wound care, wound monitoring, and wound documentation.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement measures to promote pressure ulcer healing and prevent further pressure ulcers from developing for 1 of 3 residents (R33) who had a current pressure ulcer. Findings include: R33 was admitted to the facility 7/18/14 according to the admission form. The physician orders dated 7/9/15 listed diagnoses that included:	F 314	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the	8/19/15

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F 314	Continued From page 23 morbid obesity, Stage III chronic kidney disease, polyneuropathy, diabetes, coronary heart disease, R33 was intermittently observed on 7/7/15 from 2:47 p.m. to 6:42 p.m. sitting in the wheelchair with foam boots on both feet. The feet were dependent on the footrests of the wheelchair. Both feet had socks inside the foam boots. On 07/08/15 at 2:23 p.m. R33 was out of room and a standard mattress was observed on the bed and a foam orthopedic boot was laying in chair. At 2:29 p.m. R33 was observed sitting in a wheelchair during a music program. The resident had a regular shoe on the right foot and a foam boot and gripper sock on the left foot. At 3:15 p.m. R33 was observed in the dining room. The left foot remained in the foam boot but was not resting on the foot rest. At 3:53 p.m. on 7/8/15 nursing assistant (NA)-D stated that R33 was checked and changed every 2 hours for bladder incontinence. During the day a foam pad was on his foot to protect it since developing pressure ulcers and at night the heel was to be floated. On 7/9/15 at 7:22 a.m. R33 was observed lying on his back in bed with legs in frog position and feet pushing against the wooden foot board of the bed. R33 did not have on any socks. The feet were not floated or elevated. R33's feet were observed on 7/9/15 at 8:15 a.m. with licensed practical nurse (LPN)-A and registered nurse (RN)-C a consultant. The left foot had an area that was dark in color and blister like with loose skin that involved the entire left heel. The resident was noted to have his foot placed in a foam boot without covering on the foot while lying in bed. The foot was flat on a	F 314	facility states that with respect to: 1. R33 recieved an evaluation from Occupational Therapy for w/c positioning. Care plan has been reviewed and revised. Wound treatment and monitoring was initiated with the discoverly of the pressure area. R33 admitted to hospice care and is no longer in facility. 2. All residents have a comphrehensive skin assessment upon admission, quarterly and with a significant change. 3. Nursing staff will recieve re-education related to care plan interventions, repositioning, and skin observation. 4. DNS/Designee will audit 2 resident records per week related to pressure areas and repositioning for 4 weeks the 1 resident record for 4 weeks. The data collected will be reviewed/disucssed at the Quality Improvement meetings for further evluation. 5. Responsible for Monitoring: DNS/Designee 6. Completion Date: 08/19/2015	

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standard mattress and not elevated or floated. LPN-A and RN-C stated they do not routinely cover the wound/blister if not open. RN-C stated she had spoken yesterday to the occupational therapy to check into the wheelchair and foot positioning. On 7/9/15 at 8:37 a.m. LPN-A measured the area on the left heel at 3.2 cm x 5 cm.

On 7/9/15 at 8:54 a.m. the physician's assistant (PA)-A was interviewed. PA-A stated she had observed the wound area last week and had ordered the use of the foam boot but that she would be looking at the area again today. At 9:39 a.m. LPN-A stated the new orders included floating the foot at night or when in bed. At 1:19 p.m. a therapeutic mattress was observed on the bed. At 2:50 p.m. R33 was observed sitting in the wheelchair. The left foot had a formed plastic boot on and the right foot had a foam boot on. A calf panel had been placed on the wheelchair. Feet were in dependent position and edema was noted bilaterally in feet and toes.

On 6/15/15 a skin/wound note was documented in the progress note. It described a suspected deep tissue injury (SDTI) of the bottom of the left heel that was a blister with a dark purple center that measured 3.5 cm by 2.8 cm. The note indicated daily wound monitoring, pressure relieving boots, air mattress on bed and "heels need to be offloaded at all times." A weekly wound documentation note of 6/15/15 described the area as measuring 3.5 x 6.0 with unknown depth and described the wound as circular with middle having a blister-like appearance with dark purple center. The interventions noted: turn and reposition every 2 to 3 hours, use open heel boot. The weekly wound documentation form defined

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suspected deep tissue injury as "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear."

On 6/22/15 the skin audit identified left heel pressure wound 4.0 x 5.3 unknown depth of suspected deep tissue injury. On 7/7 the skin audit identified a left heel pressure area measuring 3.5 x 4.2 cm unknown depth that was a suspected deep tissue injury.

The physician documented on 6/18/15 a wound had developed on R33's left heel. Ecchymosis (redness) and bogginess of the heel. The physician's plan included use of padded heel boots at all times.

Care plan dated 4/21/15 noted R33 had impaired skin integrity that included blisters and open areas bilaterally of the shins and a sore on the bottom of the right foot, and suspected deep tissue injury of left heel was added on unknown date. The care plan interventions did not include management of the right foot area. Hand written interventions related to float heels and use of protective boots were added to the care plan and the nursing assistant worksheet (worksheet printed 7/7/15). Neither the care plan nor the nursing assistant worksheet noted the need to elevate legs, use calf panel or frequency of relieving pressure on the area. During an interview on 7/10/15 at 11:10 a.m. RN-C stated she had just updated the care plan and nursing assistant sheets.

The medication administration record (MAR) dated May 2015 had an entry of "elevate legs as much as possible every shift for lower extremity

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edema" dated 8/14/14. The MAR had been signed by the nurses every shift. During an interview on 7/10/15 at 9:34 a.m. the director of nursing stated the MAR was signed each shift for trying to get R33 to elevate legs. Neither the medication nor treatment record indicated R33's was to have feet elevated or to have foam boots on feet to protect them.

On 7/9/15 at 8:54 a.m. PA-A was interviewed. The PA-A stated she had observed the area last week and had ordered the use of the foam boot but that she would be looking at the area again today. At 9:39 a.m. LPN-A stated the new orders included floating the foot at night or when in bed.

PA-A's visit vote of 7/9/15 indicated R33 had a blood blister on the posterior lateral aspect of the left heel that was not open and was not draining. PA-A stated this area was a stage I pressure ulcer of left heel.

On 7/9/15 at 1:19 p.m. a therapeutic mattress was observed on the bed. And at 2:50 p.m. R33 was observed sitting in the wheelchair. The left foot had a formed plastic boot on and the right foot had a foam boot on. A calf panel had been placed on the wheelchair. Feet were in dependent position and edema was noted bilaterally in feet and toes.

On 7/10/15 at 11:10 a.m. RN-C stated that until yesterday no one had contacted therapy about wheelchair positioning and obtaining a firm boot. RN-C verified that leaving the foot uncovered and the foam boot open during the night did not protect the heel, especially when the resident would slide down in bed and put pressured against the heel on the foot board.

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F 314	Continued From page 27 On 7/10/15 at 9:20 a.m. R33 was observed sitting in the wheelchair with a sock and hard brace on the left foot and a foam boot on the right foot. No calf panel was on the wheelchair. R33's feet were in a dependent position. The calf panel that had been on the chair on 7/9/15 was found in his room placed in a chair.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		8/19/15

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F 329	Continued From page 28 by: Based on observation, interview, and document review, the facility failed to monitor blood pressure per physician orders for 1 of 5 residents (R25) reviewed for unnecessary medications; failed to monitor sleep and develop a plan of care for use of hypnotics for 1 of 5 residents (R33) reviewed for unnecessary medications; failed to ensure to clarify physician orders related to use of gentamycin (antibiotic) on open sacral ulcers for 1 of 3 residents (R39) reviewed for pressure ulcers. Findings include: R25 was admitted to the facility on 11/21/12 with primary diagnoses of atrial fibrillation [abnormal heart rhythm] and chronic systolic heart failure according to the admission form. R25's physician orders dated 6/19/15 included metoprolol [blood pressure medication] tablet 25 mg by mouth twice daily, hold if SBP (systolic blood pressure) is less than 90. On 07/10/15 at 8:42 a.m. registered nurse (RN)-B was asked where R25's blood pressure readings would be found. "They should be in point click care [computer program]. Daily's may be on the MAR (medication administration record) too." On 07/10/15 at 8:44 a.m. RN-A and facility nurse consultant RN-C were asked where blood pressure readings would be found. "Should be point click care, MAR, or may be embedded in the progress note." RN-C verified on the MAR the blood pressure was not obtained prior to administrating metoprolol. R25's MAR was reviewed for April, May, June,	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R25 consultant pharmacist has performed a review of the medication record. Blood Pressure monitoring is to be documented on the MAR. 2. R33 consultant pharmacist has performed a review of the medication. Care Plan was reviewed and revised. Sleep monitoring documented in the electronic record. R33 was admitted to hospice is no longer in facility. 3. R39 consultant pharmacist has performed a review of medication record, medication orders have been clarified. 4. All resdients will recieve a comphrehensive review of medications from the consultant pharmacist monthly. 5. Nursing staff will recieve re-education regarding medication clarification, administration and documentation. 6. DNS/Designee will audit 2 resident	

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F 329	Continued From page 29 and July 2015. The MAR indicated R25's blood pressure was not obtained prior to administration of the scheduled metoprolol. The facility's electronic medical record, Point Click Care, was reviewed for blood pressure readings. Blood pressure readings were found to be obtained weekly but did not correlate to giving of the metoprolol. R33 was admitted to the facility on 7/18/14 and also included on physician orders provided 7/9/15 listed diagnoses that include: psychotic disorder with delusions, paranoia, depression, and insomnia. Also doctors order for Trazodone HCL 75 mg at bedtime with a start date of 4/9/15. On 7/9/15 at 7:22 a.m. R33 was observed lying in bed, sleeping. On 4/13/15 at 10:05 a.m. a Behavior/Mood evaluation was completed. The note indicated R33 "had difficulty falling or staying asleep or sleeping too much. Feels tired or has little energy." The note stated, "Sleep cycle disruptions." On asking for a sleep assessment which included R33's interventions could be used to promote sleep other than medication (non-pharmacological), and a summary of R33's hours of sleep. None was provided. A Sleep History Questionnaire dated 4/13/15 was completed by RN-B. The evaluation/sleep plan addressed R33 ' s need for assist with personal cares, wakeful at night and dozing frequently during the day, but lacked analysis of data collected and possible interventions to assist R33 with sleep. The care plan dated 4/21/15 did not include a problem related to insomnia or provide staff with interventions to assist R33 to sleep.	F 329	medical records for 4 weeks then 1 resident record for 4 weeks. The data collected will be reviewed/discussed at the monthly Quality improvment meetings for further evaluation, interventions and on going audits. 7. Responsible for Monitoring: DNS/Designee 8. Completion Date: 08/19/2015	

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The RN-C stated she was unable to find a care plan related to sleep and that no monitoring of sleep had been done.
During an interview on 7/10/15 at 10:38 a.m. the pharmacy consultant stated that she would only review the physician order forms and would not have "picked this up" in regards to a comprehensive sleep assessment.

R39 was admitted to the facility on 2/28/15 with diagnoses that included pressure ulcers, congestive heart failure (as listed on the care plan dated 5/12/15).
R39 was observed during wound care on 7/9/15 at 9:14 a.m. RN-B was observed to apply gentamycin ointment (antibiotic) to two of the three areas she provided wound care to the coccyx and right ankle.
Physician orders were reviewed. On 5/6/15 the Mayo/Franciscan Wound Clinic physician ordered gentamycin ointment to the pressure ulcer on the sacrum, right dorsal foot wound, and left plant foot wound. On 6/3/15 the physician ordered gentamycin ointment to the right heel and top of right foot. The order for the sacral ulcer directed to continue foam dressing to sacral pressure ulcer. On 7/1/15 the physician orders indicated right foot gentamycin ointment daily, the left foot order was for lotion twice a day, and the sacral ulcer directions were for washing area with soap and water and change foam dressing every 3 days.
RN-B was interviewed on 7/9/15 at 2:05 p.m. RN-B verified she used the gentamycin ointment to the sacral wound and stated she would only stop the use of gentamycin if there had been a discontinue order.

The director of nursing (DON) was interviewed on

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F 329	Continued From page 31 7/9/15 at 2:10 p.m. and verified the physician orders did not include using the gentamycin on the sacral area. DON stated the physician should have been called and the orders clarified. On 7/10/15 at 8:50 a.m. the director of nursing stated she had contacted the physician for order clarification and that no gentamycin was to be used on the sacral pressure ulcer. A medication error form was completed by the director of nursing at that time. During an interview on 7/10/15 at 10:38 a.m. the pharmacy consultant stated the lack of the gentamycin order should have been clarified by nurse when transcribing the order. The pharmacy consultant stated that she would only review the physician order forms and would not have picked this up until there had been a stop order for the use of the gentamycin.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		8/19/15

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F 334	Continued From page 32 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment	F 334		

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F 334	Continued From page 33 and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain signed consents from the residents responsible party prior to the administration of the influenza immunization for 4 of 7 residents (R17, R28, R25, and R26) reviewed for influenza immunizations. Findings Include: R17 was admitted to the facility on 11/1/13 with the primary diagnosis of personality disorder [type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving] according to the admission form. On 6/17/14 R17 was appointed by Houston County to have a guardianship in place as the responsible party for decision making regarding healthcare. On 10-19-14 R17 signed a consent to have the influenza vaccine administered and received the immunization the same day. R25 was admitted to the facility on 11/21/12 with the primary diagnosis of memory loss. On 9/16/13 R25 was appointed by Houston County to have a guardianship in place as the responsible party to for decision making regarding healthcare. On 10/17/14 R25 signed a consent to have the influenza vaccine administered and received the immunization the same day.	F 334	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. R17, R28, R25 and R26 conservators/ responsible parties received notifications of immunizations. 2. All resdients and or legal representived will be offered educations regarding the benefits and potential side effects prior to recieving immunization. 3. DNS/Designee will audit resident records to ensure prior authorization is recieved prior to immunization. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings	

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F 334	Continued From page 34 R26 was admitted to the facility on 2/11/13 with the primary diagnosis of Alzheimer's disease [progressive disease that destroys memory and other important mental functions]. On 2/27/09 R26 signed forms allowing her husband to become power of attorney for decision making regarding healthcare. R26's quarterly Minimum Data Set (MDS) dated 4/27/15 revealed a Brief Interview for Mental Status (BIMS) score of six; indicating severe cognitive impairment. On 10/19/14 R26 signed a consent to have the influenza vaccine administered and received the immunization the same day. R28 was admitted to the facility on 5/31/13 with the primary diagnosis of Dementia [loss of brain function that affects memory, thinking, language, judgment, and behavior] with behavioral disturbances. Annual MDS dated 5/18/15 revealed a BIMS score of three; indicating severe cognitive impairment. On 10/17/14 R28 signed a consent to have the influenza vaccine administered and received the immunization the same day. On 7/9/15 at 8:12 a.m. the social worker for the facility stated R28's wife is his power of attorney and should be signing R28's informed consents regarding healthcare. A copy of the power of attorney paperwork was requested but not provided. On 07/09/15 at 8:14 a.m. the administrator and facility social worker verified that if a resident has a guardian who signs consents regarding healthcare that guardian should be signing the informed consent regarding influenza vaccine. Facility policy Influenza Vaccine-Resident Policy & Procedure dated 1/2010 read, "Purpose...3. To provide resident/representative with a Vaccine Information statement (VIS) at the time of admission or prior to administration of the	F 334	for further evaluation, interventions and ongoing audits. 4. Responsbile for Monitoring: DNS/Designee 5. Date of Completion: 08/19/15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 35 vaccine. Policy: 5. Consent will be given for the vaccine and documented in the resident medical record. The resident will be given the opportunity to refuse the vaccine. Procedure: 1. VIS must be provided in a format acceptable to the resident and/or responsible party before the vaccine is administered....Before receiving the vaccine, nurse will verify that the resident/responsible party received vaccine information statements, consents or declinations were obtained..."	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document the facility failed to ensure consultant pharmacist identified and report irregularities related to monitoring blood pressure for 1 of 5 residents (R25) reviewed for unnecessary medications. monitoring of sleep for 1 of 5 residents (R33) reviewed for unnecessary medications, and use of gentamycin ointment on open sacral ulcers with specific orders for 1 of 3 residents (R39) reviewed for pressure ulcers.	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the	8/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 36 Findings include: R25 was admitted to the facility on 11/21/12 with primary diagnoses of atrial fibrillation [abnormal heart rhythm] and chronic systolic heart failure according to the admission form. R25's physician orders dated 6/19/15 included metoprolol [blood pressure medication] tablet 25 mg by mouth twice daily, hold if SBP (systolic blood pressure) is less than 90. On 07/10/15 at 8:42 a.m. registered nurse (RN)-B was asked where R25's blood pressure readings would be found. "They should be in point click care [computer program]. Daily's may be on the MAR (medication administration record) too." On 07/10/15 at 8:44 a.m. RN-A and facility nurse consultant RN-C were asked where blood pressure readings would be found. "Should be point click care, MAR, or may be embedded in the progress note." RN-C verified on the MAR the blood pressure was not obtained prior to administrating metoprolol. R25's MAR was reviewed for April, May, June, and July 2015. The MAR indicated R25's blood pressure was not obtained prior to administration of the scheduled metoprolol. The facility's electronic medical record, Point Click Care, was reviewed for blood pressure readings. Blood pressure readings were found to be obtained weekly but did not correlate to giving of the metoprolol. R33 was admitted to the facility on 7/18/14 and also included on physician orders provided 7/9/15 listed diagnoses that include: psychotic disorder	F 428	facility states that with respect to: 1. R25 consultant pharmacist has performend a review of medication record. Blood Pressure monitoring is to be documented on the MAR. 2. R33 consultant pharmacist performed a review of medications. Care Plan was reviewed and revised. Sleep monitoring documented in the electronic record. R33 admitted to hospice care no longer in facility. 3. R39 consultant pharmacist has performed a review of medication record, medications have been clarified. 4. All residents will recieve a comphrehensive review of medications form the consultant pharmacist. 5. DNS/Designee will audit 2 resident medical records for 4 weeks the 1 resident records for 4 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvment meetings for further evaluation, interventions, and on going audits. 6. Responsible for monitoring: DNS/Designee 7. Completion Date: 08/19/2015	

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F 428	Continued From page 37	F 428		

with delusions, paranoia, depression, and insomnia. Also doctors order for Trazodone HCL 75 mg at bedtime with a start date of 4/9/15.

On 7/9/15 at 7:22 a.m. R33 was observed lying in bed, sleeping.

On 4/13/15 at 10:05 a.m. a Behavior/Mood evaluation was completed. The note indicated R33 "had difficulty falling or staying asleep or sleeping too much. Feels tired or has little energy." The note stated, "Sleep cycle disruptions." On asking for a sleep assessment which included R33's interventions could be used to promote sleep other than medication (non-pharmacological), and a summary of R33's hours of sleep. None was provided.
A Sleep History Questionnaire dated 4/13/15 was completed by RN-B. The evaluation/sleep plan addressed R33's need for assist with personal cares, wakeful at night and dozing frequently during the day, but lacked analysis of data collected and possible interventions to assist R33 with sleep.
The care plan dated 4/21/15 did not include a problem related to insomnia or provide staff with interventions to assist R33 to sleep.
The RN-C stated she was unable to find a care plan related to sleep and that no monitoring of sleep had been done.
During an interview on 7/10/15 at 10:38 a.m. the pharmacy consultant stated that she would only review the physician order forms and would not have "picked this up" in regards to a comprehensive sleep assessment.

R39 was admitted to the facility on 2/28/15 with diagnoses that included pressure ulcers, congestive heart failure (as listed on the care plan

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F 428	Continued From page 38 dated 5/12/15). R39 was observed during wound care on 7/9/15 at 9:14 a.m. RN-B was observed to apply gentamycin ointment (antibiotic) to two of the three areas she provided wound care to the coccyx and right ankle. Physician orders were reviewed. On 5/6/15 the Mayo/Franciscan Wound Clinic physician ordered gentamycin ointment to the pressure ulcer on the sacrum, right dorsal foot wound, and left plant foot wound. On 6/3/15 the physician ordered gentamycin ointment to the right heel and top of right foot. The order for the sacral ulcer directed to continue foam dressing to sacral pressure ulcer. On 7/1/15 the physician orders indicated right foot gentamycin ointment daily, the left foot order was for lotion twice a day, and the sacral ulcer directions were for washing area with soap and water and change foam dressing every 3 days. RN-B was interviewed on 7/9/15 at 2:05 p.m. RN-B verified she used the gentamycin ointment to the sacral wound and stated she would only stop the use of gentamycin if there had been a discontinue order. The director of nursing (DON) was interviewed on 7/9/15 at 2:10 p.m. and verified the physician orders did not include using the gentamycin on the sacral area. DON stated the physician should have been called and the orders clarified. On 7/10/15 at 8:50 a.m. the director of nursing stated she had contacted the physician for order clarification and that no gentamycin was to be used on the sacral pressure ulcer. A medication error form was completed by the director of nursing at that time.	F 428		

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F 428	Continued From page 39 During an interview on 7/10/15 at 10:38 a.m. the pharmacy consultant stated the lack of the gentamycin order should have been clarified by nurse when transcribing the order. The pharmacy consultant stated that she would only review the physician order forms and would not have picked this up until there had been a stop order for the use of the gentamycin.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 applicable. 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. 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	F 431		8/19/15

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F 431	Continued From page 40 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 document review, the facility failed to ensure medications were stored separately from food in 1 of 2 medication refrigerators and failed to obtain signed physician orders for the facility's emergency medication kit according to the Omnicare policy. Findings Include: On 7/7/15 at 7:40 p.m. the southwest medication storage room was reviewed with registered nurse (RN)-B. Upon review of the medication refrigerator the enclosed freezer was noted to have a package of frozen meat, covered with frost, next to ice packs. RN-B attempted to remove the package of meat but was unable to move the package due to frost. On 7/7/15 at 7:50 p.m. the director of nursing (DON) reviewed the medication refrigerator/freezer in the southwest medication room. The DON forcefully removed the package of meat from the freezer. The package was covered in frost and was frozen to an ice pack. Once removed the package was partially open and was able to be identified as a ring sausage. The DON was asked to verify that meat should not be in the medication refrigerator/freezer, "I will absolutely verify that meat is not to be in the	F 431	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The southwest refriderator has been cleaned and foodl articles removed. 2. Emergency medication orders have been obtained fomr the Medical Director. 3. Nursing staff will recieve re-education on the proper storage of medicatons. 4. DNS/Designee will audit medication refriderator 2 x for 4 weeks then 1 x week for 4 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvment meetings for further evaluation, interventions, and on going audits.	

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F 431	Continued From page 41 medication freezer." Omnicare Policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes, and Needles dated 12/1/07 "Procedures...3.6 Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored." On 7/8/15 at 10:20 a.m. the north medication storage room was reviewed with RN-B. RN-B was asked about the emergency kit (E-kit) of medications. The E-kit was found in the cupboard with the contents of the E-kit on a label on the E-kit. RN-B was asked about physician orders for the E-kit. RN-B was unable to locate any orders. On 7/8/15 at 11:01 a.m. the DON was asked about E-kit orders. "I know we are supposed to have it signed by the medical director. I don't know where it is, I'm new. I will try to find it." On 7/8/15 at 3:07 p.m. the DON and administrator was questioned regarding the E-Kit list provided titled, Omnicare Pinnacle Standard Emergency Box, dated 7/8/15, with the medical director's signature. The DON stated, "Yes, that was just signed today, but we do have one but I have never seen it." The DON and administrator verified they could not find a copy with medical director and pharmacist's signature. On 7/10/15 at 10:28 a.m. the pharmacy consultant was interviewed via telephone regarding the E-kit physician's order. "That has been a question that has come up this week and we do not have one for the facility. I have been a consultant with that facility for 4 months. It is	F 431	5. Responsible for Monitoring: DNS/Designee 6. Completion Date: 08/19/2015	

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F 431	Continued From page 42 usually signed within a quarter of me starting. It has been identified we do not have that. It will be completed at the next QA meeting we all attend." Omnicare Policy 6.6 Emergency Medication Supplies dated 12/1/07 "Procedure...3. Facility's pharmacy committee and Medical Director, in conjunction with Pharmacy, should determine the contents of the Emergency Medication Supply, in accordance with applicable law. 4. Facility's Medical Director, Director of Nursing, and Pharmacy should approve changes to the content of the Emergency Medication Supply. 5. Facility should not administer any Emergency Medication Supply without a valid Physician's/Prescriber's order."	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		8/19/15

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F 441	Continued From page 43 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed develop an infection control program that included surveillance, tracking, and analyzing outbreaks of infection. This had the potential to affect all 34 residents residing in the facility. Also the facility failed to thoroughly clean and disinfect the whirlpool tub after each resident use. This also had the potential to affect all 34 residents. Findings Include: Lack of a functioning infection control program: Line listing of resident infections form was reviewed for 7/2014, 11/2014 to 7/2015. Documentation lacked any tracking, analyzing, and outcome surveillance process that consisted of collecting/documentation data on individual	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The facility infection control tracking and analyzing has been reviewed and revised. 2. The whirlpool tub disinfecting	

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F 441	Continued From page 44 cases and comparing collected data. The infections on the log did not have documentation that a culture of the infection was completed to identify the correct antibiotic was prescribed or whether the infection resolved. On 7/9/15 at 1:14 p.m. the director of nursing (DON) was interviewed regarding the infection control program. DON was asked how the infection control program is monitored and she said, " Quality meetings, through orientation process with new staff, hand washing, personal protective equipment, universal precautions, Relias training (online learning program with training's due once a quarter), and Minnesota Department of Health; health information regarding resident infection control issues." Then the DON was asked how the facility monitored the condition of a resident with an infection and how the resolution of the infection is monitored and she said, "The room to room, where did it start & where did it go, who has the infection. I have a map but do not use it as the infections don't seem like they need it. I find out what percentage, if I have something that is contagious mapping would then makes sense. Vital signs, symptom resolution, repeat UA [urine analysis] on UTIs [urinary tract infections]." The last question for the DON was asked on how data analysis of infections is conducted and she said, "Do data in terms of track total patient days per month, what is my percentage of infection. I haven't seen a pattern of the same infection." On asking DON for a copy of the infection data analysis, none was provided.	F 441	procedure has been updated. 3. All staff will receive re-educaton regarding Infection Control Tracking and sanitizing of whirlpol tub. 4. DNS/Designee will be audit infection control log and disinfection of tub 2 times weekly for 4 weeks then 1 time for 4 weeks. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, intervention, and on going audits. 5. Completion Date: 08/19/2015	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		8/19/15

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F 465	Continued From page 45 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based observation and interview the facility failed to maintain an environment free from offensive urine odors in resident rooms 101 and 103, failed to ensure wheelchairs were maintained in a sanitary manner for 2 of 2 resident (R5 and R28) who utilized wheelchairs for mobility in the facility. Findings include: Lack of Room Sanitation: During an observation on 7/7/15, at 2:14 p.m. room 101 which had carpet, had a box fan that was on low and an air purifier that had been on. The room was noted to have a very strong odor of urine. At 2:38 p.m. room 103 also had the same urine smell, however was not as intense. Room 103 had laminate flooring. On 7/8/15, at 9:03 a.m. room 101 continued to have a very urine odor smell. The box fan and air purifier had been on and the window was noted to be closed. Nursing assistant (NA)-A stated the fan and air purifier had been used for air circulation because of the odor. NA-A stated the resident whom resided in the room had urinary incontinence. NA-A further stated some rooms that have carpets are a problem with orders. During an interview on 7/8/15, at 9:33 a.m. house keeper (HSKP)-A did not know when the last time carpet had been shampooed in the resident rooms. HSKP-A indicated carpet is shampooed when it smells, carpets were not on a routine cleaning schedule, stated the air purifier is	F 465	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of the State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident rooms 101 and 103 have been thoroughly cleaned. 2. Cleaning procedure has been reviewed and revised. 3. R5 and R28 w/c arm rests have been replaced. 4. The facility procedure for cleaning wheelchairs has been reviewed and revised. 5. Housekeeping staff have been re-educated on procedure of cleaning. 6. Health Care Services	

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F 465	Continued From page 46 supposed to kill the germs and the fan is used for air circulation. HSKP-A further stated the room (in reference to 101) had not smelled prior to the resident who resided in that room. In addition HSKP-A stated the resident who resided in the room was and urinates on the floor. During an interview on 7/8/15, at 9:34 a.m. HSKP-B indicated the carpet had been shampooed a couple of weeks ago in room 101. HSKP-B stated, "We don't have a routine schedule, we do it when it needs to be done, it smells a lot better after we clean the carpet." Facility could not produce a checklist or schedule that indicated the last time room 101 had been shampooed. On 7/8/15, at 10:00 a.m. HSKP-B shampooed the carpet in room 101, which subsequently left a very strong perfume fragrance mixed with a very strong urine smell. This unpleasant odor could be smelled in the lobby area and at the end of the 100 hallway by the conference room. On 7/9/15, at 7:34 a.m. room 101 and room 103 continued to have a urine smell but not as strong. The door to room 101 was opened and the window was open approximately 6-8 inches. The box fan and air purifier were noted to be on. During an interview on 7/10/15, at 10:21 a.m. nursing assistant (NA)-A indicated the resident who resided in the room 101 had behaviors of urinating on the floor at night. During an interview on 7/10/15, at 11:08 a.m. the director of housekeeping verified rooms 101 and 103 had a urine smell and stated the air purifier is used to " eat up " some of the odor. The director further stated the facility contracted out the housekeeping services and washing carpets was not part of the contract, " but occasionally we will do it." The director of housekeeping further stated there had not been a policy, a schedule, or a	F 465	manager/designee will audit 3 resident rooms per week for cleanliness. DNS/Desingee will audit 1 w/c weekly. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, intervention, and on going audits. 7. Responsible for monitoring: ED/Designee 8. Completion Date: 08/19/2015	

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	245536	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(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 465	Continued From page 47 routine shampooing in place. During an interview on 7/10/15, at 11:22 a.m. the administrator explained the facility did contract out housekeeping services and carpet cleaning services were not included in the contracted services, however the facility had a part time employee that had come in as needed to clean the carpets. Lack of Wheelchair Cleaning: R5 ' s wheel chair was observed on 7/7/15, at 1:07 p.m. the right arm rest on R5's wheelchair was noted to have been cracked and missing approximately 2 inches of vinyl which made the surface rough and un-cleanable. R28 wheelchair was observation on 7/7/15, at 2:14 p.m. the left arm rest on R28's wheelchair was noted to have been cracked vinyl which made the surface rough and un-cleanable. During an interview on 7/10/15, at 10:53 a.m. director of maintenance (DOM) verified the missing vinyl and cracks on R5's wheelchair and the cracks on R28's wheelchair. DOM stated arm rests on both wheelchairs needed to be replaced. DOM stated he routinely visually checked the wheelchairs in use by the residents while on the floor, however did not have a preventative or routine maintenance schedule to check wheelchairs for maintenance issues.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, RR 2 BOX 49** **MABEL, MN 55954**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	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 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Green Lea Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/29/2015

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
	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, RR 2 BOX 49** **MABEL, MN 55954**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us 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. Green Lea Manor is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1969, addition was constructed and was determined to be of Type II(222) construction. In 1989, another two additions were constructed and was determined to be of Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building Type II (111) . The building is fully sprinkled and has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, RR 2 BOX 49** **MABEL, MN 55954**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 34 residents. Findings include: On facility tour between 815 AM and 1115 AM on 07/09/2015, the review of the fire drill documentation for the past 12 months (July 2014 to June 2015) revealed that the drills for the day shift were completed, but did not sufficiently vary the times that the drills were conducted - 1326, 1000, 1026 and 1330 hours. This deficient practice was confirmed by the Facility Environmental Services Director (DQ) at the time of discovery.	K 050	K050 Maintenance Supervisor will monitor fire drills monthly to assure fire drill times are varied at least ninety minutes.	8/10/15

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K 050	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		