DEPARTMENT OF HEALTH A	ND HUMAN SEF	RVICES				CENT	FERS FOR	MEDICARE & ME	DICAID SERVICES
		ICARE/MEDICA							ID: 2YUS
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGEN	NCY	1	Facility ID: 00633
1. MEDICARE/MEDICAID PROVIDER No. (L1) 245396 2.STATE VENDOR OR MEDICAID NO. (L2) 049021100 049021100	0.		CARE HEA E PINE VILI T MAIN ST	ALTH S LA C C	SYSTEM	- (L6)	56352	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	VERSHIP	7. PROVIDER/SUF 01 Hospital	PLIER CATEGORY	Y 09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
 6. DATE OF SURVEY 07/0 8. ACCREDITATION STATUS: 	7/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC			FISCAL YEAR ENDIN	NG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE		06/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:						
From (a):		X A. In Complian	ce With		And/Or A	pproved	Waivers Of The	Following Requirements:	
To (b):		Program Re					al Personnel	6. Scope of Se	
12. Total Facility Beds	75 ^(L18)	Compliance	cceptable POC			24 Hour 7-Day R	RN (Rural SNF)	7. Medical Dir 8. Patient Room	
	15		-		5.	Life Saf	ety Code	9. Beds/Room	l.
13. Total Certified Beds 75 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A*						*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILIT	Y MEET	S		
18 SNF 18/19 SNF 75	19 SNF	ICF	IID		1861 (e) (1) or 186	1 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY	AGENCY API	PROVAL	Date:
Brenda Fischer, I	HFE NE II	00	5/10/2014	(L19)	Kate JohnsTon, Enforcement Specialist 06/16/2014				
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE (OR SIN	GLE STAT	E AGENCY	(== :)
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21.			al Solvency (HCFA-2572)	
X1. Facility is Eligible to Part	icipate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE	23. LTC AGREEME	ENT 2	4. LTC AGREEME	ENT	26. TERM	INATIO	NACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING I	DATE	ENDING DATI	E	<u>VOLUNTA</u> 01-Merger,		00		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisf	action W	/ Reimbursemen	nt 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE	E SANCTIONS			03-Risk of I	nvoluntary	y Termination	OTHER	
	A. Suspension of	f Admissions:			04-Other Re	ason for V	Withdrawal		ler Status Change
(L27)	B. Rescind Sus	pension Date.	(L44)					00-Active	2
			(L45)						
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMA	RKS			
		03001							
	(L28) (L31)								
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION (06/18/2014	OF APPROVAL DAT	ГЕ					

(L33)

DETERMINATION APPROVAL

(L32)

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Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245396

July 9, 2014

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa C C 525 West Main Street Melrose, MN 56352

Dear Mr. Gilbertson:

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

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

Effective June 25, 2014 the above facility is certified for or recommended for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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.

Centracare Health System - Melrose Pine Villa C C July 9, 2014 Page 2

Sincerely,

Vale Compton >

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 9, 2014

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa C C 525 West Main Street Melrose, Minnesota 56352

RE: Project Number S5396023

Dear Mr. Gilbertson:

On May 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 16, 2014. 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 July 7, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 12, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2014 and therefore remedies outlined in our letter to you dated May 29, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Tomston

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245396	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/7/2014			
Name of Facility			Street Address, City, State, Zip Code			
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			525 WEST MAIN STREET MELROSE, MN 56352			

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)	ltem		(Y5)	Date
			Correction					Correction					Correction
ID Drofin	50470		Completed		ID Drafin	50044		Completed			50040		Completed
	F0176		06/20/2014		ID Prefix			06/25/2014		ID Prefix			06/25/2014
Reg. # LSC	483.10(n)				Reg. # LSC	483.15(a)				Reg. # LSC	483.15(b)		_
					200					200			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0281		06/18/2014		ID Prefix	F0285		06/25/2014		ID Prefix	F0371		06/18/2014
	483.20(k)(3)(i)				•	483.20(m), 483.20(e)				•	483.35(i)		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0465		06/25/2014		ID Prefix					ID Prefix			
Reg. #	483.70(h)				Reg. #					Reg. #			
LSC					LSC			-		LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #								
LSC										LSC			_
				1									
Reviewed B	/	Reviewed E	Зу	Da	te:	Signature of S	Surve	yor:				Date:	
State Agenc	y	B	SF/KJ	0	7/09/20	14		10562				07/	/07/2014
Reviewed B	/	Reviewed E	Зу	Da	te:	Signature of S	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:					-				a Summary of				
	5/16/2	014				Uncor	recte	a Deficiencies		5-2567) Sent	to the Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245396	(Y2) Multiple Construction A. Building B. Wing 01 - MAI	(Y3) Date of Revisit 6/12/2014				
Name	of Facility		Street Address, City, State, Zip Code				
CE	NTRACARE HEALTH SYSTEM - MELRC	SE PINE VILLA C C	525 WEST MAIN STREET				
			MELROSE, MN 56352				

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) I	Date
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_06/02/2014	ID Prefix		_06/02/2014	ID Prefix		_
-	NFPA 101	-	-	NFPA 101		Reg. #		_
LSC	K0052		LSC	K0144				-
		O			O			Ormertien
		Correction Completed			Correction Completed			Correction Completed
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #		-	Reg. #		_
LSC		-	J J		-			_
		Correction			Correction			Correction
ID Drafiv		Completed			Completed	ID Drofin		Completed
ID Prefix		-	ID Prefix		-			_
Reg. #		-	Reg. #			Reg. #		_
LSC			LSC		-			_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		_	ID Prefix		_
Reg. #	_		Reg. #			Reg. #		
LSC		-	LSC		-	LSC		-
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. # LSC		-	Reg. # LSC		-	Reg. #		-
								_
Reviewed By	Reviewed I	Ву	Date:	Signature of Surve	eyor:	1	Date:	
State Agency	/	PS/KJ	06/16/20	14	22373	i	06	/12/2014
Reviewed By		-	Date:	Signature of Surve			Date:	
CMS RO								
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of						
5/16/2014				Uncorrecte	d Deficiencies (CMS-2567) Sent to the	Facility? YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245396	(Y2) Multiple Construction A. Building B. Wing 02 - 2007	(Y3) Date of Revisit 6/12/2014				
Name	of Facility		Street Address, City, State, Zip Code				
CE	NTRACARE HEALTH SYSTEM - MELRO	SE PINE VILLA C C	525 WEST MAIN STREET				
			MELROSE, MN 56352				

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	(Yt	i) Date	(Y4) Item	(Y5)	Date (Y4) Item	(Y5)	Date
		Correction			Correction			Correction
		Completed	ID Desfer		Completed	ID Des for		Completed
ID Prefix		06/02/2014			_06/02/2014	ID Prefix		_
-	NFPA 101	_	-	NFPA 101		Reg. #		_
LSC	K0052	_	LSC	K0144		LSC		_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		•	ID Prefix		-	ID Prefix		_
Reg. #			Reg. #			Reg. #		
LSC		_	LSC		- -	LSC		-
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		_	Reg. #		-			_
		_			-	LSC		_
		_						-
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		-	ID Prefix		_
Reg. #		_	Reg. #		-	Reg. #		_
LSC		_	LSC		-	LSC		_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		-	ID Prefix		_
Reg. #		_	Reg. #		_	Reg. #		_
LSC		_	LSC			LSC		_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:		Date:	
State Agency		PS/KJ	06/16/20		22373			/12/2014
Reviewed By		-	Date:	Signature of Surve			Date:	
CMS RO		-			-			
Followup to	Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of					
	5/16/2014					CMS-2567) Sent to the Fa	-	NO

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

	VICARE/MEDICAID CERTIFICATION A		ID: 2YUS Facility ID: 00633		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245396 2.STATE VENDOR OR MEDICAID NO. (L2) 049021100	3. NAME AND ADDRESS OF FACILITY (L3) CENTRACARE HEALTH S (L4) 525 WEST MAIN STREET (L5) MELROSE, MN	SYSTEM - MELROSE PINE (L6 36352	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 05/16/2014 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 75 (L18) 13.Total Certified Beds 75 (L17) 14. LTC CERTIFIED BED BREAKDOWN	 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: 	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: B (L12) 15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF 75 (L37) (L38) (L39)	ICF IID (L42) (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S See Attached Remarks 17. SURVEYOR SIGNATURE Bruce Melchert, HFE NE II	SHOW LTC CANCELLATION DATE): 	18. STATE SURVEY AGENCY APPROVAL Date: _Kate JohnsTon, Enforcement Specialist06/16/2014			
	(L19) BE COMPLETED BY HCFA REGIONA		(L20)		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 12/01/1986	DATE ENDING DATE	26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety		
(L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIV. A. Suspension (L27)	of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
(L27) B. Rescind Sus	pension Date: (L45)				
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRIER NO.	30. REMARKS			
(L28)	03001 (L31)	_			
31. RO RECEIPT OF CMS-1539 32 (L32)	. DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPROV	VAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: 2YUS Facility ID: 00633

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: Item 16 Continuation for CMS-1539

At the time of the standard survey completed 05/16/2014, the facility was not in substantial compliance and the most serious deficiencies were found 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 as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0372

May 30, 2014

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, Minnesota 56352

RE: Project Number S5474024

Dear Mr. Gilbertson:

On May 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

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

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

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

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

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

Centracare Health System - Melrose Pine Villa C C May 29, 2014 Page 2

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301

Telephone: (320)223-7338 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 25, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 25, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 16, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

Centracare Health System - Melrose Pine Villa C C May 29, 2014 Page 5

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0939-0391 TATEMENT OF DEFICIENCIES (V) MUTHLE CONSTRUCTION (VS) DATE SURVEY AND PLAN OF CORRECTION (V) PROVIDERSURPLIENCLA (VS) DATE SURVEY NAME OF PROVIDER OR SUPPLIER 245396 (VS) MUTHLE CONSTRUCTION (VS) DATE SURVEY NAME OF PROVIDER OR SUPPLIER 245396 (VS) DATE SURVEY (VS) DATE SURVEY CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C STEET ADDRESS, OTY, CTATE, ZIP CODE STEET ADDRESS, OTY, CTATE, ZIP CODE F 000 INITIAL COMMENTS IPROVIDERS TAA OF CORRECTION CONSTRUCTION AUGUST OF DEFICIENCIES PROVIDERS TAA OF CORRECTION CONSTRUCTION AUGUST OF DEFICIENCIES F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 The facility s plan of correction (POC) will server as your allegation of compliance. F 000 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Ta assigned tag number appears in the far left column entitled 'ID Prefix Tag.'' The assigned tag number appears in the far left column and replaces the 'TO Comply' portion of the first page of the CMS-2667 form will be used as verification. Minnesota state statute/rule out of complance been assigned to Minnesota state statute/rules for Nursing Homes. Upon receipt of an acceptable POC an on	DEPART	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED										
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED AND OF CORRECTION 245396 B. WINO DSTREET ADDRESS, CITY, STATE, 2IP CODE CONTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C STREET ADDRESS, CITY, STATE, 2IP CODE STREET ADDRESS, CITY, STATE, 2IP CODE CAND SUMMARY STREMENT OF DECIDENCES DROVERS RAN OF CORRECTION CROSS REFERENCED TO THE APPROPRIATE OPPOLING PREPIX REQUINTERY OR USC DENTIFICIENCES DROVERS RAN OF CORRECTION CROSS REFERENCED TO THE APPROPRIATE OPPOLING F 000 INITIAL COMMENTS TAG DROVERS USAN OF CORRECTION OF USAN OF CORRECTION OF USAN OF CORRECTION OF USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION OF USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION OF USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION FOR USAN OF CORRECTION OF USAN OF CORRECTION FOR USAN OF CORRECTION OF USAN OF CORRECTION FOR USAN OF CORRECTION OF USAN OF CORRECT	CENTER	<u> REDICARE NEDICARE</u>	& MEDICAID SERVICES		<u> </u>	<u> //B NO.</u>	0938-0391					
NAME OF PROVIDER OR SUPPLIER OWNER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C STREET ADDRESS, CITY, STATE, ZIP CODE S22 WEST MAIN STREET PARTIN SUMMARY STATEMENT OF DEFICIENCES PREIN PROVIDER'S PLAN OF CORRECTION DREVENDES, MISSION CORRECTION DREVENDES, MISSION CORRECTION DREVENDES PLAN OF CORPORTING DREVENDES PLAN OF CORPORTING DREVENDES PLAN OF CORRECTION OF OR DREVENDES PLAN OF CORRECTION OF OR				. ,								
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PALID DELIDER, IM 3632 (PA) ID PREFIX ISUMARY STATEMENT OF DEFICIENCIES (EGULATORY OR LSC DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFIX PREFIX TAG PREFIX (EGULATORY OR LSC DEFICIENCY) COMELETION DEFICIENCY F 000 INITIAL COMMENTS F 000 F 000 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to waikate that substantial compliance upon the bottom of the first page of the CMS-2567 form will be used as verification of compliance with the regulations has been attained in accordance with your verification. F 000 Minnesota state statute/rule number appears in the far left column entitied 1D Prefix Tag.* The sates statute/rule number and the corresponding text of Deficiencies* column and replaces the "To Comply" portion of the correction order. This column and replaces the "Ind Deficiencies* column and replaces the findings which are in violation of the state statute/rule out of compliance is listed in the "Summary Statement, This Rule is not met as evidenced by.* Following the surveyors findings are the Suggested Method of Correction. F 176 483.10(n) RESIDENT SELF-ADMINISTER SND F 176 F176 620/14				5	25 WEST MAIN STREET							
PRETX TAG CEACH OERCENCY MUST BE PRECEDED BY FULL REGULTION OR LSC IDENTIFYING INFORMATION) PRETX TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CONDUCT F 000 INITIAL COMMENTS F 000 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 000 Minnesota state statutes/rules for Nursing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes: The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule or To Comply' portion of the correction order. This column also includes the findings which are in violation of the state statute/rule out of compliance to the first are statute as the first page of the state statute are in the To Comply' portion of the correction and the Time Period For Correction. F 176 483.10(n) RESIDENT SELF-ADMINISTER Sup DRUGS if DEEMED SAFE F 176 F 176 F 176 F 176 6/20/14	CENTRA			N	IELROSE, MN 56352							
F176 SS-DD 483.10(n) RESIDENT SELF-ADMINISTER SS-DD F176 Minnesota Directors OR PROWDER/SUPPLER REPRESENTATUSE SDATUSE KIADEADEADEADEADEADEADEADEADEADEADEADEADEA	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION					
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. documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. 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. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Compl' portion of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction. F 176 S=0 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE F 176 F 176 483.10(n) RESIDENT SELF-ADMINISTER S=0 F 176	F 000	INITIAL COMMENT	rs	F 000								
F eivisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. The sasigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. F 176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE F 176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE LUBORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE THE LUBORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE THE XUE		as your allegation o Department's accept bottom of the first p be used as verificat	of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will tion of compliance.		documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned t Minnesota state statutes/rules for N	ftware.						
F 176 483.10(n) RESIDENT SELF-ADMINISTER F 176 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE F 176 VILL APPEAR ON PROVIDER REPRESENTATIVE'S SIGNATURE THE TILE OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. F 176 483.10(n) RESIDENT SELF-ADMINISTER F 176 TITLE		revisit of your facilit validate that substa regulations has bee	y may be conducted to Intial compliance with the		far left column entitled "ID Prefix Ta The state statute/rule number and t corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficiencie column and replaces the "To Comp portion of the correction order. Thi column also includes the findings are in violation of the state statute a the statement, "This Rule is not me evidenced by." Following the surve findings are the Suggested Method Correction and the Time Period For	ag." he ute/rule ss" ly" is which after t as eyors of						
F 176 483.10(n) RESIDENT SELF-ADMINISTER F 176 SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. 6/20/14 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE					OF THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	сн С						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		· · · · · · · · · · · · · · · · · · ·		F 176	SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA ST.	N FOR ATE	6/20/14					
	SS=D		U SAFE									
			JER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	IIILE		(X6) DATE 06/05/2014					

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

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245396	B. WING		05/ [,]	16/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 176	Continued From pa	ige 1	F 17	6		
	An individual reside the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this				
	practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the safe practice of self-administration of medications was completed for 1 of 1 residents (R65) who's medication was hidden in their food. Findings include: R65's Order Summary Report, dated 4/22/14, identified "Valium Tablet (Diazepam) Give 2 mg by mouth one time a day related to BENIGN PAROXYYSMAL POSITIONAL VERTIGO (386.11); Vitamin D3 Tablet (Cholecalciferol) Give 2000 unit by mouth one time a day related to UNSPECIFIED VITAMIN DEFICIENCY (269.2) crush, place in jelly, on toast; and Coumadin Tablet (Warfarin Sodium) Give 2.5 mg by mouth one time a day every Mon, Wed, Fri related to ACUTE MYOCARDIAL INFARCTION (410) Crushed, mixed with jelly on toast with supper. " The Order Summary Report did not indicate Valium could be crushed and placed in her food nor was there any physician's order that R65 could self administer her medication.			A self administration assessment completed on R65 on 6/4/2014. I determined that she was not safe administer. Care plan was update 6/4/2014. All resident s reviewed, no other residents were affected. Staff educated at a nurse meeting 5/29/2014. Policy on medication administration reviewed. Minutes meeting placed in staff communic book. Medication Administration A be completed weekly by the RN C Supervisor or her designee X 2 m until system is in place. Results of these audits will be rev and evaluated by the Director of N and brought forward to the QPS committee. Completion Date 6/20/2014	t was to self d from ation udits will linical onths or iewed	
	the practice of med R65. During observation on 5/12/14, at 5:15	ed 4/23/14, does not address lication self-administration for of medication administration p.m., the trained medication observed in the Pine Villa				

If continuation sheet Page 2 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 06/10/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245396	B. WING			0;	5/16/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C			25 WEST MAIN STREET IELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 176	mixing them in a da smeared the jelly or re-wrapped them in the tray (on the dini delivered to R65 in TMA-A then proceed dining room and left the dining cart. Nursing assistant (ft 5/12/14, at 5:28 p.m the hallway to the a was located. At 5:3 (AA)-A removed the to R65. R65 un-wrat two halves, and pla During continuous of 5:40 p.m. to 5:51 p. and ate her evening used her dinner kni of white medication those pieces on her continued to eat he same process until medication jelly toat During interview on stated they hide the disguise it because The TMA-A stated as way and the medication those that R65 ate the nursing assistant The TMA-A verified	Ark colored jelly. TMA-A then in two pieces of toast, tin foil, and placed them on ing cart) which was to be a different dining room. ded back into the Pine Villa t the medication jelly toast on NA)-F was observed on in., brought the dining cart from ctivity dining room where R65 3 p.m., the Activity aide tray from the cart and serve it apped the toast, separated the ced them on her tray to eat. observation on 5/12/14, from m., R65 took bites of toast g meal. At 5:51 p.m., R65 to fe and picked several chunks pieces out of the jelly, leaving r plate unconsumed, and r meal. R65 continued this she had eaten 100% of the	F 1	76			

If continuation sheet Page 3 of 24

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY
		245396	B. WING		05/16	6/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Continued From page 3 During interview on 5/12/14, at 6:25 p.m., licensed practical nurse (LPN)-C verified that crushing the medications and placing them in the jelly was normal practice amongst the staff for R65. LPN-C stated this practice had been discussed in morning briefing which was attended by the LPNs, Social Services, registered nurses (RN), dietary staff and activities staff. LPN-C verified the TMA should have stayed with the medication until R65 had consumed the toast.		F 17	6		
	During interview on 5/13/14, at 11 a.m., licensed social worker (LSW)- A stated the family had not been involved in the decision to hide R65's medication in her food nor had this practice been discussed at care conferences.					
	During interview on 5/15/14, at 2:05 p.m., director of nursing (DON) verified they had not completed any self-administration of medications assessment for R65, due to her cognitive status.					
	Medication, Self Ad each resident has t his/her own medica and the nursing sup safe. The policy fur does want to self-ad supervisor assesse	olicy undated entitled ministration, indicates that he right to self-administer tion if he/she desires to do so, pervisor determines that it is rther indicates if the resident dminister meds, the nursing is the resident's cognitive, I ability to carry out the r.				
F 241 SS=D		AND RESPECT OF	F 24	1	6	/25/14
	The facility must pro	omote care for residents in a				

If continuation sheet Page 4 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245396	B. WING	i		05/	16/2014
	PROVIDER OR SUPPLIER	EM - MELROSE PINE VILLA C C		5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	enhances each res full recognition of hi This REQUIREMEN by: Based on observat review, the facility fa spoken to and treat dignified manner by resident (R45) who the survey. Findings include: R45's annual Minim 3/6/14, included mo diagnoses of a stro signs of depression bad about self, and dead almost daily. required supervisio encouragement and meals. R45's Psyc Assessment (CAA) "Approach [R45] wa talk about road and brings a smile to his R45's cognition car he was able to expr directed staff to; "A to make his own AD decisions. The beh may touch staff sex comments related t intervention was list	num Data Set (MDS) dated orderate cognitive impairment, ke and depression, exhibited such as poor appetite, feeling thoughts of being better off The MDS indicated R45 n, cueing, oversight, or d set up assistance with hosocial Well-being Care Area dated 3/6/14, included, armly and positivelystaff will weather conditions, etc which	F2	241	Resident R45 does not recall the in Na-A was educated on resident rig 5/19/2014. No other residents were found to be affected. Education regarding resident rights completed to nursing staff on 5/20, 5/29/2014 and 6/10/2014. A copy of resident rights and meeting minute placed in the communication book 6/10/2014. The orientation checkli updated to include education on R Rights upon hire. Audits observing staff for resident and appropriate conversation will be conducted once a week by the RN Supervisor for 2 months or until sy in place. Audits will also be condu each meal for appropriate and digr conversation x 2 weeks or until sys in place. This audit will be comple the charge nurse or her designee. Results of these audits will be revie and evaluated by the Director of N and brought forward to the Quality Assurance (QPS) committee. Completion Date: June 25th, 2014	hts on he s was /2014, of s were on st was esident rights ce Clinical stem is cted at hified stem is ted by ewed ursing	

If continuation sheet Page 5 of 24

			()(0)			0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245396	B. WING _		05	/16/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C	;	525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 241	Continued From page 5		F 24	41		
		•				
	R45's annual Nutrition Review dated 3/13/14, included, "Family reports he typically ate two meals when he was home."					
	0	on 5/12/14, at 6:02 p.m.				
		VA)-A entered R45's room with ay. R45 was lying on is back				
	on top of the covers	s, in his bed. NA-A stated, "It				
		I5 stated, "No." NA-A then				
		ion, "Come on, I have to fight e." NA-A started to pull				
		the edge of the bed, R45				
	resisted this and sta	ated, "No, I don't want to eat."				
		oull on R45's lower legs while				
		ing sat up by her. NA-A I naughty, your going to make				
		e on you, aren't you?" While				
		by pulling on legs, and placing				
		k, NA-A stated, "Come on,				
		n." R45 pointed to the IA-A, "Look she is writing all				
		old R45, "You're going to be				
		A-A continued to attempt to				
	force R45 to sit up,	R45 then started grabbing at				
		s, without making contact, and				
		towards NA-A. NA-A stated, riate, you know that is not				
		A left the room, stating to the				
		e this all the time." NA-A				
		the hallway and asked her to				
		s room to help her when the				
		. NA-A re-entered the room m to sit up again by pulling his				
		npting to pull his back up, R45				
		stating he did not want to eat.				
	NA-A stated, "Com	e on lets' sit up, at least drink				
		sked, "Where's the chocolate				
		im there wasn't any on his				
	trov DIE again ata	rted grabbing towards NA-A's				

Facility ID: 00633

If continuation sheet Page 6 of 24

		AND HUMAN SERVICES				FORM	06/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245396	B. WING _			05/	16/2014
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C			25 WEST MAIN STREET ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	and left the room. I aide for assistance different nursing as When interviewed of stated, "They only want to eat." NA-A 6:09 p.m., alone, ar anything from his tr would like anything and NA-A removed room with it. R45 th aint hungry, they try this upsets him and people treated him guy doesn't eat is w When interviewed of director of nursing (in resident rights ar honored R45's right When interviewed of registered dietician of meals, however, milk or chocolate er was customary for day and this choice Staff should encour should not attempt When interviewed of DON stated she ha can get R45 to sit u helping him with his R45 had attempted hit her during the er	A-A asked another nurse and left the area with a sistant. on 5/12/14, at 6:08 p.m. R45 bully a guy when he doesn't re-entered R45's room at ad asked R45 if he wanted ay left in his room or if he else. R45 stated he did not, the meal tray and left the nen stated, "When a person to force you." R45 stated makes him feel bad. Most well, but others, "when a then they treat a guy rough." on 5/14/14, at 2:00 p.m. the (DON) stated staff are trained anually and NA-A should have t to refuse the meal tray. on 5/15/14, at 8:41 a.m. the (RD) stated R45 refuses a lot he will usually take chocolate nsure. R45's family told us it R45 to only eat two meals a should be honored by staff. rage R45 to eat, however, to force him. on 5/14/14, at 8:58 a.m. the d spoken to NA-A who usually p and eat something by s legs and having him sit up. to grab NA-A's breasts, not pisode on 5/12/14. The DON	F 24	11	DEFICIENCY)		
	hit her during the ep						

If continuation sheet Page 7 of 24

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		ATE SURVEY MPLETED
		0.15000			
	PROVIDER OR SUPPLIER	245396		O STREET ADDRESS, CITY, STATE, ZIP CODE	5/16/2014
		EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 241	Continued From pa	-	F 241		
	resident rights during new hire orientation on 7/8/13, and provided documentation of this.				
F 242 SS=D	Combined Federal Rights, dated 2/14, the facility has a rig self-determination . resident rights upor proactively promote Under Dignity, inclu courtesy promote a and environment th dignity and respect individuality." Under included, "You hav schedules, and hea about aspects of yous significant to you." 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and hea	ntitled, Your Rights Under The and Minnesota Resident Bill of included, " Each resident of ht to a dignified existence, All staff will be oriented to a hire, and shall protect and the rights of each resident." ided, "The facility must with nd care for you in a manner at maintains or enhances your in full recognition of your er Self-Determination e the right to choose activities, and make choices our life in the facility that are ETERMINATION - RIGHT TO e right to choose activities, alth care consistent with his or	F 242		6/25/14
	interact with memb inside and outside t about aspects of hi are significant to the This REQUIREMEN	essments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident.			
	review, the facility factor	ion, interview, and document ailed to consistently dent preferences of how often of 3 residents (R45) reviewed		Resident R 45 s care plan was updated on 6/4/2014. All other resident s were reviewed and r other resident s were affected by this practice.	

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		AND HUMAN SERVICES			FORM	06/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · /	E SURVEY PLETED
		245396	B. WING		05/ [,]	16/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	Continued From pa	ige 8	F 242			
	Findings include: R45's annual Minim 3/6/14, included modiagnoses of a stro- indicated R45 requioversight, or encour assistance with me Well-being Care Ar 3/6/14, included, "/ positivelystaff will conditions, etc whice R45's annual Nutriti included, "Family meals when he was R45's cognition car he was able to exp directed staff to; "A to make his own AI decisions. The beff may touch staff sex comments related to were directed, "Wh behavior-redirect ha nutrition care plan of ensure twice a day consume food. The R45 should be allow according to his cur During observation nursing assistant (fan evening meal tra on top of the covers	hum Data Set (MDS) dated oderate cognitive impairment, ke and depression. The MDS ired supervision, cueing, iragement and set up als. R45's Psychosocial ea Assessment (CAA) dated Approach [R45] warmly and It talk about road and weather ch brings a smile to his face." ion Review dated 3/13/14, eports he typically ate two s home." re plan dated 3/17/14, included ress his wants/needs, and Allow additional time for [R45] DL [activities of daily living] havior care plan indicated R45 cually or make sexual to depression and mood. Staff hen inappropriate touch as been successful." The dated 3/19/14, included to offer and allow ample time to e care plan failed to indicate wed to refuse a meal		Education was provided to staff or 5/29/14 and 6/10/2014 regarding rights. The orientation checklist w updated to include review of resid rights upon hire. Audits will be performed at each r weeks by the charge nurse or her designee to monitor for resident c and rights regarding meal choice. These audits will be reviewed and evaluated by the Director of Nursi her designee and the results of th audits brought forward to the QPS committee. Completion Date 6/25/2014.	resident /as ent neal x 2 hoice ng or ese	

If continuation sheet Page 9 of 24

	-				-	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		<u>0938-0391</u> E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	PLETED
		245396	B. WING		05/	16/2014
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			5	25 WEST MAIN STREET		
CENTRA	CARE REALIN STS	TEM - MELROSE PINE VILLA C C	N	IELROSE, MN 56352		
(X4) ID		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
		,	TAG	DEFICIENCY)		
F 242	• • • • • • • • • • • • • • • • • • •	-	F 242			
		I have to fight with you all the				
		ted pull R45's lower legs to the				
		45 resisted this and stated,				
		eat." NA-A continued to pull				
		s while he was resisting being A stated, "Your being naughty,				
		e me go get the nurse on you,				
		e trying to sit him up by pulling				
	2	g arm behind his back, NA-A				
	stated, "Come on, you are so stubborn." R45 pointed to the surveyor and told NA-A, "Look she					
		wn. "NA-A stated, "You're				
		ble now." NA-A continued to				
		I5 to sit up, R45 then started				
		vith his hands, without making at her. NA-A stated, "That is				
		u know that is not appropriate.				
		, stating to the surveyor, "He				
		ne." NA-A stopped a nurse in				
		ked her to come back to R45's				
		hen the nurse got a chance.				
		e room and tried to force him				
		ulling his legs over and				
		is back up, R45 continued to				
		d not want to eat. NA-A lets' sit up, at least drink your				
		, "Where's the chocolate				
		him there wasn't any on his				
		arted grabbing towards NA-A's				
		old him that was inappropriate				
		NA-A asked another nurse				
		. NA-A left the area with the				
		NA-A did not offer any				
	chocolate milk.					
	When interviewed	n 5/12/14 at 6:09 n m $B45$				
		on 5/12/14, at 6:08 p.m. R45 bully a guy when he doesn't				
		A re-entered R45's room at				
		nd asked R45 if he wanted				
	567(02-99) Previous Versions		. –	sility ID: 00633		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00633

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PRINTED: 06/10/2014 FORM APPROVED OMB NO 0938-0391

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245396			05	14 6/204 4
NAME OF	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CC		6/16/2014
CENTRA	CARE HEALTH SYS	TEM - MELROSE PINE VILLA C O	;	525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 242	anything from his ti would like anything and NA-A removed room with it. R45 ti aint hungry, they try this upsets him and people treated him guy doesn't eat is w R45 stated some of refuse certain mea During observation consented to going had eaten about ha eat lunch at 12:05 p choice. When interviewed of director of nursing in resident rights an honored R45's right When interviewed of registered dietician of meals, however, milk or chocolate e it was customary for day and this choice Staff should contine each meal, but not been care planned When interviewed of DON stated she ha usually she can ge something by helpi to sit up. R45 had NA-A's breasts, no	ray left in his room or if he else. R45 stated he did not, I the meal tray and left the hen stated, "When a person y to force you." R45 stated d makes him feel bad. Most well, but others, "when a vhen they treat a guy rough." f the staff respect his wish to ls, others do not. on 5/14/14, at 8:07 a.m. R45 to breakfast and by 8:15 a.m. alf of his meal. R45 declined to p.m. and NA-F respected this on 5/14/14, at 2:00 p.m. the (DON) stated staff are trained nnually. NA-A should have t to refuse the meal tray. on 5/15/14, at 8:41 a.m. the (RD) stated R45 refuses a lot he will usually take chocolate nsure. R45's family indicated or R45 to only eat two meals a e should be honored by staff. ue to offer and encourage attempt to force. This had not		242		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 06/10/2014 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY OMPLETED
		245396	B. WING			5/16/2014
	PROVIDER OR SUPPLIER	EM - MELROSE PINE VILLA C C		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 WEST MAIN STREET ELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 F 281 SS=D	7/8/14, and provide The facility policy er Combined Federal Rights, dated 2/14, the facility has a rig self-determination . resident rights upor proactively promote Under Dignity, inclu courtesy promote a and environment th dignity and respect individuality. "Unc included, "You hav activities, schedules choices about aspet that are significant 483.20(k)(3)(i) SER PROFESSIONAL S The services provio must meet professi This REQUIREMEN by: Based on observat review, the facility for	uring new hire orientation on d documentation of this. ntitled, Your Rights Under The and Minnesota Resident Bill of included, "Each resident of ht to a dignified existence, All staff will be oriented to hire, and shall protect and the rights of each resident. " ded, "The facility must with nd care for you in a manner at maintains or enhances your in full recognition of your ler Self-Determination we the right to choose s, and health careand make cts of your life in the facility to you. " VICES PROVIDED MEET STANDARDS led or arranged by the facility onal standards of quality. NT is not met as evidenced ion, interview and document ailed to follow the standard of nistering medications for 1 of eviewed during medication	F 2		TMA-A was aware that Resident R-65 should have been observed while taking her medications. A medication error incident report was completed on 5/13/2014 Education to all TMA s and nursing sta was provided at a staff meeting on	
		on 5/12/2014 at 5:15 p.m., istant (TMA)-A gathered R65's			5/29/2014. A review of the medication administration policy was completed. Minutes from this meeting were placed	n

Facility ID: 00633

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FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	E SURVEY
		A. BUILDIN	G	CON	MPLETED
	245396	B. WING _		05	/16/2014
ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH SYST	EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE
inued From pa	age 12	F 28	1		
medications, w hin D-3 and Va -A crushed the ly. TMA-A stop lent meal trays -A removed Re then removed e of toast from which contain- t, re-wrapped t ood back on R pushed the for ed it in the hall sician's orders im 2 mg by mout ly, on toast. Co a day every M hed, mixed with history mout to "disguise" the ications. TMA mixed in jelly, -A said such w ain people and dication] into [R s medications r, and mixed ir -A also said "w	which included Coumadin, lium, from the med cart. e medications, and mixed them pped the food cart, which held , just outside the dining area. 65's meal tray from the cart, and opened a foil-wrapped R65's tray. TMA-A spread the ed the medications, on the he toast in the foil, and placed 65's food tray. A dietary aide od cart down the hallway and way, near the dining area. dated 4-22-14 indicated: buth one time a day related to positional vertigo. Vitamin D3, h one time a day crush, place bumadin 2.5 mg by mouth one onday, Wednesday and Friday h jelly on toast with supper. 5/12/2014 at 5:15 p.m., TMA-A were routinely put in R65's hem, or else [R65] refuses -A also said after medication it was spread on R65's toast. vas "normal practice" with was the best way to get 265's] system. TMA-A stated were crushed, diluted in a little n jelly and spread on toast. ve can't do this in front of	F 28	the communication book. Medication Administration Audit completed weekly X 2 months of system is in place by the Direct nursing or her designee Results of these audits will be r and evaluated by the Director of	or until or of eviewed f Nursing	
	tinued From paramedications, which contains and varamedications, which contains then removed Related then removed Related then removed Related then removed Related to a contains then removed to a contains the removed to a contains the removed to a contains by moute a day every Med, mixed with the contains to "disguise" the removed to a contains to "disguise" the removed to a context of the contains to "disguise" the removed to a context on the contains to "disguise" the removed to a context on the context on th	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 12 medications, which included Coumadin, nin D-3 and Valium, from the med cart. A crushed the medications, and mixed them I/y. TMA-A stopped the food cart, which held hent meal trays, just outside the dining area. A removed R65's meal tray from the cart, then removed and opened a foil-wrapped e of toast from R65's tray. TMA-A spread the which contained the medications, on the t, re-wrapped the toast in the foil, and placed ood back on R65's food tray. A dietary aide pushed the food cart down the hallway and ed it in the hallway, near the dining area. 	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG tinued From page 12 F 28 medications, which included Coumadin, nin D-3 and Valium, from the med cart.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SINC (EACH CORRECTIVE ACTION SINC CROSS-REFERENCED TO THE APP DEFICIENCY) tinued From page 12 F 281 medications, which included Coumadin, nin D-3 and Valium, from the med cart. F 281 -A removed R65's meal tray from the cart, then removed and opened a foil-wrapped e of toast from R65's tray. TMA-A spread the which contained the medications, on the t, re-wrapped the toast in the foil, and placed oud back on R65's food tray. A dietary aide pushed the food cart down the hallway and ed it in the hallway, near the dining area. F 281 sician's orders dated 4-22-14 indicated: im 2 mg by mouth one time a day related to gn paroxysmal positional vertigo. Vitamin D3, 0 units by mouth one time a day crush, place ly, on toast. Coumadin 2.5 mg by mouth one a day every Monday, Wednesday and Friday hed, mixed with jelly on toast with supper. Completion Date 6/18/2014 n interview on 5/12/2014 at 5:15 p.m., TMA-A ad medications were routinely put in R65's to "diguise" them, or else [R65] refuses ications. TMA-A assid after medication mixed in jelly, it was spread on R65's toast. -A also said "we can't do this in front of .), otherwise shell catch on." TMA-A said were trained" to administra [R65's] meds this and the medication administration record	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL (EQUATORY OR LSC IDENTIFYING INFORMATION) tinued From page 12 medications, which included Cournadin, hin D-3 and Valium, from the med cart, ch crushed the medications, and mixed them ly. TMA-A stopped the food cart, which held tent meal trays, just outside the dining area. A removed R65's meal tray from the cart, then removed and opened a foil-wrapped e of toast from R65's tray. TMA-A spread the which contained the medications, on the t, re-wrapped the toast in the foil, and placed go back on R65's tray. TMA-A spread the bod back on R65's tray. TMA-A spread the sician's orders dated 4-22-14 indicated: Im 2 mg by mouth one time a day related to gn paroxysmal positional vertigo. Vitamin D3, 0 units by mouth one time a day related to gn paroxysmal positional vertigo. Vitamin D3, 0 units by mouth one time a day related to gn paroxysmal positional vertigo. Vitamin D3, 0 units by mouth one time a day related to gn paroxysmal positional vertigo. Vitamin D3, 0 units by mouth one time a day related to to "disguise" them, or else [R65's tray. 1 interview on 5/12/2014 at 5:15 p.m., TMA-A ad medications were routinely put in R65's ications. TMA-A also said after medication mixed in jelly, it was spread on R65's toast. -A said such was "normal practice" with ain people and was the best way to get dication jick to this in front of 1), otherwise shell cath on.," TMA-A said were trained" to administration record

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED	
		245396	B. WING _			05/ [,]	16/2014	
NAME OF I	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		-	25 WEST MAIN STREET ELROSE, MN 56352			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	r.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I SHOULD BE COMPLÉTIO		
F 281	At 5:28 p.m., nursin food cart, with R65' the activity area, wh dining area. At 5:33 removed R65's tray meal. R65 unwrapp two halves, and pla p.m., R65 took a bit eat her other food it a knife to pick smal medications out of those picked-out pic unconsumed. The the medications, wa TMA-A, during the of licensed practical n "normal practice", a administer R65's m jelly and spread on "what was needed" "trying to poison he discussed for R65 a departments, includ and social services have "stayed with a until R65 consumed During an interview the director of nursi medication on the to take it." In an interview on 5 worker (LSW)-A sta	t with the medication. Ig assistant (NA)-F moved the s tray, from the hallway into hich was also served as a 3 p.m., activity aide (AA)-A from the cart, and served the ped the toast, separated the ced them on her tray. At 5:40 te of toast, and continued to tems. At 5:49 p.m., R65 used I, white pieces of the crushed the jelly on her toast. R65 left eces on her plate, jelly-spread toast, containing as not supervised by the entirety of the evening meal. I/12/2014 at 6:25 p.m., urse (LPN)-C said it was the and "ordered in the MAR" to edications crushed, mixed in toast. LPN-C said it was as R65 thinks the staff are r." LPN-C said this had been among staff from various ling nursing, dietary, activities . LPN-C said staff should nd followed" the medication	F 28	31				

	MENT OF HEALTH						RINTED: 06/10/20 FORM APPROVE MB NO. 0938-03	ED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIC	IPPLIER/CLIA		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		2453	396	B. WING _			05/16/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY			
CENTRA	CARE HEALTH SYST	EM - MELROSE	PINE VILLA C C		525 WEST MAIN STREE MELROSE, MN 5635			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE ' MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	Л
F 281	Continued From pa food nor was this pr conference." In an interview on 5 consulting pharmad to be watched wher valium unattended with." In an interview on 5 attending physician R65's valium be put toast. A standard of practi Agency for Healthca (April 10, 2009), ide management guide administer and obs medication." A facility policy "Meu unlicensed personn 2013, indicated a m "in-house" orientation administration of m demonstrate the ab administer the med to assure the reside	A constraints of the second se	05 a.m., the alium "needs ' Leaving and to argue 5 p.m., R65's tended that ead over R65's ced by The nd Quality e medication cation "is to be nt takes stration by dated February omplete an he successfully ntly and safely tration, Oral er #7 ' the resident	F 28		JEFIGIENCY)		
F 285 SS=D	medication. 483.20(m), 483.20(FOR MI & MR A facility must coord	e) PASRR REQ	UIREMENTS	F 28	35		6/25/14	
FORM CMS-25	567(02-99) Previous Versions		Event ID:2YUS1	1	Facility ID: 00633	If continuati	on sheet Page 15 of	f 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER 245396 B. WING 05/16/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05/16/201			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/10/2014 APPROVED . 0938-0391
03/10/201	STATEMENT			. ,		(X3) DAT	E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			245396	B. WING		05/	'16/2014
	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C 525 WEST MAIN STREET MELROSE, MN 56352	CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
 F 285 Continued From page 15 pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires that retardation, a defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation. (i) Mental retardation, as defined in paragraph (m)(2)(ii) of the individual requires the level of services for mental retardation. (i) Mental retardation, as defined in paragraph (m)(2)(ii) of the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services provided by a nursing facility; and (B) The the individual requires such level of services provided by a nursing facility; and (B) The individual requires such level of services provided by a nursing facility; and (B) The individual requires such level of services provided by a nursing facility; and (B) The individual requires such level of services provided by a nursing facility; and (B) The individual requires such level of services provided by a nursing facility; and (B) If the individual requires such level of services for mental retardation. For purposes of this section: (I) An individual is considered to have "mental illness defined at §483.	F 285	pre-admission scree program under Meo the maximum exter duplicative testing a A nursing facility mu January 1, 1989, an (i) Mental illness a (i) of this section, un authority has detern independent physic performed by a pers State mental health (A) That, becaus condition of the indi- the level of services and (B) If the individu services, whether the specialized services (ii) Mental retardated (m)(2)(ii) of this sec- retardation or devel has determined price (A) That, becaus condition of the indi- the level of services and (B) If the individue services, whether the specialized services and (B) If the individue services, whether the specialized services and (B) If the individue services, whether the specialized services and (B) If the individue services of this (i) An individual is illness defined at §4 (ii) An individual is	ening and resident review dicaid in part 483, subpart C to and effort. ust not admit, on or after by new residents with: s defined in paragraph (m)(2) nless the State mental health nined, based on an al and mental evaluation son or entity other than the authority, prior to admission; e of the physical and mental vidual, the individual requires s provided by a nursing facility; al requires such level of he individual requires s for mental retardation. tion, as defined in paragraph tion, unless the State mental lopmental disability authority or to admission e of the physical and mental vidual, the individual requires s for mental retardation. tion, as defined in paragraph tion, unless the State mental lopmental disability authority or to admission e of the physical and mental vidual, the individual requires s provided by a nursing facility; al requires such level of he individual requires s for mental retardation. as section: considered to have "mental lual has a serious mental la83.102(b)(1). considered to be "mentally	F 28			

				NTED: 06/10/20 FORM APPROVE <u>B NO. 0938-03</u>			
		. ,		X3) DATE SURVEY COMPLETED			
	245396	B. WING		05/16/2014			
PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			525 WEST MAIN STREET MELROSE, MN 56352				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG					
defined in §483.102 related condition as This REQUIREMEN by: Based on interview facility failed to ensi Screening and Res screening was com specialized services reviewed for PASRI who had diagnoses Findings include: R33 was admitted t most current diagno admission history a 3/15/14, revealed a R33's OBRA level I developmental disa 6/24/09 identified u section, "Does the p mental retardation of was check marked, read, "Has this pers have mental retardat The form was chec questions were ans this section the form answered yes to an	2(b)(3) or is a person with a a described in 42 CFR 1009. NT is not met as evidenced and document review, the ure a Level II (Preadmission ident Review) PASRR pleted to determine need for s for 1 of 1 residents (R33) R pre-admission screening of a developmental disability. to the facility on 6/09. R33's pses, according to his nd physician orders, dated diagnosis of mental disorder. PASRR screening for abilities or mental illness, dated under the Mental Retardation person had a diagnosis of or related condition?" The form , "yes". The next question son even been considered to ation or related condition?" k marked "yes". The next two swered "No." On the bottom of n reads, "If you have by of the previous questions,	F 285	A call was placed to Stearns County social services requesting a level II f Resident R33 on May 19, 2014 and 6/4/2014. A level II PASSR will be completed on Resident R33. A chart audit will be completed to en- that all residents requiring a Level II one completed. Social Services will monitor every Le screening and will document any discrepancies in Level I screenings a address with the county. The Social Service manager will be responsible this monitoring. The results of this monitoring will be	or on sure have evel I and for			
	RS FOR MEDICARE OF DEFICIENCIES OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CARE HEALTH SYST SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pathers defined in §483.102 related condition as This REQUIREMEND by: Based on interview facility failed to ens Screening and Res screening was com specialized services reviewed for PASRI who had diagnoses Findings include: R33 was admitted to most current diagno admission history at 3/15/14, revealed at R33's OBRA level I developmental disation of 6/24/09 identified up section, "Does the p mental retardation of was check marked, read, "Has this pers have mental retardation of was check marked, read, "Has this pers have mental retardation of with development of	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245396 PROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II (Preadmission Screening and Resident Review) PASRR screening was completed to determine need for specialized services for 1 of 1 residents (R33) reviewed for PASRR pre-admission screening who had diagnoses of a developmental disability.	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 245396 B. WING PROVIDER OR SUPPLIER 245396 CARE HEALTH SYSTEM - MELROSE PINE VILLA C C ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 16 defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. F 285 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II (Preadmission Screening and Resident Review) PASRR screening was completed to determine need for specialized services for 1 of 1 residents (R33) reviewed for PASRR pre-admission screening who had diagnoses of a developmental disability. Findings include: R33 was admitted to the facility on 6/09. R33's most current diagnoses, according to his admission history and physician orders, dated 3/15/14, revealed a diagnosis of mental disorder. R33's OBRA level I PASRR screening for developmental disabilities or mental illness, dated 6/24/09 identified under the Mental Retardation section, "Does the person had a diagnosis of mental retardation or related condition?" The form was check marked, "yes". The next question read, "Has this person even been considered to have mental retardation or related condition?" The form was check marked "yes". On the bottom of this section the form reads, "If you have answered yes to any of the previous questions, refer the person to the county offices for perso	MENT OF HEALTH AND HUMAN SERVICES OM SF FOR MEDICARE & MEDICAID SERVICES OM OF DEFICIENCIES (X) PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER 245396 B. WING CARE HEALTH SYSTEM - MELROSE PINE VILLA CC STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG Continued From page 16 defined in \$483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. F 285 This REQUIREMENT is not met as evidenced by: F 285 Screening was completed to determine need for specialized services for 1 of 1 residents (R33) reviewed for PASRR pre-admission screening who had diagnoses of a developmental disability. A call was placed to Stearns Countly social services will monitor every LE social Service manager will be responsible this section the Metal Reta			

If continuation sheet Page 17 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			E SURVEY
				G		
		245396	B. WING _		05/	16/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		MELROSE, MN 56352		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
F 285		47		_		
F 200	Continued From pa	ge 17	F 28	5		
	services.					
		5/15/14, at 10:45 a.m. the				
		ocial worker (LSW)-A said "we				
		chart that a level II was done. I Stearns County to check on				
		ere since 6/09 and Stearns				
		sible for the Level II PASRR				
	screenings.					
	On 5/15/14 at 1:48	p.m. LSW-A stated she talked				
	to the county social	worker and they said the				
		troyed in 2009 and would be				
	anything they can d	pervisor to see if there is o now.				
	On 5/15/14 at 2:42	p.m. the director of nursing				
		vare R33 needed to have a				
	level II PASRR com	pleted.				
	During interview wit	h Stearns County, on 5/23/14				
	at 1:30 p.m., the Ste	earns County Worker-A				
		SRR screen should have ased on the Level I PASRR				
		ring the two "yes" questions.				
F 371	483.35(i) FOOD PR	OCURE,	F 37	1		6/18/14
SS=E	STORE/PREPARE/	SERVE - SANITARY				
	The facility must -					
		m sources approved or				
		tory by Federal, State or local				
	authorities; and	distribute and serve food				
	under sanitary conc					
	, <u>,</u>					

Facility ID: 00633

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		AND HUMAN SERVICES				FORM	06/10/2014 APPROVED 0938-0391
			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245396	B. WING			05/1	16/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C			25 WEST MAIN STREET IELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 18	F	371			
	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store and reheat food properly for 1 of 2 residents (R2) who had a late meal tray; failed to ensure staff handled food with their bare hands for 1 of 4 residents (16) observed being fed by staff. In addition, the facility failed to place systems to ensure expired and old food was discarded for 1 of 3 resident unit facility refrigerators, which was located on the secured unit. This had the potential to affect all 27 residents who resided on the secure unit. Findings include: REHEAT FOOD PROPERLY During observation on 5/13/14, at 1:30 p.m. there were two resident (R2, R3) meal trays noted in the secure dementia unit dining room after the noon meal. The trays were on the top of the stove in the activity/dining room and each contained mashed potatoes, gravy, and mixed vegetables, along with beverage cups. The meal plates were cool to touch. When asked, the dietary manager (DM) stated she did not know who the trays belonged to as there was no name on either tray. Licensed practical nurse (LPN)-A stated the trays belonged to R2 and R3 and both residents had refused to get up from their nap for lunch, and the food tray would be reheated and served once they were up. Nursing assistant (NA)-B entered the dining room on 5/13/14, at 1:49 p.m. and took one of the plates of food and placed it in the microwave for one minute. NA-B then left the dining room,				The Nutrition Service Dept policy, I Trays and Hold Trays was updated 14. Policy states that if a nursing h resident is not at the table when the are passed out, the tray will be brou- back to the kitchen and disposed. the resident is ready for their meal, nursing will call the kitchen and a n- dished up. The Nutrition Service Dept policy, M Service was updated 6-2-14 to inclu- utensils or gloved hands are used t prepare foods. The Nursing Depa Feeding Residents policy was upda 5/20/2014 to include no bare food handling. The Nutrition Service Dept policy, Sanitation was updated 5-19-14. Cleaning of refrigerators located ou department was added. Dietary sta cleans the refrigerator in the Pine H dining room twice per week; nursing are responsible for all other refriger in the nursing home. The above stated policy changes w affect all residents. Dietary Staff are educated on the u policies at staff meeting on 6-3-14. will initial the cleaning schedule who duties are completed. Nursing staff educated on 5/29/2014 and 6/10/20 Orientation checklist for new staff w updated to include no bare handling food while feeding residents. Audit meals will be daily x 2 weeks or unt system is in place for appropriate s	5-19- ome e trays ught When ew tray Aeal ude o rtment ated on at of the aff laven g staff rators rill pdated Staff en were 014. vas g of s of til	

CENTERS FOR MEDICARE & MEDICAID SERVICES			(X2) MULT		E CONSTRUCTION	OMB NO. 0938-03	
	PLAN OF CORRECTION IDENTIFICATION NUMBER: 245396		A. BUILDING			COMPLETED	
			B. WING _			05/16/2014	
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C				ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
			;		25 WEST MAIN STREET ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 371	Continued From pa	ige 19	F 37	71			
	 to the dining room with R2 at 1:57 p.m. and without first checking the temperature of the reheated food, NA-B served the plate to R2. The surveyor stopped NA-B who verified the plate of food had sat out at room temperature since approximately 11:45 a.m. and she only reheated the food for one minute in the microwave and did not check to the temperature of the food to ensure it had reached 165 degrees Fahrenheit for 15 seconds before serving the meal to R2. When interviewed on 5/13/14, at 2:00 p.m. LPN-B stated staff should have placed R2's tray in the refrigerator to store it until R2 was ready to eat. The meal trays should not be out for more than half an hour. She was unsure how long the food should have been heated, or to what temperature. When interviewed on 5/15/14, at 9:40 a.m. the 				and handling of food and food trave Audits of the weekly refrigerator cle duties will be completed by the LTC Director or her designee. The Dietary Manager and/or the N Services Dept manager monitor completion of duties for dietary sta LTC Director or her designee will n results of the nursing audits. All re will be evaluated and brought forwa the QPS committee. Corrective action completed 6/18/2	eaning utrition ff. The nonitor sults ard to	
	or reheat foods on resident's eating, th the kitchen for prop	ated nursing should not store the unit. If there is a delay in he tray should be returned to ber storing and reheating.					
	under number 6, "lan internal tempera	n policy dated 7/13, included Leftovers are rapidly heated to ature of 165 degrees F her and served immediately."					
	included, "A hold ti meal refrigerated a	old Trays policy dated 9/13, ay will have all items from a s needed until a call is ill be heated to serving					
	Refrigerator storag	e in locked unit's dining room					
			1				

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		& MEDICAID SERVICES				OMB NO. 0938-03 (X3) DATE SURVEY		
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
	245396		B. WING		05	6/16/2014		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE				
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 371	Continued From pa	age 20	F 37	1				
	locked unit's dining to contain the follow section were two has an unsealed, undat curds," and a bag which had frost coa the bags. The rhuk a year ago. In the sealed sour cream 3/10/14 and 3/17/1 and two uncovered undated. In addition cream, undated, in a zip top bag labele appeared to be dor hard. In addition, the water, one of which	room refrigerator was noted wing items: In the freezer alf loaves of bread, undated, ted bag labeled, "cheese labeled, "rhubarb," all of ating the food, on the inside of parb was dated 5/23/13, almost refrigerator section was 11 packets with use by date of 4, two uncovered dessert bars, containers of Jell-O, all on there was a bag of whipped a piping container, as well as ed, "PH snack 5/10," which but holes, but they were very here were two bottles of grape of was opened and half gone, it h a name, or dated.						
	DM stated dietary a with resident snack routinely, however, ensuring outdated discarded. DM sta	on 5/13/14, at 1:40 p.m. the aides stock this refrigerator a items and beverages dietary is not responsible for or old food items are ted the activity staff access d they would be responsible						
	activity director (AE been an activity on when. However, of were not activity sta	on 5/13/14, at 1:47 a.m. the b) stated the cheese curds had the unit, she did not recall ther items in the refrigerator aff responsibility and thought esponsible for this refrigerator.						
		on 5/13/14, at 2:00 p.m. LPN-B						

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		AND HUMAN SERVICES				FORM	06/10/2014 APPROVED 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245396	B. WING	;		05/ [,]	16/2014
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C			25 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	DON stated the refi room refrigerator w dietary. The DON w was activities responsibility of BARE HAND CON On 5/12/14 at 6:02 D was observed fe slice of white bread bare hands and feo not use gloves or si their bread. On 5/16/14, at 9:39 (RD) said staff shou bare hands but wer when feeding reside hire, were given ed items on the reside On 5/16/14, at 9:46 verified staff are no hands. Review of the faciliti revised 2/2013, did not handle food with SECURED UNIT R During observation on 5/14/14, at 7:14	on 5/13/14, at 2:15 p.m. the rigerator storage in the dining ould be the responsibility of was informed dietary stated it onsibility to discard sems, activities stated it was bility, and nursing said it was i dietary. TACT p.m. nursing assistant (NA) - eeding R16, and picked up a 1 from the plate with ungloved, 3 the bread to R16. NA-D did ilverware to assist R16 to eat 0 a.m. the registered dietitian uld not touch food with their re to "use gloves or silverware" ents. RD said when staff, upon ucation about preparing food nts's tray. 6 a.m. director of nurses (DON) at to pick up bread with bare ty policy, Feeding Resident, not address that staff should h their bare hands.		371			

Facility ID: 00633

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	NO. 0938-039 DATE SURVEY COMPLETED
			A. BUILDING	3	
		245396			05/16/2014
	PROVIDER OR SUPPLIER	EM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 371		ge 22 p of the egg carton had a note dated 4/22/14, 22 days ago.	F 371		
	any of the eggs. W R63 did not recall if any of the eggs. Th water, one which w as to who it belonge refrigerator is nursin however, there was or procedure of whe food items. She sta items for residents refrigerator also con	v if R63 had recently received then interviewed at 7:30 a.m. she had recently consumed ere were two bottles of grape as half empty and unlabeled ed to. LPN-B stated this ng staff 's responsibility; a no actual cleaning schedule en to remove any outdated ated family members bring in on the secured unit. The ntained several bags that were employee lunches/food, that abeled.			
F 465 SS=B	dated 7/13, included clean." A policy for was requested, but 483.70(h) SAFE/FUNCTIONA E ENVIRON	eiving and Storage of Food, d, "Refrigerators are kept r discarding old food items not provided by the facility. AL/SANITARY/COMFORTABL	F 465	5	6/25/14
	sanitary, and comforresidents, staff and This REQUIREMEN by: Based on observat	ortable environment for		The vents in the rooms 60, 54, 66, and 67 were cleaned. The sprinkler heads	
	maintenance and h necessary to ensur- heads were kept free	ousekeeping services e air flow vents and sprinkler ee of dust and debris for 4 of (60, 54, 66 and 67) reviewed.		room 54 and 67 were cleaned. All resident rooms vents will be assess and cleaned to ensure all vents are free dust and debris.	ed

Facility ID: 00633

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/10/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245396	B. WING		05/ [,]	16/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYST	EM - MELROSE PINE VILLA C C	_	25 WEST MAIN STREET IELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 465	Continued From pa Findings Include: During observation 5/15/14, at 10:00 a. director (MD) there visible dust and dirt 60, 66, 67. There v dust was on the fire and 67. The MD sa through the building a year the airflow ve time they will take th these "must have b "housekeeping will outside. A facility policy, Ven identified ventilation annually, and filters usually quarterly. Th	ge 23 of the facility environment on m. with the maintenance were airflow vents which had noted in resident rooms 54, vas also visible, heavily soiled e springer heads in rooms 54 id "twice a year" they go g and clean the vents and once ents are blown out. The next hem out to clean, and that een missed." He said clean the vents" on the multilation Policy, undated, n registers were cleaned semi- were changed as needed, he policy did not identify who cleaning the sprinkler heads,	TAG F 465	DEFICIENCY)	include neads in all putinely. vices vents lic ree of take e of the odated ng the esident th by ger will nonthly e	DATE

Facility ID: 00633

If continuation sheet Page 24 of 24

TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245396	B. WING)5/16/2014	
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C		525 W	ET ADDRESS, CITY, STATE, ZIP CODE /EST MAIN STREET ROSE, MN 56352		00/10/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	3	ко	00				
	FIRE SAFETY							
	ALLEGATION OF CO DEPARTMENT'S AC SIGNATURE AT THE PAGE OF THE CMS	C WILL SERVE AS YOUR DMPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST 2567 FORM WILL BE TION OF COMPLIANCE.						
	ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COM REGULATIONS HAS	AN ACCEPTABLE POC, AN YOUR FACILITY MAY BE ALIDATE THAT PLIANCE WITH THE BEEN ATTAINED IN H YOUR VERIFICATION.						
	Minnesota Departme Fire Marshal Division time of this survey, B Health System Melro to be in substantial or requirements for part Medicare/Medicaid a 483.70(a), Life Safety edition of National Fin	icipation in t 42 CFR, Subpart / from Fire, and the 2000 re Protection Association ety Code (LSC), Chapter 19						
	PLEASE RETURN T CORRECTION FOR DEFICIENCIES (K-T,	THE FIRE SAFETY						
	Health Care Fire Insp State Fire Marshal Di 445 Minnesota Stree St. Paul, MN 55101-5	ivision t, Suite 145						

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.

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE 0. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION D1 - Main Building 01		E SURVEY IPLETED	
		245396	B. WING		05/16/2014		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
K 000	Continued From page	e 1	K 000				
	By eMail to: Marian.Whitney@sta	te.mn.us					
		RECTION FOR EACH INCLUDE ALL OF THE MATION:					
	1. A description of what to correct the deficier	nat has been, or will be, done ncy.					
	2. The actual, or prop	oosed, completion date.					
	3. The name and/or t responsible for correc prevent a reoccurren	ction and monitoring to					
	(Pine Villa) was cons The original building one-story in height, h sprinklered, and was II(000) construction;	care Health System Melrose tructed as follows: was constructed in 1961, is as no basement, is fully determined to be of Type one-story in height, has no					
	The 1987 addition is basement, is fully spr determined to be of T The 1994 addition is basement, is fully spr	Type II(111) construction; one-story in height, has no rinklered, and was Type V(111) construction; one-story in height, has no					
	The facility has a fire detection in the corric corridors which is mo department notification	alarm system with smoke dors and spaces open to the unitored for automatic fire					

If continuation sheet Page 2 of 5

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ECONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE	
		245396	B. WING			05/	16/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VILLA C C			25 WEST MAIN STREET IELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page	2	к	000			
	The requirement at 42 NOT MET as evidence	2 CFR, Subpart 483.70(a) is ed by:					
K 052 SS=F		TY CODE STANDARD	K	052			
	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4						
	Based on observation facility failed to mainta system in accordance Chapter 9, Section 9. 19.3.4.1, and NFPA 7 7-3.2 and 7-5.2.2 and	6 and Chapter 19, Section 2 (1999 edition) Sections , Table 7-3.1. In a fire ient practice could adversely					
	FINDINGS INCLUDE	:					
	the facility's annual fir report dated 04/08/20 fire alarm boxes were however, no documer						

Facility ID: 00633

If continuation sheet Page 3 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/29/2014 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATI	E SURVEY PLETED	
		245396	B. WING		05	6/16/2014	
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C		525 WE	T ADDRESS, CITY, STATE, ZIP CODE Est main street OSE, MN 56352	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 052 K 144 SS=F	Devices. As such, it inspection and testing system had been pro This finding was conf manager. NFPA 101 LIFE SAFE	these Alarm Initiating could not be verified that g of the complete fire alarm perly conducted. irmed with the maintenance ETY CODE STANDARD cted weekly and exercised utes per month in	К 0				
	Based on observatio facility failed to maint (genset) in accordance NFPA 101 (2000) Cha NFPA 110 (1999). In this deficient practice 75 residents. FINDINGS INCLUDE On 05/16/2014 at 12: the facility's monthly in the "Small Engine" get twelve-month period,	20 PM, during a review of nspection and testing log for enset for the previous no documentation could be genset had been exercised					

Facility ID: 00633

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/29/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245396	B. WING		05/16/2014
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, Z 525 WEST MAIN STREET MELROSE, MN 56352	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
K 144	Continued From page nameplate rating. This finding was confi manager.	e 4	K	144	

Event ID: 2YUS21

Facility ID: 00633

If continuation sheet Page 5 of 5

TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 ADDITION		
		245396	B. WING		0	5/16/2014
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C	525	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET LROSE, MN 56352	· · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K 000			
	FIRE SAFETY					
	ALLEGATION OF CO DEPARTMENT'S AC SIGNATURE AT THE PAGE OF THE CMS- USED AS VERIFICA	C WILL SERVE AS YOUR OMPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST -2567 FORM WILL BE TION OF COMPLIANCE. AN ACCEPTABLE POC, AN				
	CONDUCTED TO VA SUBSTANTIAL COM REGULATIONS HAS	YOUR FACILITY MAY BE ALIDATE THAT PLIANCE WITH THE BEEN ATTAINED IN H YOUR VERIFICATION.				
	Minnesota Departme Fire Marshal Division time of this survey, B Health System Melro to be in substantial or requirements for part Medicare/Medicaid a 483.70(a), Life Safety edition of National Fin	icipation in t 42 CFR, Subpart / from Fire, and the 2000 re Protection Association ety Code (LSC), Chapter 18				
	PLEASE RETURN T CORRECTION FOR DEFICIENCIES (K-T,	THE FIRE SAFETY				
	Health Care Fire Insp State Fire Marshal Di 445 Minnesota Stree St. Paul, MN 55101-5	ivision t, Suite 145				

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2014 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 ADDITION			SURVEY PLETED
		245396	B. WING			05/16/2014	
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CENTRAC	ARE HEALTH SYSTEM	MELROSE PINE VILLA C C			525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
K 000	Continued From page	2 1	ĸ	000			
	By eMail to: Marian.Whitney@stat	e.mn.us					
		RECTION FOR EACH INCLUDE ALL OF THE MATION:					
	1. A description of wh to correct the deficien	at has been, or will be, done cy.					
	2. The actual, or prop	osed, completion date.					
	3. The name and/or ti responsible for correct prevent a reoccurrent	tion and monitoring to					
	(Pine Villa) consists of addition. The addition no basement, is fully	care Health System Melrose of the 2007 resident wing n is one-story in height, has sprinklered, and was ype V(111) construction.					
	detection in the corrid corridors which is mo department notification	alarm system with smoke lors and spaces open to the nitored for automatic fire on. The facility has a nd had a census of 75 at					
K 052	NOT MET as evidence	2 CFR, Subpart 483.70(a) is æd by: ETY CODE STANDARD	ĸ	052			
SS=F	A fire alarm system re installed, tested, and with NFPA 70 Nationa	equired for life safety is maintained in accordance al Electrical Code and NFPA in approved maintenance		002	-		

Facility ID: 00633

If continuation sheet Page 2 of 4

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/29/20 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 ADDITION		
		245396	B. WING		05/16/2014	
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VILLA C C		5 WEST MAIN STREET		
				ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO	
K 052	Continued From page	<u>,)</u>	K 050			
K 052		complying with applicable	K 052			
	requirements of NFPA	A 70 and 72. 9.6.1.4				
	Based on observation facility failed to mainta system in accordance Chapter 9, Section 9. 18.3.4.1, and NFPA 7 7-3.2 and 7-5.2.2 and	6 and Chapter 18, Section 2 (1999 edition) Sections , Table 7-3.1. In a fire				
	emergency, this defic affect 75 of 75 resider	ient practice could adversely nts.				
	FINDINGS INCLUDE	:				
	the facility's annual fir report dated 04/08/20 fire alarm boxes were however, no documen identifying the location outcomes for each of Devices. As such, it of	ns and functional testing these Alarm Initiating could not be verified that g of the complete fire alarm				
	This finding was confi manager.	rmed with the maintenance				
K 144	-	ETY CODE STANDARD	K 144			
SS=F	Generators are inspe- under load for 30 min	cted weekly and exercised				

Facility ID: 00633

If continuation sheet Page 3 of 4

		D HUMAN SERVICES				FORM	/ APPROVED
			(20) MUU				0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION 2 - 2007 ADDITION	(X3) DATE SURVEY COMPLETED	
		245396	B. WING			05/	16/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VILLA C C			25 WEST MAIN STREET IELROSE, MN 56352		
0(4) 15			10	, n			(15)
(X4) ID PREFIX			ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
K 144	Continued From page	23	ĸ	144			
		not met as evidenced by:					
		n and a staff interview, the ain the emergency generator					
	(genset) in accordance	e with the requirements at					
		apter 9, Section 9.1.3 and					
		a fire or other emergency, could adversely affect 75 of					
	75 residents.						
	FINDINGS INCLUDE	:					
	On 05/16/2014 at 12:	20 PM, during a review of					
	the facility's monthly i	nspection and testing log for					
	the "Small Engine" ge	•					
		no documentation could be genset had been exercised					
	monthly at not less th	-					
	nameplate rating.						
	This finding was confi manager.	rmed with the maintenance					

If continuation sheet Page 4 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO					
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245396	B. WING		05/16/2014
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
CENTRAC	ARE HEALTH SYSTEM	MELROSE PINE VILLA C C		25 WEST MAIN STREET IELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	as your allegation of o Department's accepta bottom of the first pag be used as verificatio Upon receipt of an ac revisit of your facility validate that substant	ance. Your signature at the ge of the CMS-2567 form will n of compliance. ceptable POC an on-site		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes. The assigned tag number appears in far left column entitled "ID Prefix Tag. The state statute/rule number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings wh are in violation of the state statute after the statement, "This Rule is not met a evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO	sing the " y/rule hich er s prs
				FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION I	
				VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	E
F 241 SS=D		ND RESPECT OF	F 241		6/25/14
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
Electroni	cally Signed				06/05/2014

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		G	CO	MPLETED
		245396	B. WING)5/16/2014
NAME OF PF	OVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CC	•	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 241	Continued From page	e 1	F 24	41		
	The facility must pror	note care for residents in a				
		vironment that maintains or				
	enhances each reside full recognition of his	ent's dignity and respect in or her individuality.				
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		on, interview, and document		Resident R45 does not reca		
	-	led to ensure residents was		Na-A was educated on resid	lent rights on	
	•	d respectfully, and in a staff during cares for 1 of 7		5/19/2014. No other residents were fou	nd to be	
		ares were observed during		affected.		
	the survey.			Education regarding resider	it rights was	
				completed to nursing staff o		
	Findings include:			5/29/2014 and 6/10/2014. A		
	R45's annual Minimu	m Data Set (MDS) dated		resident rights and meeting placed in the communication		
		erate cognitive impairment,		6/10/2014. The orientation		
		and depression, exhibited		updated to include education		
		such as poor appetite, feeling		Rights upon hire.		
		houghts of being better off		Audits observing staff for res	sident rights	
		he MDS indicated R45		and appropriate conversatio		
		cueing, oversight, or		conducted once a week by t		
	-	set up assistance with osocial Well-being Care Area		Supervisor for 2 months or u in place. Audits will also be	•	
		ated 3/6/14, included,		each meal for appropriate a		
	, ,	mly and positively staff will		conversation x 2 weeks or u	-	
	talk about road and w	veather conditions, etc which		in place. This audit will be c	completed by	
	brings a smile to his f	face."		the charge nurse or her des	-	
	D45's cognition core	plan dated 2/17/14 included		Results of these audits will b		
	-	plan dated 3/17/14, included ss his wants/needs, and		and evaluated by the Director and brought forward to the C		
		ow additional time for [R45]		Assurance (QPS) committee		
		[activities of daily living]		Completion Date: June 25th		
	decisions. The behave	vior care plan indicated R45				
	may touch staff sexua	-				
	comments related to	depression and mood. The				

Facility ID: 00633

If continuation sheet Page 2 of 21

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 07/29/2014 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		245396	B. WING		05/1	6/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	10/2014
				525 WEST MAIN STREET		
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
F 241	Continued From page	e 2	F 24	41		
	touch behavior-redire R45's annual Nutritio included, "Family rep meals when he was h During observation o nursing assistant (NA an evening meal tray on top of the covers, is time to eat." R45 stated in exasperatio with you all the time.' R45's lower legs to th resisted this and state NA-A continued to pu he was resisting bein stated, "Your being r me go get the nurse trying to sit him up by arm behind his back, you are so stubborn.' surveyor and told NA this down." NA-A tol in trouble now." NA- force R45 to sit up, R NA-A with his hands, used fowl language to "That is not appropria	ect has been successful." n Review dated 3/13/14, ports he typically ate two nome." n 5/12/14, at 6:02 p.m. N)-A entered R45's room with . R45 was lying on is back in his bed. NA-A stated, "It stated, "No." NA-A then n, "Come on, I have to fight ' NA-A started to pull he edge of the bed, R45 ed, "No, I don't want to eat." Ill on R45's lower legs while g sat up by her. NA-A haughty, your going to make on you, aren't you?" While y pulling on legs, and placing NA-A stated, "Come on,	F 24			
	surveyor, "He is like stopped a nurse in th	this all the time." NA-A e hallway and asked her to				
	nurse got a chance. and tried to force him	room to help her when the NA-A re-entered the room to sit up again by pulling his				
	continued to resist, s NA-A stated, "Come your juice." R45 ask	ting to pull his back up, R45 tating he did not want to eat. on lets' sit up, at least drink ted, "Where's the chocolate in there wasn't any on his				

Facility ID: 00633

If continuation sheet Page 3 of 21

PRINTED: 07/29/2014 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/29/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245396	B. WING			05/	16/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH SYSTEM	MELROSE PINE VILLA C C			25 WEST MAIN STREET //ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	tray. R45 again starter chest area, NA-A told and left the room. NA aide for assistance ar different nursing assis When interviewed on stated, "They only bu want to eat." NA-A re 6:09 p.m., alone, and anything from his tray would like anything el and NA-A removed the room with it. R45 the aint hungry, they try to this upsets him and m people treated him wo guy doesn't eat is whe When interviewed on director of nursing (D in resident rights annu- honored R45's right to When interviewed on registered dietician (F of meals, however, he milk or chocolate ens was customary for R4 day and this choice si Staff should encourage should not attempt to When interviewed on DON stated she had can get R45 to sit up helping him with his le R45 had attempted to	ed grabbing towards NA-A's him that was inappropriate A-A asked another nurse hd left the area with a stant. 5/12/14, at 6:08 p.m. R45 illy a guy when he doesn't e-entered R45's room at asked R45 if he wanted r left in his room or if he se. R45 stated he did not, he meal tray and left the n stated, "When a person to force you." R45 stated hakes him feel bad. Most ell, but others, "when a en they treat a guy rough." 5/14/14, at 2:00 p.m. the ON) stated staff are trained ually and NA-A should have to refuse the meal tray. 5/15/14, at 8:41 a.m. the RD) stated R45 refuses a lot e will usually take chocolate ure. R45's family told us it to only eat two meals a hould be honored by staff. ge R45 to eat, however, force him. 5/14/14, at 8:58 a.m. the spoken to NA-A who usually	F	241			

Facility ID: 00633

If continuation sheet Page 4 of 21

ATE			0/02 14/11		OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		245396	B. WING		05/16/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CENTRAC	ARE HEALTH SYSTEM	MELROSE PINE VILLA C C		25 WEST MAIN STREET IELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 241	resident rights during 7/8/13, and provided	ewed the facilities policy on new hire orientation on documentation of this.	F 241		
	Combined Federal ar Rights, dated 2/14, in the facility has a right self-determination A resident rights upon h proactively promote th Under Dignity, include courtesy promote and and environment that dignity and respect in individuality." Under included, "You have schedules, and health about aspects of your significant to you."	tled, Your Rights Under The ad Minnesota Resident Bill of cluded, " Each resident of to a dignified existence, All staff will be oriented to hire, and shall protect and he rights of each resident." ed, "The facility must with d care for you in a manner maintains or enhances your full recognition of your Self-Determination the right to choose activities, h careand make choices fife in the facility that are ERMINATION - RIGHT TO	F 242		6/25/14
	schedules, and health her interests, assess interact with members inside and outside the	right to choose activities, n care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that resident.			
	by:	is not met as evidenced			
	review, the facility fail	nt preferences of how often		Resident R 45 s care plan was update on 6/4/2014. All other resident s were reviewed and	

Facility ID: 00633

If continuation sheet Page 5 of 21

TATEMENT (MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE COMPLETED	
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		245396	B. WING		05/16/201	14
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMP THE APPROPRIATE D	X5) PLETIO ATE
F 242	Continued From page	e 5	F 24	2		
	for nutrition.			practice.		
	Findings include:			Education was provided to 5/29/14 and 6/10/2014 rega rights. The orientation che	arding resident	
	3/6/14, included mod diagnoses of a stroke indicated R45 require oversight, or encoura assistance with meals Well-being Care Area 3/6/14, included, "Ap positivelystaff will t	s. R45's Psychosocial Assessment (CAA) dated proach [R45] warmly and alk about road and weather		updated to include review of rights upon hire. Audits will be performed at weeks by the charge nurse designee to monitor for res and rights regarding meal of These audits will be review evaluated by the Director of her designee and the resul	each meal x 2 or her ident choice choice. ed and f Nursing or ts of these	
	R45's annual Nutrition	brings a smile to his face." n Review dated 3/13/14, ports he typically ate two nome."		audits brought forward to th committee. Completion Date 6/25/2014		
	he was able to expres directed staff to; "All to make his own ADL decisions. The behay may touch staff sexual comments related to were directed, "When behavior-redirect has nutrition care plan da ensure twice a day an	depression and mood. Staff n inappropriate touch been successful." The ted 3/19/14, included to offer nd allow ample time to care plan failed to indicate ed to refuse a meal				
	nursing assistant (NA an evening meal tray	n 5/12/14, at 6:02 p.m. \)-A entered R45's room with . R45 was lying on is back in his bed. NA-A stated, "It				

		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		245396	B. WING		0	5/16/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 242	Continued From page	e 6	F 242	2		
	stated, "Come on, I h time." NA-A started edge of the bed, R45 "No, I don't want to ea on R45's lower legs w sat up by her. NA-A your going to make m aren't you?" While to on legs, and placing a stated, "Come on, yo pointed to the survey is writing all this down going to be in trouble attempt to force R45 grabbing at NA-A with contact, and swore a not appropriate, you l "NA-A left the room, s is like this all the time the hallway and aske room to help her whe NA-A re-entered the to sit up again by pull attempting to pull his resist, stating he did us stated, "Come on let juice." R45 asked, " milk?" NA-A told him tray. R45 again start chest area, NA-A told and left the room. NA	back up, R45 continued to not want to eat. NA-A s' sit up, at least drink your "Where's the chocolate in there wasn't any on his ed grabbing towards NA-A's I him that was inappropriate A-A asked another nurse NA-A left the area with the				
	stated, "They only bu	5/12/14, at 6:08 p.m. R45 ully a guy when he doesn't e-entered R45's room at				

Facility ID: 00633

If continuation sheet Page 7 of 21

			0.00	E CONSTRUCTION		O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	E SURVEY IPLETED
		245396	B. WING		0	5/16/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 242	 6:09 p.m., alone, and anything from his tray would like anything e and NA-A removed th room with it. R45 the aint hungry, they try t this upsets him and n people treated him w guy doesn't eat is wh R45 stated some of th refuse certain meals, During observation of consented to going to had eaten about half eat lunch at 12:05 p.r choice. When interviewed on director of nursing (D in resident rights ann honored R45's right to When interviewed on registered dietician (F of meals, however, he milk or chocolate ens it was customary for I day and this choice s Staff should continue 	asked R45 if he wanted y left in his room or if he lse. R45 stated he did not, he meal tray and left the en stated, "When a person o force you." R45 stated hakes him feel bad. Most ell, but others, "when a en they treat a guy rough." he staff respect his wish to others do not. n 5/14/14, at 8:07 a.m. R45 o breakfast and by 8:15 a.m. of his meal. R45 declined to m. and NA-F respected this 5/14/14, at 2:00 p.m. the ON) stated staff are trained ually. NA-A should have o refuse the meal tray. 5/15/14, at 8:41 a.m. the RD) stated R45 refuses a lot e will usually take chocolate uure. R45's family indicated R45 to only eat two meals a hould be honored by staff. to offer and encourage tempt to force. This had not	F 243	2		
	DON stated she had usually she can get R something by helping to sit up. R45 had be	5/14/14, at 8:58 a.m. the spoken to NA-A who stated A45 to sit up and eat him with his legs to get him een attempting to grab it her during the episode on				

Facility ID: 00633

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245396	B. WING		05/16/2014
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 242	Continued From page		F 242		
	on resident rights dur	eviewed the facilities policy ing new hire orientation on documentation of this.			
F 281 SS=D	Combined Federal ar Rights, dated 2/14, in the facility has a right self-determination/ resident rights upon h proactively promote t Under Dignity, include courtesy promote and and environment that dignity and respect in individuality. " Unde included, " You have activities, schedules, choices about aspect that are significant to 483.20(k)(3)(i) SERV PROFESSIONAL ST.	the right to choose and health careand make ts of your life in the facility you. " ICES PROVIDED MEET	F 281		6/18/14
	by: Based on observatio review, the facility fai practice when admini 8 residents (R65) rev administration observ	□ is not met as evidenced on, interview and document led to follow the standard of istering medications for 1 of iewed during medication vation.		TMA-A was aware that Resident R-6 should have been observed while taki her medications. A medication error incident report was completed on 5/13/2014 Education to all TMA s and nursing s	ng
	Findings include: During observation o			was provided at a staff meeting on 5/29/2014. A review of the medication administration policy was completed.	

Event ID: 2YUS11

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			I ` '	PLETED
		245396	B. WING		05/	16/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRAC	CARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 281	Continued From page	9	F 28	1		
	oral medications, whi vitamin D-3 and Valiu TMA-A crushed the m in jelly. TMA-A stopp resident meal trays, ju TMA-A removed R65 and then removed an piece of toast from R6 jelly, which contained toast, re-wrapped the the food back on R65 then pushed the food parked it in the hallwa Physician's orders da Valium 2 mg by mout benign paroxysmal po 2000 units by mouth of in jelly, on toast. Cour time a day every Mor crushed, mixed with j	tant (TMA)-A gathered R65's ch included Coumadin, im, from the med cart. nedications, and mixed them ed the food cart, which held ust outside the dining area. 's meal tray from the cart, d opened a foil-wrapped 65's tray. TMA-A spread the the medications, on the toast in the foil, and placed cart down the hallway and ay, near the dining area. tted 4-22-14 indicated: h one time a day related to ositional vertigo. Vitamin D3, one time a day crush, place madin 2.5 mg by mouth one hday, Wednesday and Friday elly on toast with supper.		Minutes from this meeting were p the communication book. Medication Administration Audits completed weekly X 2 months or system is in place by the Director nursing or her designee Results of these audits will be rev and evaluated by the Director of N and brought forward to the QPS committee. Completion Date 6/18/2014	will be until of riewed	
	stated medications w food to "disguise" the medications. TMA-A was mixed in jelly, it w TMA-A said such was certain people and wa [medication] into [R65 R65's medications we water, and mixed in je TMA-A also said "we [R65], otherwise she' "we were trained" to a way, and the medicat (MAR) indicated to "d	2/2014 at 5:15 p.m., TMA-A ere routinely put in R65's m, or else [R65] refuses also said after medication was spread on R65's toast. s "normal practice" with as the best way to get 5's] system. TMA-A stated ere crushed, diluted in a little elly and spread on toast. can't do this in front of II catch on." TMA-A said administer [R65's] meds this cion administration record lo it that way." TMA-A said er the meal, or asked one of				

Facility ID: 00633

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				CONSTRUCTION		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		245396	B. WING		0	5/16/2014
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP COD	ΡE	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		25 WEST MAIN STREET ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 281	Continued From page	e 10	F 281			
	the nursing assistants R65 ate all the toast v	s to check and make sure with the medication.				
	food cart, with R65's the activity area, whic dining area. At 5:33	assistant (NA)-F moved the tray, from the hallway into ch was also served as a p.m., activity aide (AA)-A rom the cart, and served the				
	two halves, and place p.m., R65 took a bite eat her other food ite	ed the toast, separated the ed them on her tray. At 5:40 of toast, and continued to ms. At 5:49 p.m., R65 used				
	medications out of the those picked-out piec unconsumed. The je the medications, was	white pieces of the crushed e jelly on her toast. R65 left es on her plate, lly-spread toast, containing not supervised by the ntirety of the evening meal.				
	In an interview on 5/1 licensed practical nur	2/2014 at 6:25 p.m., se (LPN)-C said it was the				
	administer R65's med jelly and spread on to "what was needed" a "trying to poison her.'	d "ordered in the MAR" to dications crushed, mixed in bast. LPN-C said it was s R65 thinks the staff are ' LPN-C said this had been nong staff from various				
	departments, includin and social services.	ng nursing, dietary, activities LPN-C said staff should d followed" the medication				
	the director of nursing	n 5/12/2014 at 6:31 p.m., g (DON) said giving R65 ast "is the only way she will				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY IPLETED
		245396	B. WING		0	5/16/2014
		M - MELROSE PINE VILLA C C	52	REET ADDRESS, CITY, STATE, ZIP CC 5 WEST MAIN STREET		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ELROSE, MN 56352 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 281	food nor was this p conference." In an interview on S consulting pharmad to be watched when valium unattended with." In an interview on S attending physician R65's valium be put toast. A standard of pract Agency for Healthor (April 10, 2009), ide management guide administer and obs medication." A facility policy "Me unlicensed person 2013, indicated a m "in-house" orientati administer medicat A facility policy Med dated February 20' administer the medicat	5/14/2014 at 10:05 a.m., the cist stated that valium "needs in administered." Leaving and "alone is hard to argue 5/15/2015 at 2:45 p.m., R65's is stated it was intended that t in jelly and spread over R65's ice was referenced by The are Research and Quality entified under the medication elines, that medication "is to be erved as resident takes edication administration by hel (med tech), dated February hed tech must complete an on program on the edications and successfully willy to competently and safely	F 281			
F 285 SS=D	medication. 483.20(m), 483.20(FOR MI & MR	e) PASRR REQUIREMENTS	F 285			6/25/14

Facility ID: 00633

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PRINTED: 07/29/2014 FORM APPROVED

SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page facility must coordin re-admission screen rogram under Medica ne maximum extent p luplicative testing and nursing facility must anuary 1, 1989, any (i) Mental illness as of (i) Mental illness as of (i) of this section, unle unthority has determin ndependent physical performed by a person State mental health au	ate assessments with the ing and resident review aid in part 483, subpart C to practicable to avoid d effort. t not admit, on or after new residents with: defined in paragraph (m)(2) ess the State mental health ned, based on an and mental evaluation n or entity other than the		STREI		T 2 R'S PLAN OF C RECTIVE ACTIO	ORRECTION ON SHOULD	05, N BE	(X5) COMPLETIED
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SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page facility must coordin re-admission screen rogram under Medica ne maximum extent p luplicative testing and nursing facility must anuary 1, 1989, any (i) Mental illness as of (i) Mental illness as of (i) of this section, unle unthority has determin ndependent physical performed by a person State mental health au	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ate assessments with the ing and resident review aid in part 483, subpart C to practicable to avoid d effort. t not admit, on or after new residents with: defined in paragraph (m)(2) ess the State mental health hed, based on an and mental evaluation n or entity other than the	PREFIX	MEL	ROSE, MN 56352 PROVIDE (EACH CORE	2 R'S PLAN OF C RECTIVE ACTIC RENCED TO TH	ON SHOULD	BE	COMPLETIC
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A nursing facility must anuary 1, 1989, any (i) Mental illness as of the this section, unle authority has determin dependent physical performed by a person State mental health au	ing and resident review aid in part 483, subpart C to practicable to avoid d effort. t not admit, on or after new residents with: defined in paragraph (m)(2) ess the State mental health ned, based on an and mental evaluation n or entity other than the							
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(i) Mental illness as of (i) of this section, unle uuthority has determine ndependent physical performed by a person State mental health au	defined in paragraph (m)(2) ess the State mental health ned, based on an and mental evaluation n or entity other than the							
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uthority has determin ndependent physical erformed by a persor State mental health au	ned, based on an and mental evaluation n or entity other than the							
erformed by a persor State mental health au	n or entity other than the							
State mental health au								
(A) That, because c	of the physical and mental							
	dual, the individual requires							
	rovided by a nursing facility;							
	requires such level of							
,,,,,,								
	· · ·							
ind	novided by a nursing lacility;							
	requires such level of							
pecialized services for	or mental retardation.							
or purposes of this s	ection:							
(i) An individual is co	onsidered to have "mental							
	nd (B) If the individual ervices, whether the becialized services f ii) Mental retardation n)(2)(ii) of this section tardation or develop as determined prior (A) That, because of ondition of the individual ervices, whether the becialized services f or purposes of this s i) An individual is con- ness" if the individual mess defined at §483	nd (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. ii) Mental retardation, as defined in paragraph n)(2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental pondition of the individual, the individual requires e level of services provided by a nursing facility;	 and (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. ii) Mental retardation, as defined in paragraph (2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental bondition of the individual, the individual requires e level of services provided by a nursing facility; (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. brupposes of this section: (a) An individual is considered to have "mental ness" if the individual has a serious mental ness defined at §483.102(b)(1). 	 and (B) If the individual requires such level of ervices, whether the individual requires pecialized services for mental retardation. ii) Mental retardation, as defined in paragraph (2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental product of the individual, the individual requires e level of services provided by a nursing facility; (B) If the individual requires such level of ervices, whether the individual requires pecialized services for mental retardation. or purposes of this section: (a) An individual is considered to have "mental networks" 	 and (B) If the individual requires such level of ervices, whether the individual requires pecialized services for mental retardation. ii) Mental retardation, as defined in paragraph (2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental product of the individual, the individual requires e level of services provided by a nursing facility; (B) If the individual requires such level of ervices, whether the individual requires pecialized services for mental retardation. or purposes of this section: (a) An individual is considered to have "mental netses" if the individual has a serious mental 	nd (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. ii) Mental retardation, as defined in paragraph n)(2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental ondition of the individual, the individual requires e level of services provided by a nursing facility; nd (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. or purposes of this section: i) An individual is considered to have "mental ness" if the individual has a serious mental ness defined at §483.102(b)(1).	 and (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. ii) Mental retardation, as defined in paragraph (2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental bondition of the individual, the individual requires e level of services provided by a nursing facility; and (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. bor purposes of this section: i) An individual is considered to have "mental hess" if the individual has a serious mental hess defined at §483.102(b)(1). 	 (B) If the individual requires such level of ervices, whether the individual requires becialized services for mental retardation. ii) Mental retardation, as defined in paragraph (2)(ii) of this section, unless the State mental tardation or developmental disability authority as determined prior to admission (A) That, because of the physical and mental condition of the individual requires e level of services provided by a nursing facility; and (B) If the individual requires such level of ervices, whether the individual requires specialized services for mental retardation.

Facility ID: 00633

If continuation sheet Page 13 of 21

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245396	B. WING		05/16/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CENTRAC	CARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 285	Continued From page	e 13	F 28	15	
	-	dual is mentally retarded as			
		b)(3) or is a person with a			
		described in 42 CFR 1009.			
	This REQUIREMENT is not met as evidenced by:				
	Based on interview a facility failed to ensur	and document review, the re a Level II (Preadmission		A call was placed to Stearns Co social services requesting a leve	I II for
	Screening and Resid	-		Resident R33 on May 19, 2014 a	
		leted to determine need for		6/4/2014. A level II PASSR will b	be
	-	for 1 of 1 residents (R33) pre-admission screening		completed on Resident R33. A chart audit will be completed to	opouro
		of a developmental disability.		that all residents requiring a Leve	
	who had diagnoses e	a developmentar alsability.		one completed.	
	Findings include:			Social Services will monitor ever screening and will document any	
	R33 was admitted to	the facility on 6/09. R33's		discrepancies in Level I screenin	
	most current diagnos			address with the county. The Sc	
	admission history and	d physician orders, dated		Service manager will be respons	ible for
	3/15/14, revealed a d	liagnosis of mental disorder.		this monitoring.	
		ACDD correction for		The results of this monitoring wil	
	R33's OBRA level I F	ilities or mental illness, dated		brought forward to the QPS com meeting.	millee
		der the Mental Retardation		Completion Date: June 25th, 20	14
		erson had a diagnosis of			
		related condition?" The form			
	was check marked, "	yes". The next question			
		n even been considered to			
		ion or related condition?"			
		marked "yes". The next two			
	this section the form	rered "No." On the bottom of			
		of the previous questions,			
		e county offices for persons			
	-	abilities for evaluation and			
	determination of the				
		s no indication in the record			
	that R33 had receive	d a OBRA Level II PASRR			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/29/2014 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	LE CONSTRUCTION		(X3) DATE	1
		245396	B. WING		_	05/	16/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 285 F 371 SS=E	services. During interview on 5/ facility's licensed soci- couldn't find in his ch We are going to call S it". He has been here County was responsit screenings. On 5/15/14 at 1:48 p.t to the county social w paperwork was destro speaking to their supe anything they can do On 5/15/14 at 2:42 p.t said she was not awa level II PASRR comple During interview with at 1:30 p.m., the Stea verified a level II PASI been completed, base screening of answerin 483.35(i) FOOD PRO STORE/PREPARE/St The facility must - (1) Procure food from considered satisfactor authorities; and	 if R33 needed specialized (15/14, at 10:45 a.m. the al worker (LSW)-A said "we art that a level II was done. Stearns County to check on esince 6/09 and Stearns one for the Level II PASRR m. LSW-A stated she talked orker and they said the byed in 2009 and would be ervisor to see if there is now. m. the director of nursing re R33 needed to have a eted. Stearns County, on 5/23/14 rns County Worker-A RR screen should have ed on the Level I PASRR ng the two "yes" questions. CURE, ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food 	F 28	5	JEFICIENCY)		6/18/14

Event ID: 2YUS11

Facility ID: 00633

If continuation sheet Page 15 of 21

		MEDICAID SERVICES				<u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245396	B. WING _		0	5/16/2014
NAME OF PR	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, STATE, ZIP CC		
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C				525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From pag	je 15	F3	371		
	by: Based on observation review, the facility factorial properly for 1 of 2 representation meal tray; failed to be their bare hands for observed being fed to facility failed to place and old food was disulated unit facility refrigerant secured unit. This hactorial 27 residents who rest Findings include: REHEAT FOOD PRODUCE During observation of were two resident (Finder the secure dementian noon meal. The tray in the activity/dining mashed potatoes, gra along with beverage cool to touch. When (DM) stated she did belonged to as there Licensed practical means the secure and the secure of the secure and the secure of the secure and the secure cool to a sthere belonged to a sthere belong the secure and the secure and the secure of the secure and the secure of the secure and the secure of the secure and the secure and the secure of the secure of the secure and the secure of the secure	T is not met as evidenced on, interview, and document iled to store and reheat food sidents (R2) who had a late insure staff handled food with 1 of 4 residents (16) by staff. In addition, the e systems to ensure expired carded for 1 of 3 resident ors, which was located on the ad the potential to affect all sided on the secure unit.		The Nutrition Service Dept 1 Trays and Hold Trays was u 14. Policy states that if a nur resident is not at the table w are passed out, the tray will back to the kitchen and disp the resident is ready for thei nursing will call the kitchen a dished up. The Nutrition Service Dept p Service was updated 6-2-14 utensils or gloved hands are prepare foods. The Nursing Feeding Residents policy wa 5/20/2014 to include no bare handling. The Nutrition Service Dept p Sanitation was updated 5-19 Cleaning of refrigerators loc department was added. Die cleans the refrigerator in the dining room twice per week; are responsible for all other in the nursing home. The above stated policy cha affect all residents. Dietary Staff are educated o	pdated 5-19- irsing home then the trays be brought osed. When r meal, and a new tray policy, Meal to include e used to g Department as updated on e food policy, 0-14. ated out of the etary staff Pine Haven nursing staff refrigerators inges will	
	food tray would be re they were up. Nursing assistant (N on 5/13/14, at 1:49 p	m their nap for lunch, and the eheated and served once A)-B entered the dining room o.m. and took one of the aced it in the microwave for		policies at staff meeting on 6 will initial the cleaning scheo duties are completed. Nursin educated on 5/29/2014 and Orientation checklist for new updated to include no bare h food while feeding residents	lule when ng staff were 6/10/2014. / staff was nandling of	
		nen left the dining room,		meals will be daily x 2 weeks		

Facility ID: 00633

PRINTED: 07/29/2014 FORM APPROVED

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	· · ·	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245396			05/16/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRAC	CARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETIO	
F 371	Continued From pag	e 16	F 37	1		
	to the dining room wi without first checking reheated food, NA-B surveyor stopped NA food had sat out at re approximately 11:45 the food for one minu not check to the tem ensure it had reache 15 seconds before se When interviewed or stated staff should ha refrigerator to store if The meal trays shou half an hour. She wa should have been he temperature. When interviewed or dietary manager stat or reheat foods on th resident's eating, the the kitchen for prope A Food Preparation p under number 6, "Le an internal temperatu [Fahrenheit] or highe	n 5/15/14, at 9:40 a.m. the red nursing should not store be unit. If there is a delay in a tray should be returned to r storing and reheating. Poolicy dated 7/13, included effovers are rapidly heated to ure of 165 degrees F er and served immediately." Id Trays policy dated 9/13, ny will have all items from a		system is in place for appropriate and handling of food and food tr Audits of the weekly refrigerator duties will be completed by the L Director or her designee. The Dietary Manager and/or the Services Dept manager monitor completion of duties for dietary s LTC Director or her designee wil results of the nursing audits. All will be evaluated and brought for the QPS committee. Corrective action completed 6/18	ays. cleaning .TC e Nutrition staff. The I monitor results rward to	

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		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	MPLETED	
		245396	B. WING		0	5/16/2014	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			525 WEST MAIN STREET MELROSE, MN 56352				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		SHOULD BE	(X5) COMPLETIO DATE	
F 371	Continued From page	e 17	F 37	1			
	During observation on 5/13/14, at 1:30 p.m. the locked unit's dining room refrigerator was noted to contain the following items: In the freezer section were two half loaves of bread, undated, an unsealed, undated bag labeled, "cheese curds," and a bag labeled, "rhubarb," all of which had frost coating the food, on the inside of the bags. The rhubarb was dated 5/23/13, almost a year ago. In the refrigerator section was 11 sealed sour cream packets with use by date of 3/10/14 and 3/17/14, two uncovered dessert bars, and two uncovered containers of Jell-O, all undated. In addition there was a bag of whipped cream, undated, in a piping container, as well as a zip top bag labeled, "PH snack 5/10," which appeared to be donut holes, but they were very hard. In addition, there were two bottles of grape water, one of which was opened and half gone, it was not labeled with a name, or dated.						
	DM stated dietary aid with resident snack its routinely, however, di ensuring outdated or discarded. DM stated	ietary is not responsible for					
	activity director (AD) a been an activity on the when. However, othe were not activity staff	5/13/14, at 1:47 a.m. the stated the cheese curds had le unit, she did not recall er items in the refrigerator responsibility and thought ponsible for this refrigerator.					
	When interviewed on stated dietary would the refrigerator in the dini						

Facility ID: 00633

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/29/2014 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		245396	B. WING		-	05/	16/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VILLA C C		525 WEST MAIN STREET MELROSE, MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	2 18	F 371				
	DON stated the refrig room refrigerator wou dietary. The DON wa was activities respons old/outdated food iten nursing's responsibilit the responsibility of di BARE HAND CONTA On 5/12/14 at 6:02 p.1 D was observed feed slice of white bread fr bare hands and fed th not use gloves or silve their bread. On 5/16/14, at 9:39 a. (RD) said staff should bare hands but were f when feeding residen hire, were given educ items on the residents On 5/16/14, at 9:46 a. verified staff are not to hands. Review of the facility p revised 2/2013, did no not handle food with t	ns, activities stated it was y, and nursing said it was ietary. .CT m. nursing assistant (NA) - ling R16, and picked up a rom the plate with ungloved, he bread to R16. NA-D did erware to assist R16 to eat .m. the registered dietitian I not touch food with their to "use gloves or silverware" ts. RD said when staff, upon ation about preparing food s's tray. .m. director of nurses (DON) o pick up bread with bare policy, Feeding Resident, ot address that staff should heir bare hands. FRIGERATOR					
		the secured unit refrigerator m. with LPN-B a carton of					

Facility ID: 00633

If continuation sheet Page 19 of 21

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245396	B. WING		05/16/2014
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
CENTRAC	ARE HEALTH SYSTEM	- MELROSE PINE VILLA C C		25 WEST MAIN STREET IELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 371	with R 63's name, da LPN-B did not know i any of the eggs. Who R63 did not recall if s any of the eggs. Ther water, one which was as to who it belonged refrigerator is nursing however, there was r or procedure of when food items. She state items for residents or		F 371		
F 465 SS=B	were not dated or lab A policy entitled receil dated 7/13, included, clean." A policy for of was requested, but n 483.70(h) SAFE/FUNCTIONAL E ENVIRON	iving and Storage of Food, "Refrigerators are kept discarding old food items ot provided by the facility. /SANITARY/COMFORTABL ride a safe, functional, able environment for	F 465		6/25/14
	by: Based on observatio review, the facility fail maintenance and hou necessary to ensure	-		The vents in the rooms 60, 54, 66, and 67 were cleaned. The sprinkler heads room 54 and 67 were cleaned. All resident rooms vents will be assess and cleaned to ensure all vents are free	in ed

Facility ID: 00633

If continuation sheet Page 20 of 21

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , ,	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		245396	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	240000	STREET ADDRESS, CITY, STATE, ZIP CODE		0;	5/16/2014
		- MELROSE PINE VILLA C C	5	325 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		IOULD BE	(X5) COMPLETIO DATE
F 465	Continued From page	e 20	F 465			
	33 resident rooms (60 Findings Include:	0, 54, 66 and 67) reviewed.		dust and debris. Room Cleaning Policy updated the following: Sprinkler Heads:		
	 Findings Include: During observation of the facility environment on 5/15/14, at 10:00 a.m. with the maintenance director (MD) there were airflow vents which had visible dust and dirt noted in resident rooms 54, 60, 66, 67. There was also visible, heavily soiled dust was on the fire springer heads in rooms 54 and 67. The MD said "twice a year" they go through the building and clean the vents and once a year the airflow vents are blown out. The next time they will take them out to clean, and that these "must have been missed." He said "housekeeping will clean the vents" on the outside. A facility policy, Ventilation Policy, undated, identified ventilation registers were cleaned semiannually, and filters were changed as needed, usually quarterly. The policy did not identify who was responsible for cleaning the sprinkler heads, 			Maintenance will ensure sprinkle are kept free from dust and debr resident rooms and public areas Air Flow Vents: Environmental S will clean off the outside of the a monthly in resident rooms and p areas to ensure air flow vents ar dust and debris. Maintenance w down the vents and clean the ins vents/ducts every 6 months. Enviormental Service staff were in the communication book rega air flow vents updated policy and room audits. Audits will be conducted each m EVS Manager. Maintenance Ma monitor completion of duties by maintenance staff. Results from audits will be brought forward to Quality Assurance (QPS) comm	kler heads bris in all as routinely. I Services air vents public are free of will take inside of the re updated parding the nd resident month by lanager will y pm monthly	
	nor the frequency of	oouning.		Completion date: June 25th, 20		

Facility ID: 00633

If continuation sheet Page 21 of 21



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0372

May 30, 2014

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa C C 525 West Main Street Melrose, MN 56352

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5396023

Dear Mr. Gilbertson:

The above facility was surveyed on May 12, 2014 through May 16, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Centracare Health System - Melrose Pine Villa C C May 29, 2014 Page 2

and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately <u>contact Brenda Fischer at (320) 223-7338.</u>

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

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

Please feel free to call me with any questions.

Sincerely,

Tomoton

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

Centracare Health System - Melrose Pine Villa C C May 29, 2014 Page 3