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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2YUS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 SYSTEM - MELROSE PINE VILLA C C**
(L4) **525 WEST MAIN STREET**
(L5) **MELROSE, MN** (L6) **56352**

4. TYPE OF ACTION: **7** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/07/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, HFE NE II — 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/18/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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, effective June 25, 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,

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245396	A. Building B. Wing	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) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/20/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **06/18/2014**	ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/18/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	07/09/2014	10562	07/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/16/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245396	A. Building / B. Wing: 01 - MAIN BUILDING 01	6/12/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	06/02/2014	ID Prefix Reg. # NFPA 101 LSC K0144	06/02/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 06/16/2014	Signature of Surveyor: 22373	Date: 06/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/16/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245396	A. Building B. Wing 02 - 2007 ADDITION	6/12/2014

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) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 06/02/2014	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 06/02/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 06/16/2014	Signature of Surveyor: 22373	Date: 06/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/16/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2YUS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 SYSTEM - MELROSE PINE VILLA C C**
(L4) **525 WEST MAIN STREET**
(L5) **MELROSE, MN** (L6) **56352**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II — 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

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
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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		6/20/14

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

Electronically 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.

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F 176	Continued From page 1 An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has 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. The care plan, dated 4/23/14, does not address the practice of medication self-administration for R65. During observation of medication administration on 5/12/14, at 5:15 p.m., the trained medication aide (TMA)-A was observed in the Pine Villa dining room crushing R65's medications and	F 176	A self administration assessment was completed on R65 on 6/4/2014. It was determined that she was not safe to self administer. Care plan was updated 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 from meeting placed in staff communication book. Medication Administration Audits will be completed weekly by the RN Clinical Supervisor or her designee X 2 months or until system is in place. Results of these audits will be reviewed and evaluated by the Director of Nursing and brought forward to the QPS committee. Completion Date 6/20/2014	

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F 176	Continued From page 2	F 176		

mixing them in a dark colored jelly. TMA-A then smeared the jelly on two pieces of toast, re-wrapped them in tin foil, and placed them on the tray (on the dining cart) which was to be delivered to R65 in a different dining room. TMA-A then proceeded back into the Pine Villa dining room and left the medication jelly toast on the dining cart.

Nursing assistant (NA)-F was observed on 5/12/14, at 5:28 p.m., brought the dining cart from the hallway to the activity dining room where R65 was located. At 5:33 p.m., the Activity aide (AA)-A removed the tray from the cart and serve it to R65. R65 un-wrapped the toast, separated the two halves, and placed them on her tray to eat.

During continuous observation on 5/12/14, from 5:40 p.m. to 5:51 p.m., R65 took bites of toast and ate her evening meal. At 5:51 p.m., R65 to used her dinner knife and picked several chunks of white medication pieces out of the jelly, leaving those pieces on her plate unconsumed, and continued to eat her meal. R65 continued this same process until she had eaten 100% of the medication jelly toast.

During interview on 5/12/14, at 5:15 p.m., TMA-A stated they hide the medications in her food to disguise it because she refuses her medications. The TMA-A stated she was trained to do it this way and the medication administration record (MAR) directed them to do this as well. The TMA-A further stated she goes back and checks to see that R65 ate all of her toast or she will ask the nursing assistants if R65 consumed her toast. The TMA-A verified the medications crushed and placed in the jelly were Valium, vitamin D3, and Coumadin.

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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. 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. A facility supplied policy undated entitled Medication, Self Administration, indicates that each resident has the right to self-administer his/her own medication if he/she desires to do so, and the nursing supervisor determines that it is safe. The policy further indicates if the resident does want to self-administer meds, the nursing supervisor assesses the resident's cognitive, physical, and visual ability to carry out the responsibility safely.	F 176		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		6/25/14

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F 241	Continued From page 4 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents was spoken to and treated respectfully, and in a dignified manner by staff during cares for 1 of 7 resident (R45) who cares were observed during the survey. Findings include: R45's annual Minimum Data Set (MDS) dated 3/6/14, included moderate cognitive impairment, diagnoses of a stroke and depression, exhibited signs of depression such as poor appetite, feeling bad about self, and thoughts of being better off dead almost daily. The MDS indicated R45 required supervision, cueing, oversight, or encouragement and set up assistance with meals. R45's Psychosocial Well-being Care Area Assessment (CAA) dated 3/6/14, included, "Approach [R45] warmly and positively ...staff will talk about road and weather conditions, etc which brings a smile to his face." R45's cognition care plan dated 3/17/14, included he was able to express his wants/needs, and directed staff to; "Allow additional time for [R45] to make his own ADL [activities of daily living] decisions. The behavior care plan indicated R45 may touch staff sexually or make sexual comments related to depression and mood. The intervention was listed as: "When inappropriate touch behavior-redirect has been successful."	F 241	Resident R45 does not recall the incident. Na-A was educated on resident rights on 5/19/2014. No other residents were found to be affected. Education regarding resident rights was completed to nursing staff on 5/20/2014, 5/29/2014 and 6/10/2014. A copy of resident rights and meeting minutes were placed in the communication book on 6/10/2014. The orientation checklist was updated to include education on Resident Rights upon hire. Audits observing staff for resident rights and appropriate conversation will be conducted once a week by the RN Clinical Supervisor for 2 months or until system is in place. Audits will also be conducted at each meal for appropriate and dignified conversation x 2 weeks or until system is in place. This audit will be completed by the charge nurse or her designee. Results of these audits will be reviewed and evaluated by the Director of Nursing and brought forward to the Quality Assurance (QPS) committee. Completion Date: June 25th, 2014	

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F 241	Continued From page 5 R45's annual Nutrition Review dated 3/13/14, included, "Family reports he typically ate two meals when he was home." During observation on 5/12/14, at 6:02 p.m. nursing assistant (NA)-A entered R45's room with an evening meal tray. R45 was lying on is back on top of the covers, in his bed. NA-A stated, "It is time to eat." R45 stated, "No." NA-A then stated in exasperation, "Come on, I have to fight with you all the time." NA-A started to pull R45's lower legs to the edge of the bed, R45 resisted this and stated, "No, I don't want to eat." NA-A continued to pull on R45's lower legs while he was resisting being sat up by her. NA-A stated, "Your being naughty, your going to make me go get the nurse on you, aren't you?" While trying to sit him up by pulling on legs, and placing arm behind his back, NA-A stated, "Come on, you are so stubborn." R45 pointed to the surveyor and told NA-A, "Look she is writing all this down." NA-A told R45, "You're going to be in trouble now." NA-A continued to attempt to force R45 to sit up, R45 then started grabbing at NA-A with his hands, without making contact, and used fowl language towards NA-A. NA-A stated, "That is not appropriate, you know that is not appropriate." NA-A left the room, stating to the surveyor, "He is like this all the time." NA-A stopped a nurse in the hallway and asked her to come back to R45's room to help her when the nurse got a chance. NA-A re-entered the room and tried to force him to sit up again by pulling his legs over and attempting to pull his back up, R45 continued to resist, stating he did not want to eat. NA-A stated, "Come on lets' sit up, at least drink your juice." R45 asked, "Where's the chocolate milk?" NA-A told him there wasn't any on his tray. R45 again started grabbing towards NA-A's	F 241		

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F 241	Continued From page 6	F 241		

chest area, NA-A told him that was inappropriate and left the room. NA-A asked another nurse aide for assistance and left the area with a different nursing assistant.

When interviewed on 5/12/14, at 6:08 p.m. R45 stated, "They only bully a guy when he doesn't want to eat." NA-A re-entered R45's room at 6:09 p.m., alone, and asked R45 if he wanted anything from his tray left in his room or if he would like anything else. R45 stated he did not, and NA-A removed the meal tray and left the room with it. R45 then stated, "When a person aint hungry, they try to force you." R45 stated this upsets him and makes him feel bad. Most people treated him well, but others, "...when a guy doesn't eat is when they treat a guy rough."

When interviewed on 5/14/14, at 2:00 p.m. the director of nursing (DON) stated staff are trained in resident rights annually and NA-A should have honored R45's right to refuse the meal tray.

When interviewed on 5/15/14, at 8:41 a.m. the registered dietician (RD) stated R45 refuses a lot of meals, however, he will usually take chocolate milk or chocolate ensure. R45's family told us it was customary for R45 to only eat two meals a day and this choice should be honored by staff. Staff should encourage R45 to eat, however, should not attempt to force him.

When interviewed on 5/14/14, at 8:58 a.m. the DON stated she had spoken to NA-A who usually can get R45 to sit up and eat something by helping him with his legs and having him sit up. R45 had attempted to grab NA-A's breasts, not hit her during the episode on 5/12/14. The DON stated NA-A had reviewed the facilities policy on

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F 241	Continued From page 7 resident rights during new hire orientation on 7/8/13, and provided documentation of this. The facility policy entitled, Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights, dated 2/14, included, " Each resident of the facility has a right to a dignified existence, self-determination ...All staff will be oriented to resident rights upon hire, and shall protect and proactively promote the rights of each resident." Under Dignity, included, "The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." Under Self-Determination included, "You have the right to choose activities, schedules, and health care ...and make choices about aspects of your life in the facility that are significant to you."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently accommodate resident preferences of how often to eat meals, for 1 of 3 residents (R45) reviewed for nutrition.	F 242	Resident R 45□s care plan was updated on 6/4/2014. All other resident□s were reviewed and no other resident□s were affected by this practice.	6/25/14

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F 242	Continued From page 8 Findings include: R45's annual Minimum Data Set (MDS) dated 3/6/14, included moderate cognitive impairment, diagnoses of a stroke and depression. The MDS indicated R45 required supervision, cueing, oversight, or encouragement and set up assistance with meals. R45's Psychosocial Well-being Care Area Assessment (CAA) dated 3/6/14, included, "Approach [R45] warmly and positively ...staff will talk about road and weather conditions, etc which brings a smile to his face." R45's annual Nutrition Review dated 3/13/14, included, "Family reports he typically ate two meals when he was home." R45's cognition care plan dated 3/17/14, included he was able to express his wants/needs, and directed staff to; "Allow additional time for [R45] to make his own ADL [activities of daily living] decisions. The behavior care plan indicated R45 may touch staff sexually or make sexual comments related to depression and mood. Staff were directed, "When inappropriate touch behavior-redirect has been successful." The nutrition care plan dated 3/19/14, included to offer ensure twice a day and allow ample time to consume food. The care plan failed to indicate R45 should be allowed to refuse a meal according to his customary routine. During observation on 5/12/14, at 6:02 p.m. nursing assistant (NA)-A entered R45's room with an evening meal tray. R45 was lying on is back on top of the covers, in his bed. NA-A stated, "It is time to eat." R45 stated, "No." NA-A then	F 242	Education was provided to staff on 5/29/14 and 6/10/2014 regarding resident rights. The orientation checklist was updated to include review of resident rights upon hire. Audits will be performed at each meal x 2 weeks by the charge nurse or her designee to monitor for resident choice and rights regarding meal choice. These audits will be reviewed and evaluated by the Director of Nursing or her designee and the results of these audits brought forward to the QPS committee. Completion Date 6/25/2014.	

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F 242	Continued From page 9	F 242		

stated, "Come on, I have to fight with you all the time." NA-A started pull R45's lower legs to the edge of the bed, R45 resisted this and stated, "No, I don't want to eat." NA-A continued to pull on R45's lower legs while he was resisting being sat up by her. NA-A stated, "Your being naughty, your going to make me go get the nurse on you, aren't you?" While trying to sit him up by pulling on legs, and placing arm behind his back, NA-A stated, "Come on, you are so stubborn." R45 pointed to the surveyor and told NA-A, "Look she is writing all this down. "NA-A stated, " You're going to be in trouble now." NA-A continued to attempt to force R45 to sit up, R45 then started grabbing at NA-A with his hands, without making contact, and swore at her. NA-A stated, "That is not appropriate, you know that is not appropriate. "NA-A left the room, stating to the surveyor, "He is like this all the time." NA-A stopped a nurse in the hallway and asked her to come back to R45's room to help her when the nurse got a chance. NA-A re-entered the room and tried to force him to sit up again by pulling his legs over and attempting to pull his back up, R45 continued to resist, stating he did not want to eat. NA-A stated, "Come on lets' sit up, at least drink your juice." R45 asked, "Where's the chocolate milk?" NA-A told him there wasn't any on his tray. R45 again started grabbing towards NA-A's chest area, NA-A told him that was inappropriate and left the room. NA-A asked another nurse aide for assistance. NA-A left the area with the other nurse aide. NA-A did not offer any chocolate milk.

When interviewed on 5/12/14, at 6:08 p.m. R45 stated, "They only bully a guy when he doesn't want to eat." NA-A re-entered R45's room at 6:09 p.m., alone, and asked R45 if he wanted

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anything from his tray left in his room or if he would like anything else. R45 stated he did not, and NA-A removed the meal tray and left the room with it. R45 then stated, "When a person aint hungry, they try to force you." R45 stated this upsets him and makes him feel bad. Most people treated him well, but others, " ...when a guy doesn't eat is when they treat a guy rough." R45 stated some of the staff respect his wish to refuse certain meals, others do not.

During observation on 5/14/14, at 8:07 a.m. R45 consented to going to breakfast and by 8:15 a.m. had eaten about half of his meal. R45 declined to eat lunch at 12:05 p.m. and NA-F respected this choice.

When interviewed on 5/14/14, at 2:00 p.m. the director of nursing (DON) stated staff are trained in resident rights annually. NA-A should have honored R45's right to refuse the meal tray.

When interviewed on 5/15/14, at 8:41 a.m. the registered dietician (RD) stated R45 refuses a lot of meals, however, he will usually take chocolate milk or chocolate ensure. R45's family indicated it was customary for R45 to only eat two meals a day and this choice should be honored by staff. Staff should continue to offer and encourage each meal, but not attempt to force. This had not been care planned by dietary.

When interviewed on 5/14/14, at 8:58 a.m. the DON stated she had spoken to NA-A who stated usually she can get R45 to sit up and eat something by helping him with his legs to get him to sit up. R45 had been attempting to grab NA-A's breasts, not hit her during the episode on 5/12/14. NA-A had reviewed the facilities policy

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NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11 on resident rights during new hire orientation on 7/8/14, and provided documentation of this. The facility policy entitled, Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights, dated 2/14, included, " Each resident of the facility has a right to a dignified existence, self-determination ...All staff will be oriented to resident rights upon hire, and shall protect and proactively promote the rights of each resident. " Under Dignity, included, " The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. " Under Self-Determination included, " You have the right to choose activities, schedules, and health care ...and make choices about aspects of your life in the facility that are significant to you. "	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the standard of practice when administering medications for 1 of 8 residents (R65) reviewed during medication administration observation. Findings include: During observation on 5/12/2014 at 5:15 p.m., trained medical assistant (TMA)-A gathered R65's	F 281	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 staff was provided at a staff meeting on 5/29/2014. A review of the medication administration policy was completed. Minutes from this meeting were placed in	6/18/14

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F 281	Continued From page 12 oral medications, which included Coumadin, vitamin D-3 and Valium, from the med cart. TMA-A crushed the medications, and mixed them in jelly. TMA-A stopped the food cart, which held resident meal trays, just outside the dining area. TMA-A removed R65's meal tray from the cart, and then removed and opened a foil-wrapped piece of toast from R65's tray. TMA-A spread the jelly, which contained the medications, on the toast, re-wrapped the toast in the foil, and placed the food back on R65's food tray. A dietary aide then pushed the food cart down the hallway and parked it in the hallway, near the dining area. Physician's orders dated 4-22-14 indicated: Valium 2 mg by mouth one time a day related to benign paroxysmal positional vertigo. Vitamin D3, 2000 units by mouth one time a day crush, place in jelly, on toast. Coumadin 2.5 mg by mouth one time a day every Monday, Wednesday and Friday crushed, mixed with jelly on toast with supper. In an interview on 5/12/2014 at 5:15 p.m., TMA-A stated medications were routinely put in R65's food to "disguise" them, or else [R65] refuses medications. TMA-A also said after medication was mixed in jelly, it was spread on R65's toast. TMA-A said such was "normal practice" with certain people and was the best way to get [medication] into [R65's] system. TMA-A stated R65's medications were crushed, diluted in a little water, and mixed in jelly and spread on toast. TMA-A also said "we can't do this in front of [R65], otherwise she'll catch on." TMA-A said "we were trained" to administer [R65's] meds this way, and the medication administration record (MAR) indicated to "do it that way." TMA-A said R65 was checked after the meal, or asked one of the nursing assistants to check and make sure	F 281	the communication book. Medication Administration Audits will be completed weekly X 2 months or until system is in place by the Director of nursing or her designee Results of these audits will be reviewed and evaluated by the Director of Nursing and brought forward to the QPS committee. Completion Date 6/18/2014	

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F 281	Continued From page 13 R65 ate all the toast with the medication. At 5:28 p.m., nursing assistant (NA)-F moved the food cart, with R65's tray, from the hallway into the activity area, which was also served as a dining area. At 5:33 p.m., activity aide (AA)-A removed R65's tray from the cart, and served the meal. R65 unwrapped the toast, separated the two halves, and placed them on her tray. At 5:40 p.m., R65 took a bite of toast, and continued to eat her other food items. At 5:49 p.m., R65 used a knife to pick small, white pieces of the crushed medications out of the jelly on her toast. R65 left those picked-out pieces on her plate, unconsumed. The jelly-spread toast, containing the medications, was not supervised by the TMA-A, during the entirety of the evening meal. In an interview on 5/12/2014 at 6:25 p.m., licensed practical nurse (LPN)-C said it was the "normal practice", and "ordered in the MAR" to administer R65's medications crushed, mixed in jelly and spread on toast. LPN-C said it was "what was needed" as R65 thinks the staff are "trying to poison her." LPN-C said this had been discussed for R65 among staff from various departments, including nursing, dietary, activities and social services. LPN-C said staff should have "stayed with and followed" the medication until R65 consumed it. During an interview on 5/12/2014 at 6:31 p.m., the director of nursing (DON) said giving R65 medication on the toast "is the only way she will take it." In an interview on 5/12/2014, licensed social worker (LSW)-A stated R65's family had not been involved in the decision to hide medications in	F 281		

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F 281	Continued From page 14 food nor was this practice, "discussed at a care conference." In an interview on 5/14/2014 at 10:05 a.m., the consulting pharmacist stated that valium "needs to be watched when administered." Leaving valium unattended and "alone is hard to argue with." In an interview on 5/15/2015 at 2:45 p.m., R65's attending physician stated it was intended that R65's valium be put in jelly and spread over R65's toast. A standard of practice was referenced by The Agency for Healthcare Research and Quality (April 10, 2009), identified under the medication management guidelines, that medication "is to be administer and observed as resident takes medication." A facility policy "Medication administration by unlicensed personnel (med tech), dated February 2013, indicated a med tech must complete an "in-house" orientation program on the administration of medications and successfully demonstrate the ability to competently and safely administer medications. A facility policy Medication Administration, Oral dated February 2013 indicates under #7 administer the medication. Monitor the resident to assure the resident has swallowed the medication.	F 281		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the	F 285		6/25/14

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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, 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 specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, 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 specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as	F 285		

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F 285	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. 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". The next two questions were answered "No." 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 persons with development disabilities for evaluation and determination of the need for specialized services." There was no indication in the record that R33 had received a OBRA Level II PASRR screening to determine if R33 needed specialized	F 285	A call was placed to Stearns County by social services requesting a level II for Resident R33 on May 19, 2014 and on 6/4/2014. A level II PASSR will be completed on Resident R33. A chart audit will be completed to ensure that all residents requiring a Level II have one completed. Social Services will monitor every Level I screening and will document any discrepancies in Level I screenings and address with the county. The Social Service manager will be responsible for this monitoring. The results of this monitoring will be brought forward to the QPS committee meeting. Completion Date: June 25th, 2014	

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F 285	Continued From page 17 services. During interview on 5/15/14, at 10:45 a.m. the facility's licensed social worker (LSW)-A said "we couldn't find in his chart that a level II was done. We are going to call Stearns County to check on it". He has been here since 6/09 and Stearns County was responsible 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 paperwork was destroyed in 2009 and would be speaking to their supervisor to see if there is anything they can do now. On 5/15/14 at 2:42 p.m. the director of nursing said she was not aware R33 needed to have a level II PASRR completed. During interview with Stearns County, on 5/23/14 at 1:30 p.m., the Stearns County Worker-A verified a level II PASRR screen should have been completed, based on the Level I PASRR screening of answering the two "yes" questions.	F 285		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		6/18/14

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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, leaving the plate in the microwave. NA-B returned	F 371	The Nutrition Service Dept policy, Late Trays and Hold Trays was updated 5-19-14. Policy states that if a nursing home resident is not at the table when the trays are passed out, the tray will be brought back to the kitchen and disposed. When the resident is ready for their meal, nursing will call the kitchen and a new tray dished up. The Nutrition Service Dept policy, Meal Service was updated 6-2-14 to include utensils or gloved hands are used to prepare foods. The Nursing Department Feeding Residents policy was updated on 5/20/2014 to include no bare food handling. The Nutrition Service Dept policy, Sanitation was updated 5-19-14. Cleaning of refrigerators located out of the department was added. Dietary staff cleans the refrigerator in the Pine Haven dining room twice per week; nursing staff are responsible for all other refrigerators in the nursing home. The above stated policy changes will affect all residents. Dietary Staff are educated on the updated policies at staff meeting on 6-3-14. Staff will initial the cleaning schedule when duties are completed. Nursing staff were educated on 5/29/2014 and 6/10/2014. Orientation checklist for new staff was updated to include no bare handling of food while feeding residents. Audits of meals will be daily x 2 weeks or until system is in place for appropriate storage	

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F 371	Continued From page 19 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 dietary manager stated nursing should not store or reheat foods on the unit. If there is a delay in resident's eating, the tray should be returned to the kitchen for proper storing and reheating. A Food Preparation policy dated 7/13, included under number 6, "Leftovers are rapidly heated to an internal temperature of 165 degrees F [Fahrenheit] or higher and served immediately." A Late Trays and Hold Trays policy dated 9/13, included, "A hold tray will have all items from a meal refrigerated as needed until a call is received. Foods will be heated to serving temperatures ..." Refrigerator storage in locked unit's dining room During observation on 5/13/14, at 1:30 p.m. the	F 371	and handling of food and food trays. Audits of the weekly refrigerator cleaning duties will be completed by the LTC Director or her designee. The Dietary Manager and/or the Nutrition Services Dept manager monitor completion of duties for dietary staff. The LTC Director or her designee will monitor results of the nursing audits. All results will be evaluated and brought forward to the QPS committee. Corrective action completed 6/18/2014.	

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F 371	Continued From page 20 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. When interviewed on 5/13/14, at 1:40 p.m. the DM stated dietary aides stock this refrigerator with resident snack items and beverages routinely, however, dietary is not responsible for ensuring outdated or old food items are discarded. DM stated the activity staff access this refrigerator, and they would be responsible for this. When interviewed on 5/13/14, at 1:47 a.m. the activity director (AD) stated the cheese curds had been an activity on the unit, she did not recall when. However, other items in the refrigerator were not activity staff responsibility and thought nursing would be responsible for this refrigerator. When interviewed on 5/13/14, at 2:00 p.m. LPN-B stated dietary would be responsible for the refrigerator in the dining room.	F 371		

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F 371	Continued From page 21 When interviewed on 5/13/14, at 2:15 p.m. the DON stated the refrigerator storage in the dining room refrigerator would be the responsibility of dietary. The DON was informed dietary stated it was activities responsibility to discard old/outdated food items, activities stated it was nursing's responsibility, and nursing said it was the responsibility of dietary. BARE HAND CONTACT On 5/12/14 at 6:02 p.m. nursing assistant (NA) - D was observed feeding R16, and picked up a slice of white bread from the plate with ungloved, bare hands and fed the bread to R16. NA-D did not use gloves or silverware to assist R16 to eat their bread. On 5/16/14, at 9:39 a.m. the registered dietitian (RD) said staff should not touch food with their bare hands but were to "use gloves or silverware" when feeding residents. RD said when staff, upon hire, were given education about preparing food items on the residents's tray. On 5/16/14, at 9:46 a.m. director of nurses (DON) verified staff are not to pick up bread with bare hands. Review of the facility policy, Feeding Resident, revised 2/2013, did not address that staff should not handle food with their bare hands. SECURED UNIT REFRIGERATOR During observation of the secured unit refrigerator on 5/14/14, at 7:14 a.m. with LPN-B a carton of hard boiled colored eggs was noted in the	F 371		

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F 371	Continued From page 22 refrigerator. The top of the egg carton had a note with R 63's name, dated 4/22/14, 22 days ago. LPN-B did not know if R63 had recently received any of the eggs. When interviewed at 7:30 a.m. R63 did not recall if she had recently consumed any of the eggs. There were two bottles of grape water, one which was half empty and unlabeled as to who it belonged to. LPN-B stated this refrigerator is nursing staff 's responsibility; however, there was no actual cleaning schedule or procedure of when to remove any outdated food items. She stated family members bring in items for residents on the secured unit. The refrigerator also contained several bags that were identified as being employee lunches/food, that were not dated or labeled. A policy entitled receiving and Storage of Food, dated 7/13, included, "Refrigerators are kept clean." A policy for discarding old food items was requested, but not provided by the facility.	F 371		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine maintenance and housekeeping services necessary to ensure air flow vents and sprinkler heads were kept free of dust and debris for 4 of 33 resident rooms (60, 54, 66 and 67) reviewed.	F 465	The vents in the rooms 60, 54, 66, and 67 were cleaned. The sprinkler heads in room 54 and 67 were cleaned. All resident rooms vents will be assessed and cleaned to ensure all vents are free of dust and debris.	6/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 23 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 semi-annually, and filters were changed as needed, usually quarterly. The policy did not identify who was responsible for cleaning the sprinkler heads, nor the frequency of cleaning.	F 465	Room Cleaning Policy updated to include the following: Sprinkler Heads: Maintenance will ensure sprinkler heads are kept free from dust and debris in all resident rooms and public areas routinely. Air Flow Vents: Environmental Services will clean off the outside of the air vents monthly in resident rooms and public areas to ensure air flow vents are free of dust and debris. Maintenance will take down the vents and clean the inside of the vents/ducts every 6 months. Enviormental Service staff were updated in the communication book regarding the air flow vents updated policy and resident room audits. Audits will be conducted each month by EVS Manager. Maintenance Manager will monitor completion of duties by maintenance staff. Results from monthly audits will be brought forward to the Quality Assurance (QPS) committee. Completion date: June 25th, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 16, 2014. At the time of this survey, Building 01 of Centracare Health System Melrose (Pine Villa) was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Centracare Health System Melrose (Pine Villa) was constructed as follows: The original building was constructed in 1961, is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(000) construction; The 1969 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type V(111) construction; The 1994 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 75 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 75 of 75 residents. FINDINGS INCLUDE: On 05/16/2014 at 10:40 AM, during a review of the facility's annual fire alarm inspection & test report dated 04/08/2014, twenty-six (26) manual fire alarm boxes were noted on the system, however, no documentation was provided identifying the locations and functional testing	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 outcomes for each of these Alarm Initiating Devices. As such, it could not be verified that inspection and testing of the complete fire alarm system had been properly conducted. This finding was confirmed with the maintenance manager.	K 052		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator (genset) in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999). In a fire or other emergency, this deficient practice 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 inspection and testing log for the "Small Engine" genset for the previous twelve-month period, no documentation could be provided verifying the genset had been exercised monthly at not less than 30% of the EPS	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 nameplate rating. This finding was confirmed with the maintenance manager.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 16, 2014. At the time of this survey, Building 02 of Centracare Health System Melrose (Pine Villa) was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Centracare Health System Melrose (Pine Villa) consists of the 2007 resident wing addition. The addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 75 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 18, Section 18.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 75 of 75 residents. FINDINGS INCLUDE: On 05/16/2014 at 10:40 AM, during a review of the facility's annual fire alarm inspection & test report dated 04/08/2014, twenty-six (26) manual fire alarm boxes were noted on the system, however, no documentation was provided identifying the locations and functional testing outcomes for each of these Alarm Initiating Devices. As such, it could not be verified that inspection and testing of the complete fire alarm system had been properly conducted. This finding was confirmed with the maintenance manager.	K 052		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**05/16/2014**

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3	K 144		

This STANDARD is not met as evidenced by:
Based on observation and a staff interview, the facility failed to maintain the emergency generator (genset) in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999). In a fire or other emergency, this deficient practice 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 inspection and testing log for the "Small Engine" genset for the previous twelve-month period, no documentation could be provided verifying the genset had been exercised monthly at not less than 30% of the EPS nameplate rating.

This finding was confirmed with the maintenance manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		6/25/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	05/16/2014

NAME OF PROVIDER 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents was spoken to and treated respectfully, and in a dignified manner by staff during cares for 1 of 7 resident (R45) who cares were observed during the survey. Findings include: R45's annual Minimum Data Set (MDS) dated 3/6/14, included moderate cognitive impairment, diagnoses of a stroke and depression, exhibited signs of depression such as poor appetite, feeling bad about self, and thoughts of being better off dead almost daily. The MDS indicated R45 required supervision, cueing, oversight, or encouragement and set up assistance with meals. R45's Psychosocial Well-being Care Area Assessment (CAA) dated 3/6/14, included, "Approach [R45] warmly and positively ...staff will talk about road and weather conditions, etc which brings a smile to his face." R45's cognition care plan dated 3/17/14, included he was able to express his wants/needs, and directed staff to; "Allow additional time for [R45] to make his own ADL [activities of daily living] decisions. The behavior care plan indicated R45 may touch staff sexually or make sexual comments related to depression and mood. The intervention was listed as: "When inappropriate	F 241	Resident R45 does not recall the incident. Na-A was educated on resident rights on 5/19/2014. No other residents were found to be affected. Education regarding resident rights was completed to nursing staff on 5/20/2014, 5/29/2014 and 6/10/2014. A copy of resident rights and meeting minutes were placed in the communication book on 6/10/2014. The orientation checklist was updated to include education on Resident Rights upon hire. Audits observing staff for resident rights and appropriate conversation will be conducted once a week by the RN Clinical Supervisor for 2 months or until system is in place. Audits will also be conducted at each meal for appropriate and dignified conversation x 2 weeks or until system is in place. This audit will be completed by the charge nurse or her designee. Results of these audits will be reviewed and evaluated by the Director of Nursing and brought forward to the Quality Assurance (QPS) committee. Completion Date: June 25th, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 2	F 241		

touch behavior-redirect has been successful." R45's annual Nutrition Review dated 3/13/14, included, "Family reports he typically ate two meals when he was home."

During observation on 5/12/14, at 6:02 p.m. nursing assistant (NA)-A entered R45's room with an evening meal tray. R45 was lying on is back on top of the covers, in his bed. NA-A stated, "It is time to eat." R45 stated, "No." NA-A then stated in exasperation, "Come on, I have to fight with you all the time." NA-A started to pull R45's lower legs to the edge of the bed, R45 resisted this and stated, "No, I don't want to eat." NA-A continued to pull on R45's lower legs while he was resisting being sat up by her. NA-A stated, "Your being naughty, your going to make me go get the nurse on you, aren't you?" While trying to sit him up by pulling on legs, and placing arm behind his back, NA-A stated, "Come on, you are so stubborn." R45 pointed to the surveyor and told NA-A, "Look she is writing all this down." NA-A told R45, "You're going to be in trouble now." NA-A continued to attempt to force R45 to sit up, R45 then started grabbing at NA-A with his hands, without making contact, and used fowl language towards NA-A. NA-A stated, "That is not appropriate, you know that is not appropriate." NA-A left the room, stating to the surveyor, "He is like this all the time." NA-A stopped a nurse in the hallway and asked her to come back to R45's room to help her when the nurse got a chance. NA-A re-entered the room and tried to force him to sit up again by pulling his legs over and attempting to pull his back up, R45 continued to resist, stating he did not want to eat. NA-A stated, "Come on lets' sit up, at least drink your juice." R45 asked, "Where's the chocolate milk?" NA-A told him there wasn't any on his

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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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241		

tray. R45 again started grabbing towards NA-A's chest area, NA-A told him that was inappropriate and left the room. NA-A asked another nurse aide for assistance and left the area with a different nursing assistant.

When interviewed on 5/12/14, at 6:08 p.m. R45 stated, "They only bully a guy when he doesn't want to eat." NA-A re-entered R45's room at 6:09 p.m., alone, and asked R45 if he wanted anything from his tray left in his room or if he would like anything else. R45 stated he did not, and NA-A removed the meal tray and left the room with it. R45 then stated, "When a person aint hungry, they try to force you." R45 stated this upsets him and makes him feel bad. Most people treated him well, but others, "...when a guy doesn't eat is when they treat a guy rough."

When interviewed on 5/14/14, at 2:00 p.m. the director of nursing (DON) stated staff are trained in resident rights annually and NA-A should have honored R45's right to refuse the meal tray.

When interviewed on 5/15/14, at 8:41 a.m. the registered dietician (RD) stated R45 refuses a lot of meals, however, he will usually take chocolate milk or chocolate ensure. R45's family told us it was customary for R45 to only eat two meals a day and this choice should be honored by staff. Staff should encourage R45 to eat, however, should not attempt to force him.

When interviewed on 5/14/14, at 8:58 a.m. the DON stated she had spoken to NA-A who usually can get R45 to sit up and eat something by helping him with his legs and having him sit up. R45 had attempted to grab NA-A's breasts, not hit her during the episode on 5/12/14. The DON

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F 241	Continued From page 4 stated NA-A had reviewed the facilities policy on resident rights during new hire orientation on 7/8/13, and provided documentation of this. The facility policy entitled, Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights, dated 2/14, included, " Each resident of the facility has a right to a dignified existence, self-determination ...All staff will be oriented to resident rights upon hire, and shall protect and proactively promote the rights of each resident." Under Dignity, included, "The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." Under Self-Determination included, "You have the right to choose activities, schedules, and health care ...and make choices about aspects of your life in the facility that are significant to you."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently accommodate resident preferences of how often to eat meals, for 1 of 3 residents (R45) reviewed	F 242	Resident R 45□s care plan was updated on 6/4/2014. All other resident□s were reviewed and no other resident□s were affected by this	6/25/14

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F 242	Continued From page 5 for nutrition. Findings include: R45's annual Minimum Data Set (MDS) dated 3/6/14, included moderate cognitive impairment, diagnoses of a stroke and depression. The MDS indicated R45 required supervision, cueing, oversight, or encouragement and set up assistance with meals. R45's Psychosocial Well-being Care Area Assessment (CAA) dated 3/6/14, included, "Approach [R45] warmly and positively ...staff will talk about road and weather conditions, etc which brings a smile to his face." R45's annual Nutrition Review dated 3/13/14, included, "Family reports he typically ate two meals when he was home." R45's cognition care plan dated 3/17/14, included he was able to express his wants/needs, and directed staff to; "Allow additional time for [R45] to make his own ADL [activities of daily living] decisions. The behavior care plan indicated R45 may touch staff sexually or make sexual comments related to depression and mood. Staff were directed, "When inappropriate touch behavior-redirect has been successful." The nutrition care plan dated 3/19/14, included to offer ensure twice a day and allow ample time to consume food. The care plan failed to indicate R45 should be allowed to refuse a meal according to his customary routine. During observation on 5/12/14, at 6:02 p.m. nursing assistant (NA)-A entered R45's room with an evening meal tray. R45 was lying on is back on top of the covers, in his bed. NA-A stated, "It	F 242	practice. Education was provided to staff on 5/29/14 and 6/10/2014 regarding resident rights. The orientation checklist was updated to include review of resident rights upon hire. Audits will be performed at each meal x 2 weeks by the charge nurse or her designee to monitor for resident choice and rights regarding meal choice. These audits will be reviewed and evaluated by the Director of Nursing or her designee and the results of these audits brought forward to the QPS committee. Completion Date 6/25/2014.	

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F 242	Continued From page 6	F 242		

is time to eat." R45 stated, "No." NA-A then stated, "Come on, I have to fight with you all the time." NA-A started pull R45's lower legs to the edge of the bed, R45 resisted this and stated, "No, I don't want to eat." NA-A continued to pull on R45's lower legs while he was resisting being sat up by her. NA-A stated, "Your being naughty, your going to make me go get the nurse on you, aren't you?" While trying to sit him up by pulling on legs, and placing arm behind his back, NA-A stated, "Come on, you are so stubborn." R45 pointed to the surveyor and told NA-A, "Look she is writing all this down. "NA-A stated, " You're going to be in trouble now." NA-A continued to attempt to force R45 to sit up, R45 then started grabbing at NA-A with his hands, without making contact, and swore at her. NA-A stated, "That is not appropriate, you know that is not appropriate. "NA-A left the room, stating to the surveyor, "He is like this all the time." NA-A stopped a nurse in the hallway and asked her to come back to R45's room to help her when the nurse got a chance. NA-A re-entered the room and tried to force him to sit up again by pulling his legs over and attempting to pull his back up, R45 continued to resist, stating he did not want to eat. NA-A stated, "Come on lets' sit up, at least drink your juice." R45 asked, "Where's the chocolate milk?" NA-A told him there wasn't any on his tray. R45 again started grabbing towards NA-A's chest area, NA-A told him that was inappropriate and left the room. NA-A asked another nurse aide for assistance. NA-A left the area with the other nurse aide. NA-A did not offer any chocolate milk.

When interviewed on 5/12/14, at 6:08 p.m. R45 stated, "They only bully a guy when he doesn't want to eat." NA-A re-entered R45's room at

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F 242	Continued From page 7	F 242		

6:09 p.m., alone, and asked R45 if he wanted anything from his tray left in his room or if he would like anything else. R45 stated he did not, and NA-A removed the meal tray and left the room with it. R45 then stated, "When a person aint hungry, they try to force you." R45 stated this upsets him and makes him feel bad. Most people treated him well, but others, " ...when a guy doesn't eat is when they treat a guy rough." R45 stated some of the staff respect his wish to refuse certain meals, others do not.

During observation on 5/14/14, at 8:07 a.m. R45 consented to going to breakfast and by 8:15 a.m. had eaten about half of his meal. R45 declined to eat lunch at 12:05 p.m. and NA-F respected this choice.

When interviewed on 5/14/14, at 2:00 p.m. the director of nursing (DON) stated staff are trained in resident rights annually. NA-A should have honored R45's right to refuse the meal tray.

When interviewed on 5/15/14, at 8:41 a.m. the registered dietician (RD) stated R45 refuses a lot of meals, however, he will usually take chocolate milk or chocolate ensure. R45's family indicated it was customary for R45 to only eat two meals a day and this choice should be honored by staff. Staff should continue to offer and encourage each meal, but not attempt to force. This had not been care planned by dietary.

When interviewed on 5/14/14, at 8:58 a.m. the DON stated she had spoken to NA-A who stated usually she can get R45 to sit up and eat something by helping him with his legs to get him to sit up. R45 had been attempting to grab NA-A's breasts, not hit her during the episode on

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F 242	Continued From page 8 5/12/14. NA-A had reviewed the facilities policy on resident rights during new hire orientation on 7/8/14, and provided documentation of this. The facility policy entitled, Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights, dated 2/14, included, " Each resident of the facility has a right to a dignified existence, self-determination ...All staff will be oriented to resident rights upon hire, and shall protect and proactively promote the rights of each resident. " Under Dignity, included, " The facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. " Under Self-Determination included, " You have the right to choose activities, schedules, and health care ...and make choices about aspects of your life in the facility that are significant to you. "	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the standard of practice when administering medications for 1 of 8 residents (R65) reviewed during medication administration observation. Findings include: During observation on 5/12/2014 at 5:15 p.m.,	F 281	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 staff was provided at a staff meeting on 5/29/2014. A review of the medication administration policy was completed.	6/18/14

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F 281	Continued From page 9 trained medical assistant (TMA)-A gathered R65's oral medications, which included Coumadin, vitamin D-3 and Valium, from the med cart. TMA-A crushed the medications, and mixed them in jelly. TMA-A stopped the food cart, which held resident meal trays, just outside the dining area. TMA-A removed R65's meal tray from the cart, and then removed and opened a foil-wrapped piece of toast from R65's tray. TMA-A spread the jelly, which contained the medications, on the toast, re-wrapped the toast in the foil, and placed the food back on R65's food tray. A dietary aide then pushed the food cart down the hallway and parked it in the hallway, near the dining area. Physician's orders dated 4-22-14 indicated: Valium 2 mg by mouth one time a day related to benign paroxysmal positional vertigo. Vitamin D3, 2000 units by mouth one time a day crush, place in jelly, on toast. Coumadin 2.5 mg by mouth one time a day every Monday, Wednesday and Friday crushed, mixed with jelly on toast with supper. In an interview on 5/12/2014 at 5:15 p.m., TMA-A stated medications were routinely put in R65's food to "disguise" them, or else [R65] refuses medications. TMA-A also said after medication was mixed in jelly, it was spread on R65's toast. TMA-A said such was "normal practice" with certain people and was the best way to get [medication] into [R65's] system. TMA-A stated R65's medications were crushed, diluted in a little water, and mixed in jelly and spread on toast. TMA-A also said "we can't do this in front of [R65], otherwise she'll catch on." TMA-A said "we were trained" to administer [R65's] meds this way, and the medication administration record (MAR) indicated to "do it that way." TMA-A said R65 was checked after the meal, or asked one of	F 281	Minutes from this meeting were placed in the communication book. Medication Administration Audits will be completed weekly X 2 months or until system is in place by the Director of nursing or her designee Results of these audits will be reviewed and evaluated by the Director of Nursing and brought forward to the QPS committee. Completion Date 6/18/2014	

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F 281	Continued From page 10	F 281		

the nursing assistants to check and make sure R65 ate all the toast with the medication.

At 5:28 p.m., nursing assistant (NA)-F moved the food cart, with R65's tray, from the hallway into the activity area, which was also served as a dining area. At 5:33 p.m., activity aide (AA)-A removed R65's tray from the cart, and served the meal. R65 unwrapped the toast, separated the two halves, and placed them on her tray. At 5:40 p.m., R65 took a bite of toast, and continued to eat her other food items. At 5:49 p.m., R65 used a knife to pick small, white pieces of the crushed medications out of the jelly on her toast. R65 left those picked-out pieces on her plate, unconsumed. The jelly-spread toast, containing the medications, was not supervised by the TMA-A, during the entirety of the evening meal.

In an interview on 5/12/2014 at 6:25 p.m., licensed practical nurse (LPN)-C said it was the "normal practice", and "ordered in the MAR" to administer R65's medications crushed, mixed in jelly and spread on toast. LPN-C said it was "what was needed" as R65 thinks the staff are "trying to poison her." LPN-C said this had been discussed for R65 among staff from various departments, including nursing, dietary, activities and social services. LPN-C said staff should have "stayed with and followed" the medication until R65 consumed it.

During an interview on 5/12/2014 at 6:31 p.m., the director of nursing (DON) said giving R65 medication on the toast "is the only way she will take it."

In an interview on 5/12/2014, licensed social worker (LSW)-A stated R65's family had not been

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F 281	Continued From page 11 involved in the decision to hide medications in food nor was this practice, "discussed at a care conference." In an interview on 5/14/2014 at 10:05 a.m., the consulting pharmacist stated that valium "needs to be watched when administered." Leaving valium unattended and "alone is hard to argue with." In an interview on 5/15/2015 at 2:45 p.m., R65's attending physician stated it was intended that R65's valium be put in jelly and spread over R65's toast. A standard of practice was referenced by The Agency for Healthcare Research and Quality (April 10, 2009), identified under the medication management guidelines, that medication "is to be administer and observed as resident takes medication." A facility policy "Medication administration by unlicensed personnel (med tech), dated February 2013, indicated a med tech must complete an "in-house" orientation program on the administration of medications and successfully demonstrate the ability to competently and safely administer medications. A facility policy Medication Administration, Oral dated February 2013 indicates under #7 administer the medication. Monitor the resident to assure the resident has swallowed the medication.	F 281		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR	F 285		6/25/14

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A facility must coordinate assessments with the 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, 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 specialized services for mental retardation.
(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--
(A) That, because of the physical and mental condition of the individual, 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 specialized services for mental retardation.

For purposes of this section:
(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).
(ii) An individual is considered to be "mentally

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F 285	Continued From page 13 retarded" if the individual is mentally retarded as 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. 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". The next two questions were answered "No." 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 persons with development disabilities for evaluation and determination of the need for specialized services." There was no indication in the record that R33 had received a OBRA Level II PASRR	F 285	A call was placed to Stearns County by social services requesting a level II for Resident R33 on May 19, 2014 and on 6/4/2014. A level II PASSR will be completed on Resident R33. A chart audit will be completed to ensure that all residents requiring a Level II have one completed. Social Services will monitor every Level I screening and will document any discrepancies in Level I screenings and address with the county. The Social Service manager will be responsible for this monitoring. The results of this monitoring will be brought forward to the QPS committee meeting. Completion Date: June 25th, 2014	

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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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 285	Continued From page 14 screening to determine if R33 needed specialized services. During interview on 5/15/14, at 10:45 a.m. the facility's licensed social worker (LSW)-A said "we couldn't find in his chart that a level II was done. We are going to call Stearns County to check on it". He has been here since 6/09 and Stearns County was responsible 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 paperwork was destroyed in 2009 and would be speaking to their supervisor to see if there is anything they can do now. On 5/15/14 at 2:42 p.m. the director of nursing said she was not aware R33 needed to have a level II PASRR completed. During interview with Stearns County, on 5/23/14 at 1:30 p.m., the Stearns County Worker-A verified a level II PASRR screen should have been completed, based on the Level I PASRR screening of answering the two "yes" questions.	F 285		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		6/18/14

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F 371	Continued From page 15 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,	F 371	The Nutrition Service Dept policy, Late Trays and Hold Trays was updated 5-19-14. Policy states that if a nursing home resident is not at the table when the trays are passed out, the tray will be brought back to the kitchen and disposed. When the resident is ready for their meal, nursing will call the kitchen and a new tray dished up. The Nutrition Service Dept policy, Meal Service was updated 6-2-14 to include utensils or gloved hands are used to prepare foods. The Nursing Department Feeding Residents policy was updated on 5/20/2014 to include no bare food handling. The Nutrition Service Dept policy, Sanitation was updated 5-19-14. Cleaning of refrigerators located out of the department was added. Dietary staff cleans the refrigerator in the Pine Haven dining room twice per week; nursing staff are responsible for all other refrigerators in the nursing home. The above stated policy changes will affect all residents. Dietary Staff are educated on the updated policies at staff meeting on 6-3-14. Staff will initial the cleaning schedule when duties are completed. Nursing staff were educated on 5/29/2014 and 6/10/2014. Orientation checklist for new staff was updated to include no bare handling of food while feeding residents. Audits of meals will be daily x 2 weeks or until	

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	245396	A. BUILDING _____ B. WING _____	05/16/2014

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CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352

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F 371	Continued From page 16 leaving the plate in the microwave. NA-B returned 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 dietary manager stated nursing should not store or reheat foods on the unit. If there is a delay in resident's eating, the tray should be returned to the kitchen for proper storing and reheating. A Food Preparation policy dated 7/13, included under number 6, "Leftovers are rapidly heated to an internal temperature of 165 degrees F [Fahrenheit] or higher and served immediately." A Late Trays and Hold Trays policy dated 9/13, included, "A hold tray will have all items from a meal refrigerated as needed until a call is received. Foods will be heated to serving temperatures ..." Refrigerator storage in locked unit's dining room	F 371	system is in place for appropriate storage and handling of food and food trays. Audits of the weekly refrigerator cleaning duties will be completed by the LTC Director or her designee. The Dietary Manager and/or the Nutrition Services Dept manager monitor completion of duties for dietary staff. The LTC Director or her designee will monitor results of the nursing audits. All results will be evaluated and brought forward to the QPS committee. Corrective action completed 6/18/2014.	

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F 371	Continued From page 17	F 371		

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.

When interviewed on 5/13/14, at 1:40 p.m. the DM stated dietary aides stock this refrigerator with resident snack items and beverages routinely, however, dietary is not responsible for ensuring outdated or old food items are discarded. DM stated the activity staff access this refrigerator, and they would be responsible for this.

When interviewed on 5/13/14, at 1:47 a.m. the activity director (AD) stated the cheese curds had been an activity on the unit, she did not recall when. However, other items in the refrigerator were not activity staff responsibility and thought nursing would be responsible for this refrigerator.

When interviewed on 5/13/14, at 2:00 p.m. LPN-B stated dietary would be responsible for the refrigerator in the dining room.

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F 371	Continued From page 18 When interviewed on 5/13/14, at 2:15 p.m. the DON stated the refrigerator storage in the dining room refrigerator would be the responsibility of dietary. The DON was informed dietary stated it was activities responsibility to discard old/outdated food items, activities stated it was nursing's responsibility, and nursing said it was the responsibility of dietary. BARE HAND CONTACT On 5/12/14 at 6:02 p.m. nursing assistant (NA) - D was observed feeding R16, and picked up a slice of white bread from the plate with ungloved, bare hands and fed the bread to R16. NA-D did not use gloves or silverware to assist R16 to eat their bread. On 5/16/14, at 9:39 a.m. the registered dietitian (RD) said staff should not touch food with their bare hands but were to "use gloves or silverware" when feeding residents. RD said when staff, upon hire, were given education about preparing food items on the residents's tray. On 5/16/14, at 9:46 a.m. director of nurses (DON) verified staff are not to pick up bread with bare hands. Review of the facility policy, Feeding Resident, revised 2/2013, did not address that staff should not handle food with their bare hands. SECURED UNIT REFRIGERATOR During observation of the secured unit refrigerator on 5/14/14, at 7:14 a.m. with LPN-B a carton of	F 371		

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F 371	Continued From page 19 hard boiled colored eggs was noted in the refrigerator. The top of the egg carton had a note with R 63's name, dated 4/22/14, 22 days ago. LPN-B did not know if R63 had recently received any of the eggs. When interviewed at 7:30 a.m. R63 did not recall if she had recently consumed any of the eggs. There were two bottles of grape water, one which was half empty and unlabeled as to who it belonged to. LPN-B stated this refrigerator is nursing staff 's responsibility; however, there was no actual cleaning schedule or procedure of when to remove any outdated food items. She stated family members bring in items for residents on the secured unit. The refrigerator also contained several bags that were identified as being employee lunches/food, that were not dated or labeled. A policy entitled receiving and Storage of Food, dated 7/13, included, "Refrigerators are kept clean." A policy for discarding old food items was requested, but not provided by the facility.	F 371		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine maintenance and housekeeping services necessary to ensure air flow vents and sprinkler heads were kept free of dust and debris for 4 of	F 465	The vents in the rooms 60, 54, 66, and 67 were cleaned. The sprinkler heads in room 54 and 67 were cleaned. All resident rooms vents will be assessed and cleaned to ensure all vents are free of	6/25/14

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F 465	Continued From page 20 33 resident rooms (60, 54, 66 and 67) reviewed. 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 semi-annually, and filters were changed as needed, usually quarterly. The policy did not identify who was responsible for cleaning the sprinkler heads, nor the frequency of cleaning.	F 465	dust and debris. Room Cleaning Policy updated to include the following: Sprinkler Heads: Maintenance will ensure sprinkler heads are kept free from dust and debris in all resident rooms and public areas routinely. Air Flow Vents: Environmental Services will clean off the outside of the air vents monthly in resident rooms and public areas to ensure air flow vents are free of dust and debris. Maintenance will take down the vents and clean the inside of the vents/ducts every 6 months. Enviormental Service staff were updated in the communication book regarding the air flow vents updated policy and resident room audits. Audits will be conducted each month by EVS Manager. Maintenance Manager will monitor completion of duties by maintenance staff. Results from monthly audits will be brought forward to the Quality Assurance (QPS) committee. Completion date: June 25th, 2014	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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