

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3G27
Facility ID: 00633

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245396		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: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 049021100		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)			FISCAL YEAR ENDING DATE: (L35) 06/30	
6. DATE OF SURVEY 04/13/2017 (L34)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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				
8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u>2. Technical Personnel</u> <u>6. Scope of Services Limit</u> Compliance Based On: <u>1. Acceptable POC</u> <u>3. 24 Hour RN</u> <u>7. Medical Director</u> <u>4. 7-Day RN (Rural SNF)</u> <u>8. Patient Room Size</u> <u>5. Life Safety Code</u> <u>9. Beds/Room</u>				
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		12.Total Facility Beds 75 (L18) 13.Total Certified Beds 75 (L17)			* 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):

17. SURVEYOR SIGNATURE Marietta Lee, HFE NE II (L19)		Date : 05/08/2017	18. STATE SURVEY AGENCY APPROVAL Kate JohnsTon, Program Specialist (L20)		Date: 05/24/2017
---	--	-----------------------------	---	--	----------------------------

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

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28)		30. REMARKS Posted 05/24/2017 Co. DETERMINATION APPROVAL	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 8, 2017

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

****AMENDED LETTER: This letter supercedes and replaces the letter dated April 28, 2017.****

RE: Project Number S5396026

Dear Mr. Gilbertson:

On April 13, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

Electronic Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
brenda.fischer@state.mn.us
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 May 23, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 23, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 13, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Centracare Health System - Melrose Pine Villa Care Center

May 8, 2017

Page 6

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 28, 2017

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

RE: Project Number S5396026

Dear Mr. Gilbertson:

On April 13, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
brenda.fischer@state.mn.us
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 March 23, 2017, 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 March 23, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 13, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

April 28, 2017

Page 6

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston", with a large, sweeping flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 4/10/2017 to 4/13/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). CentraCare Health System-Melrose was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 441		5/19/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/08/2017

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

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 1</p> <p>accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 2</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include analysis of collected data to prevent potential spread of infection in the facility. This had potential to affect all 75 residents of the facility, staff and visitors in the facility.</p> <p>Findings include:</p> <p>The facility collected infection control data for each month from January 2017 through the present date was provided by director of nurses (DON) on 4/13/17, and identified the following information:</p> <p>A document, titled CCH(CentraCare Health)-Melrose Resident Control Log (Illness Log) from January of 2017, with dates of entry starting on 1/5/17 through 4/10/2017. This was a cumulative five page log with consecutive entries made chronologically. The log identified the following column headings; unit, room number, resident, signs and symptoms, onset date, site, community acquired, nosocomial/healthcare facility acquired, GI (gastrointestinal), urinary, respiratory, skin/soft</p>	F 441	<p>A new Monthly facility infection analysis worksheet was created. The monthly analysis report will be presented to the infection prevention committee meetings which are held every quarter. The Resident illness tracking form was modified to more easily identify illness within each wing. Education was provided to nursing staff on 5/2/2017 regarding completely filling in the form Resident illness tracking form. The symptom surveillance policy was updated. Audit of the illness tracking log will be completed by the LTC Director or her designee. This audit will be done weekly x 2 months or until compliance is met. The Director of Nursing will monitor the results of this audit and the results of this monitoring will be brought forward to the quality assurance committee.</p> <p>Completion Date: May 19, 2017</p>		

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 3</p> <p>tissue, ophthalmic/other infection/illness, findings charted, MD (medical doctor) notified, Lab (laboratory), x-ray results-date, recorded in chart, isolate/room (isolated to room), antibiotics treatment dose, treatment date range, ordering provider, change of antibiotic if needed, follow up date, and date resolved/treatment effective. The data collection tracking form had recently changed in January 2017 so the data reviewed was after the change in process and formatting. The reports identified the following:</p> <p>JANUARY 2017:</p> <p>The facility Resident Control Log data entered for January of 2017, identified 24 identified symptoms/infections for 22 residents, including four incidents of urinary tract infections (UTI's) occurring (one resident did have a recurrent infection), four skin infections, five incidents of GI symptoms, nine episodes with respiratory symptoms, one incident with fever identified, one non-healing wound, and one septic infection. The document identified two ordering providers out of the ten identified orders for antibiotic therapy. The log identified that five residents experienced diarrhea or loose stools during the period from 1/19/17 to 1/22/17 and three of the five residents were noted to reside on one unit, with no location information provided for the other two residents. The log failed to identify whether the infections were nosocomial (healthcare facility acquired) or community acquired, and did not indicate the dates the infection or symptoms resolved or if treatment was effective.</p> <p>An undated document document, Infection Control Summary Q(quarter) 3-Jan (January)-March 2017 identified that January had</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 4</p> <p>14 total infections with three respiratory infections, four UTI's, and five skin infections with two residents treated twice. This total was different from the numbers reflected on the Resident Control Log data as identified above. The report also identified two infections were identified as "other", with one being a tooth infection and the other a vaginal infection. The information regarding the tooth infection and vaginal infection was not identified in the Resident Control Log data. The Infection Control Summary identified no patterns or trends were noted.</p> <p>No additional information was provided to demonstrate any analysis of the collected data had been completed, if identified infections were related and /or spreading, or if any action plans had been identified or implemented to address identified concerns.</p> <p>FEBRUARY 2017:</p> <p>The Resident Control Log data entered for February of 2017, identified 15 symptoms/infections for 14 residents, with two incidents of UTI's having been redcurrant, three incidents of GI symptoms, nine episodes with respiratory symptoms, and one classified as "other". The document identified six ordering providers out of the eight identified orders for antibiotic therapy. The log identified that six residents experienced respiratory symptoms during the period from 2/21/17 to 2/27/17 with two residents identified as residing on the west wing, and no designation of location for the other three residents. The log identified that two of the 15 incidents were nosocomial, however, failed to identify whether the remaining 12 incidents were healthcare facility acquired or community</p>	F 441			

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 5 acquired, and did not indicate the date resolved or if treatment was effective.</p> <p>An undated document, Infection Control Summary Q(quarter) 3-Jan (January)-March 2017 identified that February had 22 total infections with 12 respiratory infections, two positive influenza cases, four skin infections, two infections classified as other, and four UTI's. This total was different from the numbers reflected on the Resident Control Log data which identified 14 infections. The Infection Control Summary identified a "definite pattern was seen with the increase in respiratory illness." It was noted the West wing had five cases, the N/S (North/South) wing had 4 cases and the Villa Court had three cases for a total of 12 respiratory cases. The Resident Control Log reflected 8 episodes of respiratory symptoms, and one "other" infection that included respiratory symptoms. The Infection Control Summary identified that isolation precautions were put into place "as appropriate" and table mates were monitored closely but specific interventions were not identified. The summary identified that more one to one interaction was encouraged versus large group activities. The information reflected that a large number of staff wore masks, even if vaccinated. Signs were posted which requested no visitors. The summary did not define when the visitor restriction were initiated, how long it was in effect, and when the restriction was lifted.</p> <p>MARCH 2017:</p> <p>The Resident Control Log data entered for March of 2017, identified 17 incidents of symptoms/infections for 16 residents, with three</p>	F 441			

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 6</p> <p>incidents of UTI's occurring, eight incidents of respiratory symptoms/infections, three incidents of skin/soft tissue and two incidents of illness were uncategorized. The document identified four prescribing provider out of the thirteen courses of treatment were identified. The log identified that one infection was nosocomial, but failed to identify whether the remaining 16 infections/symptoms were nosocomial or community acquired, and did not indicate the date resolved or if treatment was effective.</p> <p>An undated document document, Infection Control Summary Q(quarter) 3-Jan (January)-March 2017 identified that March had 14 total infections with three skin infections, five UTI's (two occurring with one resident), four respiratory infections (two occurring on west, and two occurring on Villa Court), two incidents of positive influenza, and one roommate treated preventatively. The summary identified there were no patterns or trends and that isolation precautions were placed "as appropriate". It was identified that influenza remained present in the community. The total presented in the Infection Control Summary differed from the numbers reflected on the Resident Control Log data as identified above. The restriction on visitors, as identified in February, was not identified in the information from this summary, however, was not addressed as being previously lifted.</p> <p>During interview on 4/13/17, at 10:15 a.m. with registered nurse (RN)-A and the director of nursing (DON), the DON stated when a resident was started on antibiotics, information was entered into the computer which begins the process for Infection Control Care plan. At that</p>	F 441			

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 7</p> <p>time isolation precautions are implemented if appropriate. If other symptoms have presented, the symptom tracker is utilized. The DON stated the information was reviewed at the morning meeting, held Monday through Friday to determine level of occurrence and identify there were any patterns. This was discussed as a interdisciplinary team to see if there were any department specific interventions needed. Registered nurse (RN)-A stated when assessing the information, consideration of symptoms presented and possible exposure was considered (i.e. roommates and table mated in the dining room). In the event of a positive testing for influenza, RN-A stated all tablemate's in the dining room were monitored. In addition, if an individual tested positive for influenza, and had a roommate, the affected individuals physician was contacted. The DON stated they had four confirmed cases of influenza but this had been sporadic. During this period, both DON and RN-A stated large group activities were decreased in favor of one to one activities, identifying that church services were held, allowing residents to participate via streaming through television instead of the large social gathering. RN-A stated precautions were implemented to decrease outside visitors, but these restrictions were for a very short period of time, approximated about five days. The DON stated tracking of interventions, their effectiveness, and duration of the utilization was not currently documented.</p> <p>During the interview on 4/13/17, at 10:30 a.m. RN-A stated there were additional upper respiratory infections, although not tested positive for influenza, which occurred later in January 2017. RN-A identified two residents were hospitalized with this and, upon review of the log</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 8 at this time, noted the information had not been logged onto the tracking tool. The DON stated they had been changing the CentraCare process of integration with policy and procedures. The nursing staff look at the infections and determine what was occurring. In addition to the log, the facility also uses User Defined Assessments (UDA's) for infections which are treated with antibiotics. This system was not used for other symptoms of illness without use of antibiotics. The facility policy, titled Infection Control-Purpose and Goals, dated as revised on 4/12 identified the purpose of the program is to interrupt the transmission of infectious disease and educate healthcare workers. The policy identified under guidelines the facility was to implement and maintain a clearly defined system of identifying and resolving problems related to infection control. This process identified the importance of communication for problem investigation and resolution, and of assuring resolution by follow up monitoring.	F 441			
F 520 SS=C	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 520		5/19/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 9</p> <p>staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently ensure the medical director or their designee were regularly attending the quarterly Quality Assurance (QA) meetings. This had the potential to affect all 75 residents whom resided in the facility, staff, and visitors.</p> <p>Findings include:</p> <p>A review of the Quality Patient Care Safety</p>	F 520	<p>The QA policy was updated to state that the committee will meet at least quarterly and required members were added to the policy. In the event that the Medical Director or her designee is unable to attend the quarterly QA meeting, the meeting minutes will continue to be forwarded to the Medical Director for review. A form will be sent along for the Medical Director</p>		

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

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 10</p> <p>Meeting minutes from 8/24/16 to 2/3/17 identified the facility had met on three occasions since the last facility survey on the following date: 8/24/16, 11/3/16 and 2/3/17. The medical director was only noted to be in attendance on 11/3/16. The medical or their designee had not attended the QA meeting on 8/24/16, or 2/3/17 which exceeded the quarterly requirement.</p> <p>When interviewed on 4/13/17, at 12:55 p.m. the director of nursing stated that Quality Patient Safety Meetings were held quarterly over the noon lunch hour to facilitate attendance of the medical director. The DON stated when the medical director does not attend a meeting, the meeting minutes are emailed to them. There was no process in place for the medical director to have suggestions to help evaluate activities or identifying issues when they missed a meeting. Also, there was no process in place for them to review the meetings minutes.</p> <p>The facility policy Quality Patient Safety (QPS), revised 9/15 did not identify the frequency of meetings, nor did it outline the whom should attend.</p>	F 520	<p>to add any comments/questions/ concerns/recommendations. This form will be added to the minutes to reflect the Medical Directors involvement in the QA meeting. The medical Director will be given a reminder phone call/e-mail one week prior to the quarterly QA meeting to allow time for the Medical Director or designee to have input in the meeting if not able to attend. The Quality Nurse will monitor this process every quarter and bring forward the results of this monitoring to the QA committee. Completion Date May 19th, 2017.</p>		

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

F5396025

PRINTED: 05/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>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.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 13, 2017. At the time of this survey, Centracare Health System Melrose (Pine Villa) was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p>	K 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
05/09/2017

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

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

PRINTED: 05/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 2007 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	K 000			

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

PRINTED: 05/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Both buildings have been surveyed as one.	K 000			
K 923 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		5/18/17	

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

PRINTED: 05/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2017
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C			STREET ADDRESS, CITY, STATE, ZIP CODE 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 923	<p>Continued From page 3</p> <p>STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect all of the 75 residents and an undetermined amount of staff and visitors.</p> <p>Findings include:</p> <p>On the facility tour between 8:30 am to 2:00 PM on 04/13/2017 observations and staff interview revealed:</p> <p>1) 1 oxygen bottle in the oxygen storage room 27 in Pine Haven that was not restrained. 2) E- Cylinders were not separated.</p> <p>This deficient condition was confirmed by the facility Maintenance Supervisor</p>	K 923	<p>Secured storage boxes were installed for full and empty tanks. Cylinder storage is separated and clearly marked as such. Staff will be reminded to secure tanks and keep separate. The LTC Director will monitor for compliance.</p>		