CENTERS FOR MEDICARE & MEDICAID SERVICES

			AKE/MEDICAL TO DE COMDI							ID: 52WT	640
			TO BE COMPI			IE SURVEI A	GENCI			Facility ID: 00	649
1. MEDICARE/MEDIC (L1) 245383	AID PROVIDER N	NO.	3. NAME AND AI (L3) OWATONN .					4. TYPE	OF ACTIO	ON: 7(L8)	
(L1) 245383 2.STATE VENDOR OR	MEDICAID NO		(L4) 201 SOUTH					1. Initia		2. Recertif	
(L2) 633442000			(L5) OWATONN		~	(L6) 55	5060	3. Termi 5. Valida		4. CHOW 6. Compla	
5. EFFECTIVE DATE (CHANCE OF OW	NEDCHID			CODY	<u>03</u> (L7)		7. On-Si		9. Other	
(L9) 01/01/2011	CHANGE OF OW.	NEKSHIP	7. PROVIDER/SU 01 Hospital	05 HHA	OKY 09 ESRD	<u>03</u> (L7) 13 PTIP	22 CLIA	8. Full S	Survey After	r Complaint	
6. DATE OF SURVEY	01/04/201	14 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	22 CLIA		-		
8. ACCREDITATION S	01/04/201	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III			FISCAL YE	EAR ENDI	NG DATE:	(L35)
0 Unaccredited	1 TJC	(E10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		1	2/31		
2 AOA	3 Other										
11LTC PERIOD OF C	ERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:						
From (a):			X A. In Complia	nce With		And/Or Approve	ed Waivers Of	The Following	Requirem	ents:	
To (b):				equirements			ical Personnel	6. S	cope of Se	rvices Limit	
12.Total Facility Beds		55 (L18)	•	e Based On: cceptable POC		3. 24 Hot	ur RN RN (Rural SN		Medical Dir Patient Rooi		
12. Total Facility Beds		55 (L16)	1. A	cceptable FOC		5. Life Sa			Beds/Room		
13.Total Certified Beds		55 (L17)		npliance with Pro		<u>—</u>	•	_			
			Requireme	ents and/or Appl	lied Waivers:	* Code: A		(L12)			
14. LTC CERTIFIED BI	ED BREAKDOWN	1				15. FACILITY ME	ETS				
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (i) (1):	((L15)		
	43	12				1001 (1) (1)	() /(-)/				
(L37)	(L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY A	GENCY REMARI	KS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):						
See Attached Remarks											
17. SURVEYOR SIGN	ATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL		Date:	
Brenda Fi	scher, Unit Sı	inervisor	0	2/17/2012		rz 1 m. 1 m		7 C	. 0	. 1	
		aper (1801		3/17/2013	(L19)	Kamala Fiske-I	Jowning, I	Enforceme	nt Speci	1 <u>a11s</u> t 03/21	/2014 (L20)
	PART	II - TO BE (COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR	SINGLE S	TATE AGE	ENCY		
19. DETERMINATION	OF ELIGIBILITY	7	20. COM	IPLIANCE WIT	'H CIVIL	21. 1. Sta	tement of Finan	icial Solvency	(HCFA-257	72)	
X 1. Facility	is Eligible to Partic	cinate	RIGI	HTS ACT:			nership/Contro th of the Above		osure Stmt	(HCFA-1513)	
-	y is not Eligible					3. Bo.	ar or the rice ve	·			
		(L21)									
22. ORIGINAL DATE	2	3. LTC AGREEN	MENT 24	4. LTC AGREE	MENT	26. TERMINATI	ION ACTION:			(L30)	
OF PARTICIPATIO	ON	BEGINNING	DATE	ENDING DA	ATE	VOLUNTARY	_00	_	INVOLUN	NTARY	
12/01/1986						01-Merger, Closur	re	_		Meet Health/Sa	ıfety
(L24)		(L41)		(L25)		02-Dissatisfaction	W/ Reimburse	ement	06-Fail to	Meet Agreemer	nt
25. LTC EXTENSION	DATE: 2		VE SANCTIONS	(===)		03-Risk of Involun	tary Termination	n	OTHER		
			of Admissions:			04-Other Reason fo	or Withdrawal			er Status Chan	ge
				(L44)					00-Active		
	(L27)	B. Rescind Su	spension Date:								
				(L45)							
28. TERMINATION D	ATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS					
			00320								
		(L28)	20220		(L31)	Posted 03	/31/2014	CO			
						1 03104 03	, 51/2014				
31. RO RECEIPT OF C	MS-1539	32	. DETERMINATION	OF APPROVAL	L DATE						

(L33)

DETERMINATION APPROVAL

01/24/2014

(L32)

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00649

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

24-5383

Minnesota Department of Health completed a Post Certification Revisit (PCR) on January 4, 2014 and the Minnesota Department of Public Safety completed a PCR on March 4, 2013. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the November 22, 2013 standard survey as of February 28, 2014 and a Federal Monitoring Survey on March 4, 2013. Mandatory denial of payment for new Medicare and Medicaid admissions did go into effective from February 22, 2013 to February 27, 2014 in response to the denial of Payment the facility will be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 22, 2014 since the facility did not attained substantial compliance on February 22, 2014. Refer to the CMS 2567b for both health, life safety code and the FMS. Effective February 28, 2013, the facility is certified for 55 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245383

March 21, 2014

Ms. Brianne Wolters, Administrator Owatonna Care Center 201 Southwest 18th Street Owatonna, Minnesota 55060

Dear Ms. Wolters:

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 February 28, 2014 the above facility is certified for:

- 12 Skilled Nursing Facility Beds
- 43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds located in rooms.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumalu Fiske Downing

Licensing and Certification Program, Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 17, 2014

Ms. Brianne Wolters, Administrator Owatonna Care Center 201 Southwest 18th Street Owatonna, Minnesota 55060

RE: Project Number S5383026

Dear Ms. Wolters:

On December 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 22, 2013. 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.

In addition, on January 16, 2014, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of you facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. 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.

On January 29, 2014, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 22, 2014.

Also, the CMS Region V Office notified you in their letter of January 29, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), if your facility failed to achieve substantial compliance by February 22, 2014, your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 22, 2014.

Owatonna Care Center March 17, 2014 Page 2

On January 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 4, 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 November 22, 2013 and the FMS completed on January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 22, 2013 and the FMS completed on January 16, 2014. As a result of the PCR findings, this Department recommended to the CMS Region V Office the following actions related to the CMS letter dated January 29, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions will be discontinued, effective February 28, 2014.

In the CMS letter of January 29, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 22, 2014 if denial of payment for new admissions should go into effect. Since your facility did not attained substantial compliance on February 22, 2014, the original triggering remedy, denial of payment for new admissions, did go into effect on February 22, 2014.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245383	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/4/2014
Name of Facility		Street Address, City, State, Zip Code	
OWATONNA CARE CENTER		201 SOUTHWEST 18TH STRE	ET

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	ı	(Y5) Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. # LSC	F0157 483.10(b)(11)		Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii),	Correction Completed 01/01/2014 (c)(2) -	ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 01/01/2014
ID Prefix Reg. # LSC	F0272 483.20(b)(1)		Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 01/01/2014
ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0323 483.25(h)	Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 01/01/2014
ID Prefix Reg. # LSC	F0334 483.25(n)		Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0353 483.30(a)	Correction Completed 01/01/2014		F0356 483.30(e)		Correction Completed 01/01/2014
ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)	Correction Completed 01/01/2014	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 01/01/2014
Reviewed I	-	Reviewed GN/KFI	•	Date: 03/21/201	Signature of	Surveyor:	10160		Date:	01/04/2014
Reviewed I		Reviewed		Date:	Signature of	Surveyor:	10100		Date:	
Followup t	to Survey Cor 11/22	npleted on 2/2013	:		Check for any U Uncorrected I	ncorrected Defic Deficiencies (CM				NO

OWATONNA CARE CENTER

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245383	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 3/4/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
\cap	MATONNA CARE CENTER		201 SOUTHWEST 18TH STREE	ΞT

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).

OWATONNA, MN 55060

(Y4) Item		(Y5)) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction Completed				Correction Completed					Correction Completed
ID Prefix			02/28/2014	ID Prefix			02/28/2014		ID Prefix			02/28/2014
Ū	NFPA 101		_		NFPA 101		_		Ū	NFPA 101		
LSC	K0018			LSC	K0025				LSC	K0027		
			Correction				Correction					Correction
			Completed				Completed					Completed
			02/28/2014	ID Prefix			02/28/2014		ID Prefix	-		02/28/2014
	NFPA 101		-	_	NFPA 101		-			NFPA 101		_
LSC	K0029			LSC	K0052			<u> </u>	LSC	K0062		_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			02/28/2014	ID Prefix			02/28/2014		ID Prefix			<u> </u>
	NFPA 101			_	NFPA 101		-		Reg. #			_
LSC	K0064			LSC	K0147				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
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L30				LSC				<u> </u>	LSC			<u> </u>
			Correction				Correction					Correction
			Completed				Completed					Completed
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Reg. #				Reg. #					Reg. #			_
				200				<u> </u>				
Reviewed B	Ву	Reviewed	I By	Date:	Signatu	re of Su	veyor:				Date:	
State Agen	су	GS/I	KFD	03/21/20	14		25	822				03/04/2014
Reviewed B	Ву	Reviewed	I By	Date:	Signatu	re of Su	veyor:				Date:	
CMS RO												
Followup t	to Survey Co	•	1:							Summary of		
	1/16	5/2014			Uncorrec	tea Defic	ciencies (CM	S-25	o/) Sent to	the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 52WT

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00649	
1. MEDICARE/MEDIC (L1) 245383 2.STATE VENDOR OF			3. NAME AND AD (L3) OWATONN (L4) 201 SOUTH	A CARE CEN	TER		4. TYPE OF AC 1. Initial 3. Termination	2. Recertification	
(L2) 63344200)		(L5) OWATONN	A, MN		(L6) 55060	5. Validation	6. Complaint t 9. Other	
5. EFFECTIVE DATE	CHANGE OF OWNE	RSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit		
(L9) 01/01/2011			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey	After Complaint	
6. DATE OF SURVEY 8. ACCREDITATION		(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR E	NDING DATE: (L35)	
0 Unaccredited	1 TJC 3 Other	(L10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
2 AOA 11LTC PERIOD OF C			10.THE FACILITY	' IS CERTIFIED	ι Δ ς.				
From (a):			A. In Complian		715.	And/Or Approved Waivers Of	f The Following Requi	irements:	
To (b):			Program Re	equirements		2. Technical Personne	1 6. Scope o	of Services Limit	
12.Total Facility Beds	2	55 (L18)	•	e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SI	7. Medical NF)8. Patient l		
12. Total Facility Beds	•	(L10)		есериале 1 ос		5. Life Safety Code	9. Beds/R		
13.Total Certified Beds	5	55 (L17)	X B. Not in Com Requirement	npliance with Pro ents and/or Appl		* Code: B*	(L12)		
14. LTC CERTIFIED B	ED BREAKDOWN		•			15. FACILITY MEETS			
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
	43	12							
(L37)	(L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY	AGENCY REMARKS	(IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):				
See Attached Remarks	5								
17. SURVEYOR SIGN	IATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
yla <u>Einertson,</u> HFE	NE II		0	1/04/2014	(L19) K	amala Fiske-Downing,	Enforcement Sp		(L20
	PART II	- TO BE	COMPLETED I	BY HCFA RI	` ′	OFFICE OR SINGLE S	STATE AGENCY	`	LZO
19. DETERMINATION	N OF ELIGIBILITY			IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina			
1. Facilit	y is Eligible to Participa	ate	RIGE	HTS ACT:		Ownership/Contr Both of the Abov	rol Interest Disclosure S /e:	Stmt (HCFA-1513)	
2. Facili	ty is not Eligible	(L21)							
22. ORIGINAL DATE	23. 1	LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	1:	(L30)	
OF PARTICIPATION 12/01/1986	ON	BEGINNING	G DATE	ENDING DA	XTE .	VOLUNTARY 01-Merger, Closure		LUNTARY il to Meet Health/Safety	
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs		il to Meet Agreement	
25. LTC EXTENSION		1 1	IVE SANCTIONS	(L23)		03-Risk of Involuntary Termination		_	
23. Ere Extendion			n of Admissions:			04-Other Reason for Withdrawal		ovider Status Change	
	(L27)			(L44)			00-Ac	tive	
	(127)	B. Rescind S	uspension Date:	(L45)					
28. TERMINATION D	ATE:	20	9. INTERMEDIARY/			30. REMARKS			—
		2,							
	(L	28)	00320		(L31)				
31. RO RECEIPT OF C	MS-1539	30	2. DETERMINATION	OF APPROVA	LDATE				
III NO RECENT FOR C			<i>5212</i> 10111111111	J. III RO M	(L33)	DETERMINIATION APP	DOWAL		
	(L	32)			(L33)	DETERMINATION APP	KUVAL		

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00649

C&T REMARKS - CMS 1539 FORM

CCN-245383

STATE AGENCY REMARKS

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. 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), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7048

December 16, 2013

Ms. Brianne Wolters, Administrator Owatonna Care Center 201 Southwest 18th Street Owatonna, Minnesota 55060

RE: Project Number S5383026

Dear Ms. Wolters:

On November 22, 2013, 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>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;

Owatonna Care Center December 16, 2013 Page 2

<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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 1, 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 January 1, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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;

Owatonna Care Center December 16, 2013 Page 3

- 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner

Owatonna Care Center
December 16, 2013
Page 4
than the latest correction date on the PoC.

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 February 22, 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 May 22, 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:

Owatonna Care Center December 16, 2013 Page 5

> 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 a PoC 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 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 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist Licensing and Certification Program

Division of Compliance Monitoring
Minnesota Department of Health

Telephone: (651) 201-4124

Dre Klegge

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Owatonna Care Center December 16, 2013 Page 6

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Tara B 4 7 5	- OLUD) (E) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction ngDEC 3 1 2013	COMF	E SURVEY PLETED
		245383	B. WING _	BANIS	1	22/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIPCODE		
OWATON	INA CARE CENTER			201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	,	
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F 000	INITIAL COMMEN	TS	F 00	00		
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.				
F 157 SS=D	revisit of your facili validate that substa regulations has be your verification. 483.10(b)(11) NOT	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with TIFY OF CHANGES E/ROOM, ETC)	F 1	57 SEE AHached		1-1-14
	consult with the resknown, notify the reor an interested far accident involving injury and has the intervention; a sign physical, mental, o	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in potential for requiring physician ifficant change in the resident's or psychosocial status (i.e., a				
	status in either life clinical complication significantly (i.e., a existing form of treatment); or a de-	alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment need to discontinue an eatment due to adverse to commence a new form of ecision to transfer or discharge the facility as specified in	1-4-1 GPI			
	and, if known, the or interested family change in room or	lso promptly notify the resident resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in				
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	12-	(X6) DATE
	By and	110000		administrator	19	0113

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.

Facility ID: 00649

		8 MEDICAID SERVICES	(X2) MUI	TIPLE (CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			nr-a	2013	OWN FELLER
		245383	B. WING		MN Dept of He	CITTI	11/22/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE SOUTHWEST 18TH STREET	<u>:</u>	
	NA CARE CENTER				VATONNA, MN 55060		
OWATOR	OLUMBA DV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
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E 457	Continued From p	age 1	F	157			
F 157	ident rights und	der Federal or State law or ecified in paragraph (b)(1) of					
	u darooo ond r	ecord and periodically update shone number of the resident's ve or interested family member.					
	This REQUIREM	ENT is not met as evidenced					
	facility failed to no	ew and document review, the otify a family when a resident after a fall for 1 of 1 resident or notification of change.					
	Findings include:	R50 experienced a fall and wa 1/15/13, the resident's family until the afternoon of 11/16/15 of					
	requested to spe concerns related had been transfe	:37 p.m., family member (F)-4 eak to a surveyor as she had I to R50's cares. F-4 stated R50 erred to the hospital on 11/15/13 been notified until 11/16/13 It by a nurse from the care cente					
	documentation of	is reviewed. According to on the face sheet, R50 was facility on 3/26/13 with diagnose t were not limited to osteoporos	s is.				
	registered] repo	urse progress notes dated ed, "NAR [nursing assistant orted at 8:15 p.m. that resident ed" writer was able to hear audil ughing, and noted res [resident] ema bilateral feet. Res was very	iO				had David Sala
1	nave pitting out	F ID: 50	NACT 44	F	Facility ID: 00649	r continuati	on sheet Page 2 o

NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 21	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUC	TION	(X3) DA	ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 2 lethargic as well. LS [lungs sounds]-Rhonchi and rubs. Flu [follow up] fall as well neuros [neurological check]/witas WML. [within normal limits] Call placed to on-call physician but no return call as of 11:15 p.m. Resident was sent to ER [emergency room] by ambulance at 9:40 p.m. without consent for her safety. Still awaiting call from on-call at this time. " Review of a nurse's progress note dated 11/16/13 indicated, "Daughter notified of fall and res [resident] admitted to hospital." During an interview on 11/20/13 at 2:38 p.m. the administrator confirmed R50's family should have been notified as soon as R50 left the building to be hospitalized and after R50 had her fall on 11/15/13. Review of the Resident Change in Condition Guidelines dated 6/2013 indicated, "Notification of physician and/or responsible parties shall be documented in the resident's medical record as well as on the 24-hour report form." F 225 483.13(c)(1)(ii)-(iii), c)(2) - (4) SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	AND PLAN O	FCORRECTION					:	1.	1/22/2013
OWATONNA CARE CENTER 201 SOUTHWEST 18TH STREETS Dept of Houth OWATONNA, MN 50506			245383	B. WING		SEET ADDD		-2 H A RE-BRIDGE	1/22/2010
SUMMARY SINEMAN TO SECRET STATE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 2 lethargic as well. LS [lungs sounds]-Rhonchi and rubs. F/u [follow up] fall as well neuros [neurological check]/vitals WNL [within normal limits]Call placed to on-call physician but no return call as of 11:15 p.m. Resident was sent to ER [emergency room] by ambulance at 9:40 p.m. without consent for her safety. Still awaiting call from on-call at this time. " Review of a nurse's progress note dated 11/16/13 indicated, "Daughter notified of fall and res [resident] admitted to hospital." During an interview on 11/20/13 at 2:38 p.m. the administrator confirmed R50's family should have been notified as soon as R50 left the building to be hospitalized and after R50 had her fall on 11/15/13. Review of the Resident Change in Condition Guidelines dated 6/2013 indicated, "Notification of physician and/or responsible parties shall be documented in the resident's medical record as well as on the 24-hour report form." F 225 SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have					201	SOUTHW VATONNA	EST 18TH STREEN De , MN 55060	ept of Health ochester	
lethargic as well. LS [lungs sounds]-Rhonchi and rubs. F/u [follow up] fall as well neuros [neurological check]/vitals WNL [within normal limits]Call placed to on-call physician but no return call as of 11:15 p.m. Resident was sent to ER [emergency room] by ambulance at 9:40 p.m. without consent for her safety. Still awaiting call from on-call at this time. " Review of a nurse's progress note dated 11/16/13 indicated, "Daughter notified of fall and res [resident] admitted to hospital." During an interview on 11/20/13 at 2:38 p.m. the administrator confirmed R50's family should have been notified as soon as R50 left the building to be hospitalized and after R50 had her fall on 11/15/13. Review of the Resident Change in Condition Guidelines dated 6/2013 indicated, "Notification of physician and/or responsible parties shall be documented in the resident's medical record as well as on the 24-hour report form." F 225 SS=D The facility must not employ individuals who have	PREFIX	/EACH DEFICIENC	Y MIJST BE PRECEDED BY FULL	PREF	1	(FAC	H CORRECTIVE ACTION S-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETION DATE
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been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry		Guidelines dated physician and/or r documented in the well as on the 24-483.13(c)(1)(ii)-(ii) INVESTIGATE/RI ALLEGATIONS/III The facility must been found guilty mistreating reside had a finding entergistry concernir of residents or mand report any known to flaw again indicate unfitness	6/2013 indicated, "Notification of responsible parties shall be resident's medical record as hour report form." i), (c)(2) - (4) EPORT NDIVIDUALS not employ individuals who have of abusing, neglecting, or ents by a court of law; or have red into the State nurse aide ing abuse, neglect, mistreatment isappropriation of their property; nowledge it has of actions by a last an employee, which would as for service as a nurse aide or	F	225	SEE	Attached		1-1-14

		A WEDICAID GETTATGE	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DATE S	URVEY	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		Dra.	COMPLETED		
AND PLAN O	FOUNCOTION				020 3 1 711:		10040	
		245383	B. WING		MN Dept of Heate.	11/22	/2013	
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, 21 CODE			
					SOUTHWEST 18TH STREET			
OWATON	INA CARE CENTER			OW	ATONNA, MN 55060	011	(VE)	
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E 005	Continued From p	20e 3	F	225				
F 225								
	or licensing author							
	The facility must e	nsure that all alleged violations						
	involving mistreatr	nent, neglect, or abuse,						
	lingluding injuries (of Linknown Source and						
	misappropriation of	of resident property are reported administrator of the facility and						
	to other officials in	accordance with State law						
	through established	ed procedures (including to the						
	State survey and	certification agency).						
	1							
	The facility must h	nave evidence that all alleged roughly investigated, and must						
	violations are tho	tential abuse while the						
	investigation is in	progress.						
	The results of all	investigations must be reported						
	to the administrat	or or his designated d to other officials in accordance	е					
	with State law (in	cluding to the State Survey and						
	cortification agen	cv) within 5 working days of the						
	incident and if the	e alleged violation is verified						
	appropriate corre	ective action must be taken.						
	This REQUIREM	ENT is not met as evidenced						
	by:							
	Based on obser	vation, interview and document y failed to report allegations of						
	habuso/podlect im	mediately to the State Agency						
	and immediately	to the administrator for 1 or 4						
	residents (R20)	reviewed for vulnerable adult						
	protocol		h					
	Findings include	: R20 had an allegation of roug	11					
	treatment report	ed by staff on 10/7/13 however, not been reported immediately	to					
	the administrate	r or to the designated state	1					
	agency but had	been reported the day after the					-t Dogo 4 of	
	-g-//-j ::	E	A/T-44	Ea	cility ID: 00649	ntinuation she	et Page 4 of	

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA DEC 3 1 2013 STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _____ 11/22/2013 AND PLAN OF CORRECTION MN Dept of Health B. WING STREET ADDRESS, CITY, STATE, ZIF CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE ID CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PRÉFIX TAG F 225 Continued From page 4 F 225 incident was reported by staff. Review of a vulnerable adult report for R20 dated 10/7/2013 5 p.m., revealed activity staff observed nursing staff identified as being rough with the resident, during repositioning of the resident in the wheelchair. The administrator and state agency were not notified until the next day 10/8/2013. On 11/20/2013 at 2:20 p.m., the administrator was interviewed regarding the incident. She verified the activity staff reported it the morning of 10/8/2013 to her and it was also reported to the office of health and facility complaints (OHFC). The administrator indicated per facility policy, the staff should have notified her right away and OHFC. Review of the Deseret Health Group Policy on Abuse-Allegations and Reporting, identified 1. The facility must ensure that all alleged violations and/or reasonable suspicion of a crime involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriate of resident property, are reported immediately to the 1-1-14 F 226 SEE Attachment Administrator of the facility, State Survey Agencies and Law Enforcement.

FORM CMS-2567(02-99) Previous Versions Obsolete

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

policies and procedures that prohibit

The facility must develop and implement written

mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced

Event ID: 52WT11

Facility ID: 00649

If continuation sheet Page 5 of 6

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		(X3) DATI	E SURVEY PLETED
AND PLAN OF	CORRECTION	245383	B. WING			DEC 3 1 2013	11/	22/2013
	ROVIDER OR SUPPLIER	245363		STI 20	REET ADDRESS, CITY 1 SOUTHWEST 18T WATONNA, MN 5:	H STREET		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER' (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTI ECTIVE ACTION SHOUI ENCED TO THE APPRO DEFICIENCY)	LD DE	(X5) COMPLETION DATE
F 226	by: Based on intervie facility failed to im procedure for rep state agency imm (R20) reviewed for Findings include: treatment reporte the incident had reported the incident had reported the incident was reported. Review of a vulne 10/7/2013 5 p.m. nursing staff ider resident, during resident resi	w and document review, the plement their facility policy and porting to the administrator and ediately for 1 of 4 residents or Abuse Prohibition. R20 had an allegation of rough d by staff on 10/7/13 however, not been reported immediately to or to the designated state een reported the day after the orted by staff. Perable adult report for R20 dated, revealed activity staff observed tiffied as being rough with the repositioning of the resident in the administrator and state notified until the next day at 2:20 p.m., the administrator regarding the incident. She inty staff reported it the morning and it was also reported to the and facility complaints (OHFC), or indicated per facility policy, the notified her right away and the seeret Health Group Policy on the ensure that all alleged violatio ble suspicion of a crime involving teglect or abuse, including injurity	of did of ne	226				
	recident proper	urce and misappropriate of ty, are reported immediately to f the facility, State Survey	the		Facility ID: 00649	If co	ontinuation	sheet Page 6 of

TATEMENT (OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI				DEC 3 1	2013	COM	E SURVEY IPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NO					MN Dept of I		11/	22/2013
		245383	B. WING	CTD	EET ADDR	RESS, CIT	Y, STATE, ZI	P CODE		
NAME OF P	ROVIDER OR SUPPLIER			201	SOUTHW	VEST 18	TH STREET			
				OW	ATONNA	4, MN 5	5060			
OWATON	NA CARE CENTER		l			50\ (IDED	IC DLAN OF	CORREC	TION	(X5) COMPLETION
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				226						
F 226	Continued From p	age 6		226				_1		1-1-14
•	Agencies and Law	, Enforcement.		272	SEE	AHa	chmer	T		L
E 272	483.20(b)(1) COM	IPREHENSIVE	Г.	212	<i>J</i>					
SS=D	ASSESSMENTS									
	The facility must (conduct initially and periodically								
	011 (0	accurate Stational dieco								
	reproducible asse	essment of each resident's								
	functional capacit	ry.								
		ake a comprehensive								
	by the State The	e assessment must include at								
	I + the followin	u.								
	Identification and	demographic information;								
	Customary routing	ne;								
	Cognitive patterr	ns;								
	Communication;									
	Vision;	ior natterns.								
	Mood and behav	all haina.								
	Psychosocial we	ning and structural problems;								
	Otimonoo:									
	Disease diagno	sis and health conditions;								
	Dental and nutri	itional status;								
	Skin conditions:									
	Activity pursuit;									
	Modications:	r and procedures.								
		ents and procedures;								
	Discharge pote	at cummany initiality i casis	ling							
	areas trinnered	by the completion of the Minim	ium							
	Documentation	of participation in assessment.								
										n sheet Page 7
1					Facility ID:	00040		1f	continuatio	n sneet Page /

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		ction DEC 3 1 2013	COM	PLETED
		245383	B. WING		MN Dept of Health Rochester	11/	22/2013
NAME OF I	PROVIDER OR SUPPLIER	210000			RESS, CITY, STATE, ZIP CO	`	LL/ LO 10
OWATON	NA CARE CENTER				VEST 18TH STREET A, MN 55060		
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F 272	Continued From pa	ge 7	F 27	2			
	by: Based on observat review, the facility for comprehensive inition assessment for 1 of for resident assess	ial Minimum Data Set (MDS) f 3 residents (R68) reviewed					
	Record review reversely, and PPS reading documented, hower assessment with capeen completed for five day dated 10/2.	itted to the facility on 10/22/13. caled a PPS five day, PPS 14 mission MDS had been ver no comprehensive initial are area assessments had R68. According to the PPS 4/13, R68 had diagnoses were not limited to diabetes ee amputation.					
F 309 SS=D	director of nursing vinitial comprehension	CARE/SERVICES FOR	F 30	SEE	Attachment	-	1-1-14
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment					

Facility ID: 00649

OENTED!	S FOR MEDICARE	& MEDICAID SERVICES	0.40) 14111	(2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
CENTER	OF DEFICIENCIES		, .				COMI ELTER			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				3 4	10012043		
		245383	B. WING			B. Ah. I. po	111	/22/2013		
				STRE	ET ADDRESS	, CITY, STATE PERIOCO	ODE			
NAME OF P	ROVIDER OR SUPPLIER			201	SOUTHWEST	T 18TH STREET				
				OW	ATONNA, M	N 55060		(VE)		
OWATON	NA CARE CENTER		ID			IDER'S PLAN OF COF ORRECTIVE ACTION		(X5) COMPLETION		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL ASC IDENTIFYING INFORMATION)	PREF		(EACH C CROSS-RE	FERENCED TO THE	APPROPRIATE	DATE		
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TAG										
			F	309						
F 309	Continued From p	page 8	•							
	This REQUIREM	ENT is not met as evidenced								
	by:	ew and document review, the								
	of 1 resident (R1)	2) reviewed for dialysis; failed to								
	comprehensively	assess dental needs and care								
•	resident (R68) W	and investigate a bruise for 1 of	3							
	failed to identify	reviewed for skin conditions.								
			_							
	Findings include	: R12's dialysis catheter site had	۱ د							
	not been monito	red daily per physician orders.								
	-	idmitted on 7/2/12. R12's quarte	rly							
	R12 had been a	Set (MDS) dated 8/27/13,						-		
	Minimum Data	oses of chronic renal failure and								
	renal dialysis st	atus.								
	1									
	R12's care plan	dated 10/29/13, indicated elated to chronic renal failure, ris	sk							
			n/							
	11	hada Tiressillu silouiu isiiisii	υ у,							
		a dry sterile dressing. Monitor fo ptoms of bleeding, hemorrhage								
	_		1							
	R12's physicia	in orders dated 11/13, identified	ilv							
	1	Channe veni circuit occin-	my,							
	dialysis if dres	ection. Do not get wet, as yether sing gets wet, and replace with								
	dressing.									
	D12's treatme	ent sheets dated 11/13, identified	d it							
		CONT CITCHII CAIHELEI GOIN	itor							
	for infection.	Do not get wet, notify dialysis if			Facility ID: 006	40	If continuati	on sheet Page S		

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ DEC 3 1 70k AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZECODE alth 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DEFICIENCY) (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG F 309 Continued From page 9 dressing gets wet, and replace with dry dressing. F 309 R12's treatment sheet identified night shift to check with 11/2/13 only date for month of November of having been completed. During interview on 11/22/13, at 9:45 a.m., director of nursing stated she expected staff to check site daily and initial treatment sheet when completed and if R12 refuses staff should initial, circle initials and document resident refused. Director of nursing verified treatment sheet had been initialed on 11/2/13 as only date of having been completed for month of November. Document review of the facility Hemodialysis Access Care dated revised 10/10, indicated to prevent infection and/or clotting check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care and at regular intervals. R68 had two broken teeth on upper gum line that had not been identified on oral assessment. R68 had been admitted on 10/22/13. R68 had diagnoses which included but not limited to diabetes, below knee amputation. R68 had not received a completed full admission Minimum Data Set to determine oral/dental needs. R68 's temporary care plan dated 11/9/13 identified oral care: own teeth and partial upper denture. However, there was no information as to the broken teeth or if there was a problem with pain, chewing or talking due to broken teeth. R68 had a note that stated there had been an

oral assessment dated 11/9/13, which identified own teeth, partial upper denture and does not need dental exam. However, this lacked the

DEPARTMENT OF DEPICIENCES (X1) PROVIDENSIVE PREVIOUS (X2) MULTIPLE CONSTRUCTION A BUILDING 245383 NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER (X4) D. SUMMARY STATEMENT OF DEPICIENCY SEARCH (X2) MULTIPLE CONSTRUCTION (X4) D. PREVIOUS (X2) CONTROLL (X2) CONTROLL (X2) CONTROLL (X3) CONTROLL (X4) CONTR	DEPARTI	S FOR MEDICARE	& MEDICAID SERVICES	ANUTIDI E	CONSTRUCTION		(X3) DAT	E SURVEY PLETED	
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healing of this bruise.		determined to	s bruise.	of					
healing of this bruise. During document review R23 had diagnoses of During document review R23 had diagnoses of Figure ID: 52WT11 Facility ID: 00649 If continuation sheet Page 11 of		During docur	nent review R23 had diagnoses	i Ol	= -:::- ID: 006	49	If continuatio	n sheet Page	11 of

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 R WING STREET ADDRESS, CITY, STATE ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 OWATONNA CARE CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 309 Continued From page 11 F 309 vascular dementia and cerebral vascular accident. Review of the physician orders it was noted R23 was on a low dose of aspirin start date of 10/19/13. R23 had a readmission Minimum Data Set (MDS) completed on 10/25/13 and with this assessment R23 scored a 5/15 on a brief interview for mental status indicating severe cognitive impairment. Upon review of November 2013 nursing progress notes there was no documentation in regards to the bruise on the back of left hand. During review of weekly skin assessment last completed on 11/1/13 had not identified any bruises. During interview on 11/20/13, at 1:24 p.m. R23 indicated had not known how the bruise occurred. During interview on 11/20/13, at 1:26 p.m. registered nurse (RN)-A verified bruise was on back of left hand dark purple in nature. RN-A indicated was unaware of the bruise and had not been informed by any staff that bruise was present. RN-A indicated if find a bruise would check in the nurses progress notes to see if the bruise had been identified. RN-A also indicated would check if R23 had lab drawn and if occurred in the area of the bruise. RN-A would expect the nursing assistants to let the nurse know of bruising. At 2:03 p.m., RN-A verified there was no documentation on the bruise and would start the investigation now. During interview on 11/22/13, at 11:01 a.m. the director of nursing (DON) indicated bruises were included in unusual occurrences policy. DON verified R23 had cognitive impairment and the nursing assistants should have noted the bruise with cares and notified the nurse immediately so documentation, monitoring and investigation

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	LOP MEDICARE	& MEDICAID SERVICES	TIDI E	CONSTRUCTION		(X3) DATE S	FTED
CENTERS	FOR WILDIO TIVE	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING	30140111.001.01	- DE O a		
ATEMENT C	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		DEC 3 1 2013	7013	
ID FLANCI			D MING		MN Dant - c.	11/22	2/2013
		245383	B. WING	DEET ADDRESS (CITY, STATE ZIE CODE		
	on OURDLIED		511	SOUTHWEST	ISTH STREET		1
NAME OF PE	ROVIDER OR SUPPLIER		20	SOUTHWEST	55060		
OVAZANI	NA CARE CENTER		0	VATONNA, MN	ER'S PLAN OF CORRECTION SHOULD	ON	(X5)
DVVATOR	(IA 6)	OF DEFICIENCIES	ID				COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN) REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REF	RRECTIVE ACTION SHOOT ERENCED TO THE APPRO DEFICIENCY)	PRIATE	
170							
			F 309				
F 309	Continued From p	page 12					
, 555			2				
	had not been a w	reekly skin assessment done					
	since 11/1/13.						
		requested and had not					
	Policy on bruising	g was requested and had not		arr MH	fachnent		1-1-14
	L provided h	/ tacilly.	F 314	SEE A	- when		
F 314	483.25(c) TREA	TMENT/SVCS TO L PRESSURE SORES					
SS=D	PREVENT/HEA	L PINLOGGINE G					
	- the 00	imprehensive assessment of a					
	they were unav	oidable; and a resident having	ad				
	pressure sores	receives necessary treatment a	nd				
	i to prof	note fleating, provent	110				4
	prevent new so	res from developing.					
	•	·					-
		MENT is not met as evidenced					
	by:	ervation, interview and documer	nt				
i ·							
1							
١	document trea	itments for 1 of 1 100 a.m.					
	reviewed for D	ressure ulcers.					
	1641CAACA 131 b		ed				
1	Findings inclu	de: R75 had not been reposition	he				
	for two hours	and thirty minutes even though t	R75				
	temporary car	re plan states very two hours as	had				
	had a history	of Skill Dieakdown and					
	a stage II pre	ssure uicei.					
		hast noted R75 had been admit	ted				
		LIER AIGHNOSES INCIDACE CONTRACTOR					
	on 11/14/13 V	tus post motor vehicle crash,					
1	limited to sta	ius posi motor roman			If o	ontinuation s	heet Page 13
1				Facility ID: 00649	a If c	continuation s	meeri age it

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA

CNITED	S FOR MEDICARE	& MEDICAID SERVICES Tourn province // SUPPLIER/CLIA	LOVON MULTIT	IPLE CONSTRUCTION		(X3) DAT	1PLETED	
ENTER	STOR WEBS	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULI	NG				
PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII					
,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			B. WING				22/2013	
		245383	B. WING	STREET ADDRESS, CI	TY, STATE, ZIP COD	E		
	- OLUBER OR SUPPLIER			201 SOUTHWEST 18	TH STREET			
	ROVIDER OR SUPPLIER			OWATONNA, MN	55060			
WATON	NA CARE CENTER				DIAN OF CORRE	ECTION	(X5)	
		DEFICIENCIES	ID				COMPLETION DATE	
(X4) ID	SUMMARY ST	TATEMENT OF DEPOSITIONS OF MUST BE PRECEDED BY FULL OF SECTION O	PREFI TAG	CDOSS-REEL	RECTIVE ACTION OF RENCED TO THE AP DEFICIENCY)	PROPRIATE		
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1710		DEFICIENCY			
TAG	_		-					
				314				
F 314	Continued From p	page 13	•	514				
1 314	traumatic brain in	iury, loss of consciousness,						
	diabetes, fracture	es (multiple).						
	D75 's temporar	y care plan dated 11/19/13,						
	identified at risk f	or skin breakdown, reposition						
	two staff sometime	mes staff of three, wound care.						
	R75 's hospital (dismissal summary orders date	u					
	11/14/13. identifi	led pressure ulcer stage two	nt					
	coccyx cleanse	daily with normal saline (Anase	ιρι (Ol					
	if stool) use frict	ion to remove slough; apply nick	r .					
			١.					
	Left heel, deep	tissue injury, and hospital						
	treatment 5x9 p	lus mist therapy. Left lateral foo	ι,					
	deen tissue inju	ry, hospital treatment ace wrap						
	plus mist therap	oy.						
	1 '							
	R75 ' s admissi	on/re-admission assessment						
			re)					
			3)					
	2cm	V 30M and left too pro-						
	unstageable m	easures 2cm x 2cm.						
	During observa	ation on 11/21/13, at 7:10 a.m.,	1					
	foot floated on	pillow. At 7:15 a.m., registered	ned					
	R75 with a bla	anket. R75 remained laid on bac	,					
			, , , ,					
1	remained laid	on back. At 7:27 a.m., nursing	aht					
	assistant (NA)-C had entered room and brou	R75					
			1110					
	entered room	and asked R75 about pain and	back					
1	delivered bre	aktasi ilay, 1770 torriam): 52WT11	Facility ID: 00649		If continuatio	n sheet Page 14	

TEMENT OF PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	NG		11	/22/2013		
AME OF PRO	OVIDER OR SUPPLIER	245383	B. WING	STREE	T ADDRESS, CITY, STATE, Z DUTHWEST 18TH STREE	IP CODE			
WATONNA	A CARE CENTER			OWAT	ONNA, MN 55060	CORRECTION	(X5)		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE		
A n s s s s s s s s s s s s s s s s s s	nedications, R75 a.m., R75 remained owered head of be had entered to rerect remained laid on laid. R75 remained laid on laid. R75 remained laid on laid. R75 remains same surveyor revealed off back for a total minutes, at which laid. During interview verified had not reshift at 6:00 a.m. ask to be reposited laid. During interview stated R75 shout two hours. RN-B room and the on been legs and feeling interview director of nursite to reposition R7 two hours. Direct staff to keen reposition Director of nursite between shifts repositioned. 483.25(d) NO CRESTORE BLACE.	remained laid on back. At 8:40 remained laid on back. At 8:40 red laid on back, R75 had ead. At 8:51 a.m., staff person move breakfast tray out of room don back. At 9:03 a.m., R75 back in bed, sleeping. At 9:22 red laid on back in bed, sleeping. At 9:43 a.m., ref. Continuous observation by dr. R75 had not been repositioned of two hours and thirty three remains same. At 9:43 a.m., ref. Continuous observation by dr. R75 had not been repositioned of two hours and thirty three remains surveyor informed staff. On 11/21/13, at 9:43 a.m., NA-Continuous of the propositioned R75 since started NA-C stated R75 will normally inned once R75 gets pain pills. On 11/21/13, at 9:47a.m., RN-E at the propositioned at least event at the propositioned, had been and one half hours between the propositioned and one half hours of the proposition on the proposition of nursing stated she would expect staff the proposition of the propos	d d s s s s	314 F 315	SEE AHOCHMA	ut	1-1-1		
	Based on the re	esident's comprehensive			sility ID: 00649	If continuation	sheet Page 15		

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

DEPART	MENT OF HEALTH	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIDLE C	ONSTRUCTION	(X3) DATE COMI	SURVEY
CENTER	S FOR MEDICANE	L COMPERISHER IER/CLIA	(X2) MUL	ING	ONOTIVE 1		
STATEMENT	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BOILD			11/3	22/2013
ANDIDAG		245383	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE		
				STR	SOUTHWEST 18TH STREET		
NAME OF F	PROVIDER OR SUPPLIER			201	VATONNA MN 55060		
	NNA CARE CENTER					CTION	(X5) COMPLETION
OWATOR		FEIGIENCIES	ID PRE	FIX	(EACH CORRECTIVE ACTION OF	ROPRIATE	DATE
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TA		DEFICIENCY)		
				315			
	Continued From	nage 15		310			
F 315	Continued 1 ton	facility must ensure that a					
	assessment, the	ers the facility without an car is not catheterized unless the	.	,			
	indwelling cathet	ers the facility without and er is not catheterized unless the licondition demonstrates that					
	resident's Cillilla	and a resident					
	catheterization v	vas ricodotas roceives appropria	ate				
	who is incontine	THE OF BLOOM IN THE UTINARY TRACE					
	treatment and s	ervices to prevent unitary disco- o restore as much normal bladd	er				
	function as pos	sible.					
	Tunction as pos						
		as evidenced	1				
	This REQUIRE	MENT is not met as evidenced					
	bv:	document review, the	:				
	Based on intel	comprehensively reassess a comprehensively reassess a continence status for 1 of 1					
	facility failed to	ary continence status for 1 of 1 ary continence status for 1 of 1 croviewed who had a change in					
	rosident (R62)	ary continence status to reviewed who had a change in					
	continence Size	มเนอ.					
		and a decline in contin	ence				
	Findings inclu	de: R62 had a decime had been reassessed to determine had a decime had	_				
	and had not b	een reassessed to determine to restore or prevent further los	s of				
	interventions	[0 (03:010 1					
	continence.		itted				
	R62 's face s	sheet noted R62 had been adm	ere				
	on 8/8/13 wit	n diagnosos transpanial injury Wi	thout				
	not limited to	Alaboimer's diseas	se,				
	mention of s	kull fracture, Alzheimer e she yndrome with left leg weakness					
	post- polio s	yridionic with	lated				
	Des's quarte	erly Minimum Data Set (MDS) o	aleu				
	11/3/13 indic	erly Minimum Data Set (MDE) cated R62 was always incontine decline for R62) of urine, was n	ot on a				
	(this was a	decline for read extensive					
	toileting pro	grani and roganic accessment	t of				
	assistance	to tollet. The tribating program v	vas not				
	11/3/13 indi	Icaleu inat a temper incontinenc	e.				
	being used	to manage urinary incommended he previous admission MDS da aluded R62 was frequently inco	tea ntinent				tion sheet Page 16 o
1	MOWEVEI, 1	CILIDEU IVOZ WAR	ot ID: 52WT		Facility ID: 00649	If continua	HOLL SHOOT O

TEMENT (OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		MPLETED
		245383	B. WING	STREET ADDRESS, CITY, STATE, ZI		/22/2013
	ROVIDER OR SUPPLIER			201 SOUTHWEST 18TH STREET OWATONNA, MN 55060		
OWATON	NA CARE CENTER			TROUGHT PLEASE PLAN OF I	CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACT	HE APPROPRIATE	DATE
F 315	Urinary Continence indicated R62 was needed to go to the of incontinence si was incontinent or dementia. Indicate however usually a Indicated R62 required to be hours and as need. Urinary Continent indicated R62 was with a Foley catheter. Indicated R6 was department on 8 concentrated uring diagnosed with a Foley catheter. Indicated R6 was department on 8 concentrated uring diagnosed with a Foley catheter woccasional incorreturned from he reported that R6 nocturnal and eathroughout the CR62 requested meal. Staff was commode before The care plan prindicated that R6 bladder, and direvery two hours plan goal was fooder.	e Evaluation dated 11/2/13 is unable to determine when she he bathroom and had a history ince admission. Indicated R62 f bladder due to Alzheimer's ed R62 could use the call light already had a wet pad had. Quired an assist of 1 for all cares e checked and changed every 2 ded. It is admitted to facility on 7/31/13 eter with no orders to remove. It is transferred to emergency 1/4/13 due to increased confusion in eand lethargy. R62 was a urinary tract infection and the rest incomplete when first incomplete incomplete in the pattern of bladder when first incomplete inc	3 e of	315		
	Nursing assista	ant/registered (NAR) care guides at the time of the survey included	111	Facility ID: 00649	If continuation	n sheet Page 17

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245383	B. WING			11/	22/2013
	ROVIDER OR SUPPLIER	240000	STREET ADDRESS, CITY, STATE, ZII 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060				
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RE	(X5) COMPLETION DATE
F 315	Continued From pathe following informundated Re-admis Communication for catheter. "-11/5/13 MDS Kard Center, "occasion frequently inconting The care plan prolindicated that R62 bladder, and directing before and and free of odor. During an intervienursing assistant incontinent of blad toileted upon rising the evening or up there have been significant.	age 17 nation: ssion Awareness rm, " Incontinent of bowel and dex Report for Owatonna Care nal incontinent of bowel and		318			
	During an intervier registered nurse decline in inconting the bladder diary, and MDS assess was not effective facility did not full prevent further demaintain optimal the facility should continence check determine if there incontinence to related to her incontinence.	ew on 11/21/13 at 9:46 a.m. (RN)-A stated R62 displayed a nence and verified according to urinary continence evaluation ment the current toileting plan for R62. RN-A verified the ly assess R62's toileting plan tecline in incontinence or to bladder function. RN-A stated I have implemented hourly ks and attempted toileting to e was a pattern to R62's plan of care continence to help prevent further ications. RN-A verified the care	er				

PRINTED: 12/16/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 713 11/22<u>/2013</u> B. WING STREET ADDRESS, CITY, STATE, ZIR 6 9 DE Health 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 OWATONNA CARE CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 315 F 315 Continued From page 18 sheets used to communicate the resident plan of care to the nursing assistants were not updated to reflect accurate toileting plan or incontinence of R62. During an interview on 11/22/13 at 12:37 p.m. the director of nursing verified when the MDS assessment identified a concern with the change in bladder incontinence for R62 the nurse should have initiated a bowel and bladder diary for three days to establish a pattern of incontinence to make the determination of what the correct toileting program should be and the care plan should have been revised to reflect the change in incontinence and toileting needs. The DON verified a comprehensive bladder assessments should have been done for R62 to help maintain optimal bladder function and prevent further decline in bladder incontinence. The DON verified there had not been communication to the nursing assistants 1-1-14 F323 SEE Attachment regarding a change in R62's incontinence and toileting needs. 483.25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES SS=D The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

by:

This REQUIREMENT is not met as evidenced

Based on interview and document review, the

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

)EPAR IIV	SENT OF TIERES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Toyo MIII	TIPLE CONS	TRUCTION	COM	PLETED
ENTERS	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A RIIII D	ING			
ATEMENT O	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BOILD			111	22/2013
D D " "		045393	B. WING				
		245383		STREET	ADDRESS, CITY, STATE, ZIP COI	<i>-</i>	
IAME OF PE	ROVIDER OR SUPPLIER	8		201 SOU	THWEST 18TH STREET		
				OWATO	ONNA, MN 55060	PECTION	(X5)
OWATON	NA CARE CENTER	- OLEMOIES	ID		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S	SHOULD BE	COMPLETION DATE
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREI TA	FIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	
PRÉFIX	(EACH DEFICIENT REGULATORY OR	CY MUST BE PRECEDED BY TOLE LSC IDENTIFYING INFORMATION)			DEFICIENT		
TAG	\\L01=						
			F	323			
F 323	Continued From	page 19					
	facility failed to co	page 19 omplete a comprehensive fall owing a fall to determine possibl	e				
	assessment folio	a fall in order to develop					
	root cause/s or u	and further falls from					
	interventions to	of 4 residents (R3) who were					
ı	reviewed for free	quent falls.					
	TEALESMENT TO THE	· · · · · · · · · · · · · · · · · · ·					
	Findings include	e: R3 had history of falls and					
	recent falls while	e in the facility without thorough					
	implemented, a	III Eliconvolle					
	intervention eva						
	Do was re-adm	nitted on 10/5/2013 after					
	R3 was re-aun	of pneumonia (9/26/2013 to					1
	10/5/2013) with	n diagnoses included: bipolar					
	disorder, diabe	etes, and high blood pressure.					
		t dated 10/6/20	13				
	Admission fall	It identified R3 at high risk of the R3 had a history of falls in	falls				
	was reviewed.	It identified R3 at flight flock of f 30. R3 had a history of falls in 8/2013 and 2 in 10/201	the				
	with a score of	f 30. R3 had a flistory of father ith 2 in 10/201 and 2 in 10/201 and 2 in the parties had changed over the parties and changed over	3.				
	last 90 days w	vith 2 in 9/2013 and 2 in 16/20 e status had changed over the personal pers	de of				
	year and the	e status had changed over the period resident had behaviors of period retion or awareness of surround	inas				
	altered perce	ption or awareness of surround	dav.				
	mental function	on valles over the cares. The resi	dent				
	abusive and v	was resistive to our paired vision	on,				
	was identified	d with moderately impalied the with moderately impalied the whole with moderately impalied the without m	ical				
	confined to w	meelchair, arrays	, and				
	support, nad	actors (impaired hearing,					
	perceptual	actors (impaired fleating, rtigo). The resident's re-admiss	sion at as				
	MDS dated	rtigo). The resident 3 to dame 10/11/2013 identified the reside	111 05				
	having mode	erate cognitive impairment and	tivities				
	required ext	ensive assist of the					
	of daily living	9.					
		t dated 10/10/20	13 was				
	An accident	t/incident report dated 10, 15, 25 The resident was found sitting of	on the			If continuat	on sheet Page
1	reviewed.	THE resident was the	+ ID: 52WT1	1 Fa	acility ID: 00649		

ENTERS FOR MEDICA TEMENT OF DEFICIENCIES PLAN OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
	245000	B. WING			22/2013
AME OF PROVIDER OR SUPPL			STREET ADDRESS, CITY, STATE, ZIP 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	CODE	
WATONNA CARE CENTE	R		TO DI AN OF CO	ORRECTION	(X5) COMPLETION
SUMMARY	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION OF THE CORRESPONDED TO THE	IE APPROPRIATE	DATE
F 323 Continued From floor and stated. The intervention pressure alarm. Tested and for Resident configuration weakness/fair wear and amb. Although the asystem in place alarms routing malfunction. An accident/in reviewed. The alarm to find stated, "I war bathroom," in in room, drow poor lighting after the fall identified. R3's care place high risk of fair history of fair within reach exercise, for on floor nexe and treat as cause of fall Educate fair care plan with a alarms. On 11/22/2 nursing (Do	d, "I don't know what happened in was the malfunctioning bed in replaced with new alarm pad. Ind to be working properly. Used. Impaired decision making cent change in condition, ted, gait imbalance. Improper for sulating without assist. No injury. In alarm was replaced, there was note to monitor the function of the ely to reduce the occurrence of a modern of the resident on floor. The resident are staff responded to bed pressuresident on floor. The resident are to get up. I had to go to the originary. The report identified clusty, impaired decision making, and interventions were identified and no actual causal factors were an date of 3/30/2013 noted: I an all related to unsteady gait, and its: Interventions include: call light participate in activities that proform to bed, physical therapy evaluated ordered or as needed. Determing the record possible root causes. The as not updated to address the united to addr	was re tter nd de ht mote stops te ne ese of f staff ing.	323		n sheet Page 21

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE ID SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG F 323 Continued From page 21 resident; they are to check the alarms. At 2:30 F 323 p.m., the DON was again interviewed and indicated there was no monitoring system that she was aware of to maintain or check the alarms for functionality used on the residents. On 11/22/2013 at 11:44 a.m., the administrator was interviewed regarding the system the facility used after a resident experienced a fall. An incident report was made out by nurse manager, family and physician was called, she and the director of nursing was notified to consider vulnerable adult report needed, and the nurses had to put intervention into place immediately. Every Monday, the administrator and DON meet to look at all the falls for previous week and look for trends. They make sure interventions had been care planned. R3's incident of 10/25/2013 fall when the alarm had not sounded was reviewed with the administrator. At 12:40 p.m., the administrator provided a focus rounds sheet as a tool to monitor alarms and then stated that they do audits and fill out the sheet monthly and turn it into the maintenance staff. However, the

provided. . 483.25(I) DRUG REGIMEN IS FREE FROM F 329 UNNECESSARY DRUGS SS=D

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose

form did not include or identify checking and maintaining resident alarms. No further

information or auditing of the alarms was

F 329 SEE Attachment

1-1-14

TEMENT (OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COM	IPLETED
) PLAN OF	CORNECTION	245383	B. WING			22/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	CODE	
NOTAWC	NA CARE CENTER		ID	TO UDEDIC DI AN OF CO	ORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		E ALL KOLK	DATE
F 329	should be reduced combinations of the Based on a compresident, the facility who have not use given these drugs therapy is necessed as diagnosed and record; and resided drugs receive grant services as diagnosed and resided trugs receive grant services as diagnosed and record; and resided trugs receive grant services as diagnosed and record; and resided trugs receive grant services as diagnosed and record; and resided trugs receive grant services as diagnosed and records are services are services as diagnosed and records a	d or discontinued; or any		329		
	by: Based on intervention of a cility failed to it as needed (PRN non-pharmacold administering at effectiveness of (R71 and R72) behaviors or diamedications; are effectiveness of 5 residents (medications; and behaviors/modications; and behaviors/modications and behaviors/modications.	MENT is not met as evidenced view and document review, the dentify parameters for use of an	nts let for r 1			

TEMENT (OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	NSTRUCTION	COM	IPLETED
) PLAN OF	CORRECTION	IDENTIFICATION NOMBER				11/	22/2013
		245383	B. WING	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
AME OF P	ROVIDER OR SUPPLIER			201 S	SOUTHWEST 18TH STREET ATONNA, MN 55060		
NOTAW	NA CARE CENTER			OVV	THE PLAN OF CORRECT	ION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 329	Continued From p	age 23	F	329	·		
L 258	Findings include: identified for use of medication, had not interventions offe PRN pain medicated for PRN pain medicated for provided f	R71 had not had parameters of as needed (PRN) pain not had non-pharmacological red prior to administration of ation, had not had effectiveness ication documented, had not icors identified and monitored for ychotic medication and had not entified for medications R71 had not in form it was learned that R71 ed on 11/2/13. R71's admissional entified for medications R71 had not in form it was learned that R71 ed on 11/2/13. R71's admissional entified for medications R71 had indicated cognitively and no behaviors. In form it was learned that R71 ed on 11/2/13, identified use edication related to schizoaffer or/record occurrences of for taxons and document per facility ver, there were no specific ified to determine if antipsychological entities and direct the effectiveness of pain and monitor/document relieving dismissal summary dated 11/2 hoses of acute exacerbation of the pair of the p	or to the ad or				
	chronic COPD disease), acut respiratory fail pulmonary dis	e hypoxemic and hypercapnic lure due to chronic obstructive lease (COPD), diabetes, e disorder, obstructive sleep a nephropathy, tardive dyskines	pnea,		Facility ID: 00649	continuatio	n sheet Page 2

	IENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				(V2) DATE	0938-0391 SURVEY
NITEDS	FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE C	ONSTRUCTION	COM	PLETED
- LENT O	E DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	ING			
PLAN OF	CORRECTION	IDENTIFICATION	1			11/	22/2013
		245383	B. WING	3	OUT)/ STATE 7IP		
				STR	EET ADDRESS, CITY, STATE, ZIP		1
ME OF PF	ROVIDER OR SUPPLIER			201	SOUTHWEST 18TH STREET		
				OV	VATONNA, MN 55060	ODDECTION	(X5)
NOTAW	NA CARE CENTER		IE		PROVIDER'S PLAN OF C	ON SHOULD BE	COMPLETION DATE
	SUMMARY ST	TATEMENT OF DEFICIENCIES	PRE	FIX			
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TA	(G	CROSS-REPERCIONENCY	1)	
TAG	REGULATORY OR						
	/			- 000			
	d From t	page 24	1	329			
F 329	Continued From	page 2 ·					
١	ital die	smissal summary orders dated					
	R71's nospital dis	d orders for the following					
	11/2/13, luentined	no corresponding diagnosis: no metric medication) 30 mg					
	medications with	anxiety medication) 30 mg	_				
	(milligrams) two	anxiety medication) 56 mg times a day, aspiring 81 mg on in D3 1 000 unit tablet one time					
	time daily, vitam	times a day, aspiring of ingline in D3 1,000 unit tablet one time (an anti-depressant medication)				
	daily, fluoxetine	in D3 1,000 unit tablet of the can anti-depressant medication as an autes (60 mg) one time da	íly,			•	
	20 mg capsule	Capsulos (ti coizure					
	lamotrigine (Lar	nictal) (an anti-seizure) mg tablet 3.5 tablets (350 mg) Tonamax (an anti-seizure					
	medication) 100	Ing lablet ord					
	every beatime,	toparriax (amblets (50 mg) two					
	medication) 25	mg tablet 2 tablets (66 mg/ d torsemide (Demadex) (loop tion) 5 mg tablet one time daily					
	times a day and	tion) 5 mg tablet one time daily and of R71's medication					
	diuretic medica	ew of R71's medication					
	odministration	ew of R/15 medication record dated 11/2/13, indicated receiving the above medication	16				
	p71 had been	record dated 1172713, indication receiving the above medication	13				
i	since admission	on.					
1	311100 23	· amony orders date	ed				
1	R71's hospital	dismissal summary orders date					
	11/2/13, identi	fied order for acetaminophen	ery				
1	(Tylenol) 500 I	mg lablet one to the order for					
	six hours as n	leeded for paint,	ablet				
	Risperdal (an	ti-psychotic medication) of the stage of the	eview				
1	2 tablets (6 ff	g) every permission record of	ated				
1	of R/1 's me	dication administration receiving that deal R71 had been receiving the	ne l				
	11/2/13, maic	ated R71 had been receiving ations since admission on a rou	ine				
1	above medic	uuo					
	basis.	TLCD	OUP				
	Document re	eview of DESERT HEALTH GR	11/13.				
	Pain Manage	eview of DESERT HEALTH ement Assessment Tool dated to had received PRN Tylenol (p	ain				
	identified R7	ement Assessment 100, used 11 had received PRN Tylenol (p	blets				
	medication)	for pain on dates of 11/5 two ta	the				
	for pain rate	for pain on dates of 1776 the (rating of 0 to 10 with 10 being	of				
	worst) of six	(, 11/0 two tables					
	nine, 11/7 tv	vo tablets with no pain rate d, 11/8 two tablets pain rate of f	our,			If continuat	ion sheet Page
	Jacumenter	4 11/0 IWU Labiote P	t ID: 52WT		Facility ID: 00649		

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) D	ATE SURVEY OMPLETED
		245383	B. WING			1/22/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP C 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060 ochoster	alth	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ODOCC DECEDENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
F 329	11/10 received two six and four, 11/11 documentation if repain rate of five, 11 five, 11/20 two tab tablets pain rate of that non-pharmace attempted to relieve the phase of target behaviors in antipsychotic medication of the physician of the ph	tablets twice with pain rate of received Tylenol with no eceived one or two tablets for 1/14 two tablets pain rate of lets pain rate of five, 11/21/ two f three. There was no indication ological interventions were	n s x	329		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245383	B. WING		11	/22/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ODGGG DEFENDED TO THE	N SHOULD BE	(X5) COMPLETION DATE
F 329	of an anti-psychotic nursing stated PRN clarification from physics one tablet or the expect staff to offer interventions prior is should be following regarding effectived. Document review of Medication Orders Specifications for Dimedications must if for which given. " Document review of revised 4/10, read request or as need little as possible. In circumstances for medication. Policy Implementation 1. documentation shaunder which the medication properly implemented, nurs of such medication properly implemented, nurs of such medication could be because the problem. Document review of Review Committee read "POLICY: "antipsychotic drugs reductions and bery given and bery greductions and bery given and per policy."	e medication. Director of I Tylenol order should have hysician regarding when to wo tablets and she would non-pharmacological to giving PRN Tylenol and staff up within one hour maximum hess of PRN Tylenol. If the facility Physician dated revised 4/10, read "Orug Orders 6. Orders for include: e. Reason or problem of the facility PRN Orders dated "Policy Statement PRN (on ed) orders shall be used as 'PRN "orders must clarify the offering or giving the Interpretation and PRN orders or related all specify the circumstances edication shall be offered or detail as is needed to give the y. 2. When PRN orders are ing staff must monitor the use to determine: a. the nature of hether it persists; b. whether on is needed; or c. whether the discontinued entirely	F3	329		

ENTERS FOR MEDICARE FEMENT OF DEFICIENCIES PLAN OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
PLAN OF CORRECTION	245293	B. WING			22/2013
ME OF PROVIDER OR SUPPLIER	245383		STREET ADDRESS, CITY, STATE, ZIP 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	CODE	
WATONNA CARE CENTER SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFI	PROVIDER'S PLAN OF C		(X5) COMPLETION DATE
	ATEMENT OF DETICIENT STEELS Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	")	
will discuss approagration of OBRA requirement documentation of Document review Documentation A Monitoring dated To assist the faci residents who remedications. PR require antipsych following information Antipsychotic Marestorative, and participating in the eliminating med problem(s) identification order following: c. added daily or weekly R72 had physic pain medication Oxycodone with when to use white the same of the admitted on 12 included close Review of the admitted on 12 included close with the same of the admitted on 12 included close in the same of the same	drugs. PROCEDURE. 2. FIGO priateness of therapy based on hits regarding: d. quantitative appropriate target behaviors. " of the facility Nursing antipsychotic Medication revised 6/13, read "POLICY: lity in assessing and monitoring quire the use of antipsychotic OCEDURE: 2. All residents who notic medication will have the edication Log: j. List intervention behavior interventions resident to assist in decreasing and lication. k. List of behavior tified on the care plan. I. List of m(s) identified on the Behavior et. 3. Residents with antipsychologist. 3. Residents with antipsychologist will be reviewed for the equate monitoring of antipsychologist. Tylenol, Tramadol, and nout identified parameters for an incomplant pain non-pharmacological interventics attempted and documented as attempted and documented as of the medications once given has seed. Admission form noted that R72 /14/2013 with a diagnosis that diffracture of humerus, atrial	s, is ic tic ons nd	329		
	t physician orders, dated		Facility ID: 00649	If continuation	sheet Page 28

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY COMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION A. BUILDING _ IDENTIFICATION NUMBER: 11/22/2013 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245383 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060 NAME OF PROVIDER OR SUPPLIER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OWATONNA CARE CENTER CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PRÉFIX TAG F 329 Continued From page 28 11/14/2013 from the patient discharge F 329 instructions identified the following pain medications: oxycodone 5 milligrams every 6 hours as needed for pain; tramadol 50 mg every 4 hours as needed for pain (25 mg at breakfast, noon and supper, 25 mg as needed at bedtime) and acetaminophen 325 mg 2 tablets every 6 hours as needed for pain. There were no parameters for use identified in the order, nor on the medication should administration record, to determine which pain medication (Tylenol, Tramadol or Oxycodone) be used to treat R72's pain. Review of the PRN medication sheets from November 14, 2013 through November 20, 2013 revealed the following medication usage: (1) 11/15/2013, 11/16, 11/17, 11/18, 11/19 and 11/20-Tramadol 25 mg given at 0800, 1200, 1800. No reason was identified for the use of the pain medication on the medication sheet and no pain level was documented. (2) 11/18 and 11/19-Tramadol 50 mg orally every 4 hours as necessary for pain was given. No documentation was evident of the resident 's pain level, where the pain was neither located, non-pharmacological interventions attempted first nor effectiveness of the pain medication. (3) 11/15, 11/17, 11/18, 11/19, and 11/20/2013-Oxycodone 5 mg one table orally every 6 hours prn pain. No documentation was evident of the resident's pain level, where the pain was neither located, non-pharmacological interventions attempted first nor effectiveness of

the pain medication.

(4) 11/18/2013-Acetaminophen 325 mg (2) tabs

by mouth every 6 hours as necessary for pain.

TEMENT	S FOR MEDICANE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILD	TIPLE CONSTRUCTION ING	COM	IPLETED
) PLAN OF	COMMEDITOR		B. WING			22/2013
	ROVIDER OR SUPPLIER	245383	B. WING	STREET ADDRESS, CITY, STATE, ZII 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060	PCODE	
MATON	NA CARE CENTER			THE PLAN OF	CORRECTION	(X5)
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F 329	Continued From phon-pharmacologinor effectiveness On 11/20/2013 at (RN)-C was interved to give the resident wanted something the pain at 8 of 1 appropriate than were no specific give but usually go to R72. Tating and how signed the resident Tramadol medication. However, in the pain at 8 of 1 appropriate than were no specific give but usually go to R72. The pain at 8 of 1 appropriate than were no specific give the resident Tramadol medication and the resident Tramadol medication. However, in the resident there were defectiveness of and use of non before giving the effectiveness of the resident the effectiveness of the resident the resident the resident the resident the resident there were effectiveness of the resident the r		t en e e e e e e e e e e e e e e e e e e	329		

	UEALTH	AND HUMAN SERVICES				OMB NO.	SURVEY
DEPARTM	ENT OF HEALTH	AND HOMAIN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	COMF	PLETED
05	- DEELCHENOIS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING			22/2013
TATEMENT OF AND PLAN OF (CORRECTION	IDENTIFICATION					22/2013
		245383	B. WING		ET ADDRESS, CITY, STATE, ZIP COD	E	
				201 9	SOUTHWEST 18TH STREET		
NAME OF PR	OVIDER OR SUPPLIEF	₹		OWA		FOTION	(X5)
OWATON	A CARE CENTER				PROVIDER'S PLAN OF CORN	HOULD BE	COMPLETION DATE
OWATON	WADY 6	TATEMENT OF DEFICIENCIES	ID PRE	FIX	(EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	
(X4) ID PREFIX TAG	SUMMART S (EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCE		
IAG				329			
	. F	nage 30		- 329			
F 329	Continued From	page 56 at 12:45 p.m., the director of projewed regarding the as needs	- d				
	On 11/21/2013 a	at 12:45 p.m., the director of erviewed regarding the as needs tuse. She would expect	eu				
	nursing was into	rviewed regarding the use. She would expect ogical interventions to be offere	d				
	non-pharmacon	ogiosi max ioi					
	challa lall	W MP Landication	1				
	- offectiveness u	for the USE OF LIFE	as				,
	Should have sh	pecific criteria for the door ledication. Verified this resident teramadol, and Oxycodone as					
1	needed pair in	redication. Verified this football, tramadol, and Oxycodone as					
	naeded						
	11003	ribed Trazodone and Ambien fo	r				
	R3 was presci	er R3 had not been tolk assessed or monitored for s	oloen				
	sleep; howeve	er R3 had not been vely assessed or monitored for s	Siech				
	patterns.						
		e Admission form it was noted the	nat				
	Review of the	e Admission form It was noted and mitted on 10/5/13, with diagnost and insomnia, bipolar disorder, a	ses				
	D2 was re-ac	Illilled on the lar disorder a	nu l				
	which include	ed insomnia, bipolar disordor, bia. A re-admission Minimum Da lated 10/18/13 identified R3 with	n l				
	0-+ (001)510	lated 19 havelelan	nucio				
	moderate CC	Dyninivo """ (a contra identified t	3 Was				
	dated 10/5/4	2013 and Warrame by mo	uui				
	- receribed	liazudono a pasiliarams	DV				
	every bedui	me and Ambien 12.5 milligrame y bedtime as needed. Howeve had not been assessed upon	1, 1100				
	sleep cycle	y bedtime as needed. What had not been assessed upon back to the facility.					
	admissi	off pack to an	1-				
	1	from facility in I	egards				
1.	On reques	ting information from facility was pattern and comprehensive sleep assessment was pro	ep vided				
	Laccossme	ill a sicop of	nieleu				
	and dated	int a sleep assessment was pro- 3/30/13 which as not fully comi was provided after R3 's readn was 210/5/13.	nission				
	to the fact						
	0= 11/21	/2013 at 12:20 p.m., a registere	esident				
	(RN)-B W	/2013 at 12:20 p.m., a registered ras interviewed and stated the r on refusing the Trazodone at hs (hours of			If continu	ation sheet Page 3
	had beer	refusing the Trazodone at he	vent ID: 52W	/T11	Facility ID: 00649		

	LUMAN SERVICES				OMB NO.	0938-0391
DEPARTMENT OF HEALTH A	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTI	ON	(X3) DATE COMI	SURVEY PLETED
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	IDENTIFICATION NOMBER	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			11/3	22/2013
	245383	B. WING	ADDRE	SS, CITY, STATE, ZIP CO)DE	
			STREET ADDRES	ST 18TH STREET		
IAME OF PROVIDER OR SUPPLIER			OMATONNA	MN 55060		
OWATONNA CARE CENTER			PR	OVIDER'S PLAN OF CO	RECTION	(X5) COMPLETION DATE
(X4) ID SUMMARY ST. PREFIX REGULATORY OR	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX (EACH	OVIDER'S PLAN OF COOR I CORRECTIVE ACTION -REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
F 329 Continued From R sleep) and didn't fonly monitor sleep assessment period effectiveness door was taken or nor were attempted. On 11/21/2013 and nursing (DON) with monitoring of sleep do not monitor stresident was on and Ambien primedications should be documeded medicated 3/16/202 recent one. So a sleep assess re-admission physician had 10/9/2013. The monitoring of medical recommedical r	page 31 take the Ambien very often. Exp patterns during the initial and and every quarter. No cumented when the medication and pharmacological interventions at 12:45 p.m., the director of was interviewed regarding seep patterns. She indicated the sleep patterns and she verified a Trazodone at hs (hour of sleep and have parameters for when all interventions first. The staff amenting effectiveness of as a stations within an hour. At 1:15 pages at a sleep assessment/evaluations within an hour and indicated that was the manual to the facility 10/5/2013. The ordered the Ambien medication when the patterns for R3 evident in the patterns for R3 evident in the cological interventions were a soft the antianxiety was not soft the antianxiety was not	ey the p) ded not to common the ever, and common th	329			tion sheet Page 3

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION OWATONNA CARE CENTER PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DEFICIENCY) (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX TAG F 329 Continued From page 32 dysphagia (difficulty swallowing), antisocial personality, and schizophrenia. R3 had a physician order for Ativan 0.5 mg every 6 hours as needed for agitation or for anxiety. R3 used the as needed medication 8 times in 10/13 and 5 times in 11/2013. On 11/21/2013 at 12:20 p.m., a registered nurse (RN)-B was interviewed and stated that she gave it to R3 for anxiety or agitation. Then went on to explain " If the resident was yelling. " However, RN-B verified there were no specific criteria for when to give the medication. She verified the medication sheets did not show documentation if the medication had been effective or non-pharmacological interventions had been attempted prior to the use of the Ativan. On 11/21/2013 at 12:45 p.m., the director of nursing was interviewed regarding use of as needed Ativan medication. The as needed Ativan medication should have specific criteria for when to use and the staff should be attempting non pharmacological interventions first. The staff 1-1-14 F 334 SEE Attachment should be documenting effectiveness of the as needed medications within an hour. 483.25(n) INFLUENZA AND PNEUMOCOCCAL

immunization;

IMMUNIZATIONS

that ensure that --

The facility must develop policies and procedures

representative receives education regarding the

(i) Before offering the influenza immunization,

each resident, or the resident's legal

benefits and potential side effects of the

F 334

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OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 OWATONNA CARE CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) (X4) ID TAG PRÉFIX TAG F 334 Continued From page 33 F 334 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING _ STATEMENT OF DEFICIENCIES 11/22/2013 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OWATONNA CARE CENTER CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PRÉFIX TAG F 334 Continued From page 34 representative was provided education regarding F 334 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced Based on interview and document review, the by: facility failed to obtain information regarding residents pneumococcal immunization status for 3 of 5 residents (R34, R20, and R16) reviewed for immunizations. Findings include: R34 was admitted on 9/11/2013 and had no pneumococcal information identified in the chart to determine whether or not the resident had been immunized or needed to be immunized. R20 was admitted on 4/3/2012 and had no pneumococcal information identified in the chart to determine whether or not the resident had

been immunized or needed to be immunized.

	UEALTH	AND HUMAN SERVICES					(X3) DATE	SURVEY	
DEPARTM	ENT OF HEALTH	& MEDICAID SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) MILIT	TIPLE C	ONSTRUCTION		COMF	PLETED	
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AND PLAN OF	00111.2		B. WING			TATE ZIP COD	, Æ		
		245383	1	STR	EET ADDRESS, C	ITY, STATE, ZIP COD			
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NAME OF PE	(OVIDER OTT =			OV	VATONNA, MN	ER'S PLAN OF CORR	ECTION	(X5) COMPLETION	
OWATON	NA CARE CENTER		ID		PROVIDI	ER'S PLAN OF CORR RRECTIVE ACTION S	HOULD BE	DATE	
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F 334	Continued From	ther or not the resident had or needed to be immunized.							l
	to determine who	or needed to be immunized.							1
1	been immunized	in the otor of							
	On 11/22/2013 a	t 2:30 p.m., the director of							1
	Inursing (DON) v	bad not been obtaine	d						1
	immunization	officer it would be in							
	for R34, R20, ar	nd R16 otherwise it would be bord or located in the binder with a forms							
	the medical reco	n forms.							
	The facility Imm	nunization Program	of						
	Implementation	nunization Program Guidelines, with revised date of the control o	vill						
	2/2012, was re	i Guidelines, with revised data viewed and read, "The facility w pended immunizations as							
1	ensure reconn	neridod							1
	annlicable are	Official of the and	c						- 1
1	administration	to all facility residents and that accurate documentation are maintained.	OT						- 1
	employees and	ations are maintained.							1
1	Immunization	requirements \ / - * those with	high						
	residents over	requirement: (1) All facility 65 years of age or those with will be offered the Pneumocol No Vaccine upon admission.	ccal						
1	risk conditions	will be on upon admission.							
	Polysaccharic	le vaccine on the Vaccine							
	Document ad	If the							
	Administration is	n Record for Addition in the series refused by the resident, the series will be required. The	waiver				•	1-1-1	4
	Vaccination	s refused by the resident, the n Waiver will be required. The size in the resident chart or	warvo.			Attachme	+	1-1-1	ļ
	will be maint	allieu iii uio	1		CEE	Attachm			
	employee's f	ille."	STAFF	F	353				
··· F	400 20(2) 51	JEFICILITY -							
',	SO F PER CARE	PLANO	1						
\		er tank nursing Sta	aff to						
	The facility	must have sufficient full sing out sing and related services to atta spignest practicable physical, i	mental						
	provide nul	sing and related services to daily e highest practicable physical, i englal well-being of each reside	ent. as						
	and nsvcho	e highest practicable physical, obsocial well-being of each resident assessments and	J.11						
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	individual p	plans of care.						ii shoot Dage	36 o
					Facility ID: 00	0649	If continua	ation sheet Page	
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OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 OWATONNA CARE CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID DATE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 353 Continued From page 36 F 353 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced Based on observation, interview and document review, the facility failed to consistently provide sufficient nursing staff to meet resident's needs in a timely manner as evidenced by 12 of 22 residents (R29, R74, R3, R68, R38, R72, R18, R13, R9, R12, R47 and R22), and 1 of 3 family members (F-1) who voiced concerns regarding resident needs not being met in a timely manner due to lack of staffing. This would have the potential to affect all 39 residents currently residing in the facility. Findings include: R29 did not have their call light answered in a timely manner. During observation on 11/20/13, at 9:11 a.m. R29's call light had been turned on in resident room. At 9:15 a.m. NA-E was observed entering R29's room and shut off call light and immediately left the room grabbed the staff bathroom key. During interview at 9:16 a.m. R29 indicated they If continuation sheet Page 37 of 69

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE S COMPLE	
		245383	B. WING			11/22/	2013
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F 353	had turned the call still waiting to get o again at 9:22 a.m., (RN)-A went into R: and immediately ca a.m. surveyor aske and resident indicas someone to help ma.m. RN-A again had NA-C walked past in been shut off previous RN-A walked into roa.m. NA-E came in what resident need shut off light and leneeded to use commould need to get ranged and NA-E were sident to the commould need to get ranged and resident to commount been respondent to the commount been respondent though the RN and off call light but immediately was admitted significant status of (MDS) completed of cognitively intact, where the same resident to the complete of cognitively intact, where the same resident to common the same resident to the same resident to the common of the same resident to common the same resident to the same resident to the common the same resident to the same resident to the same resident to the common the same resident to	light on at 8:42 a.m. and was ut of bed. R29 put call light on at 9:26 a.m. registered nurse 29's room and shut off light ame out of the room. At 9:29 d resident if needs were met ted staff were looking for the that does not exist. At 9:31 and entered and left the room. The resident room (call light had busly by RN-A). At 9:35 a.m., from with medication. At 9:41 to resident room and asked the other time they just fit the room), R29 indicated amode. NA-E indicated they have to assist. At 9:42 a.m. and into room and assisted amode. From 8:42 a.m. until and NA-E physically assisted the residents request had do to for 60 minutes even NA went into room and shut mediately left looking for help.) The staff of the properties of the properties of the residents request had a mange Minimum Data Set on 11/21/13, identified R29 was as able to communicate a extensive assistance with ansfers with two staff, be with one staff with toileting,	F3	53			
ORM CMS-25	667(02-99) Previous Versions	Obsolete Event ID: 52WT1	1	Facility ID: 00649	If continuat	ion sheet Pa	ge 38 of 69

	I = A I TL	AND HUMAN SERVICES				(X3) DATE	SURVEY	
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	OF DEFICIENCIES	(X1) PROVIDER/SUFF EIE IN IDENTIFICATION NUMBER:	A. BOILDI			11/2	22/2013	
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		a38	F	353				1
F 35	3 Continued From	eat me well. R29 revealed they properties to having to						1
	nicely so they tre	eat me well. R29 Tevelled in neontinence) due to having to be answered.						
	had accidents (I	t to be answered.						
	wait for call light	((0 00 0						
	DZ4's quarterly	MDS with assessment reference	5					
	date of 11/11/13	MDS with assessment 793, identified R74 was cognitively iron extensive assistance with be	ed					1
	intact and requ	lied Chieffer and						1
	mobility, transi	ers, tollow of the R/4 Wa	5					
	personal hygie	ers, toileting, dressing and ne with one to two staff. R74 wa ning able to communicate needs	-					1
	identified as D	anig abis 12						
	- intervie	ew on 11/18/13, at 4:41 p.m. R74	· \					1
	During intervie	ew on 11/18/13, at 4.41 p.m. not felt enough staff at facility as the times needed to wait an hour fo	or					1
	evidence by a	not felt enough stall at lacing of the stall at lacing of the stall light. R74 was interviewed	J.					1
	staff to answe	at times needed to wait arriversely times needed to wait arriversely call light. R74 was interviewed and a said they						1
	again on 11/4	.2/10, at the engietance R/4						1
	Lwore depend	ed on starretaffed and	1					1
	Lindicated SIQ	11 Says (110) 5	ng to					1
	busy helping	others as to why they want so wered. R74 indicated they felt so were burnt out and revealed had were burnt out and revealed ha	aited					1
	get light ans	wered. R74 indicated tries lost or re burnt out and revealed had were and half to get help some days	ancu					1
	of the stand	re burnt out and revealed the grand half to get help some days feet like I don't matter, like they d	lon't					
	D74 cald "11	eel like i don't						
	dive a lours	e word.						
	V	LANGO 113 identil	ied					
	R3's admiss	sion MDS dated 10/29/15, identified to cognitive impairment and requires tance with bed mobility, transportance with bed mobility, transportance with second control of the	red					
	R3 had mile	d cognitive impairment and requisions are supplied to consist ance with bed mobility, transpared by the constant in the constant is a constant to constant in the constant in	sters,					
	extensive a	ersonal hygiene and was able to						
	communica	ate needs.						
			R3					
	During inte	erview on 11/18/13, at 4:30 p.m.	y as					
	indicated I	lau not lone an hol	ar. I					
	avidence	00 SUITICITITIES - 40 06 a m	1. K3					
	During Inte	erview oir i i i i a room drar	าห เบเจ					
	Indicated	last night in the dining footh disc nd had to go down by therapy to name B3 stated staff was just no	yo lo st					
\	the hathro	nd had to go down by the app oom. R3 stated staff was just no good they soiled their clothing wh	ile			If continua	ation sheet Page	39 of
	available	oom. R3 stated stall was just and they soiled their clothing wh	ent ID: 52WT	11	Facility ID: 00649	,,		
1			111 10.02.7					

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (x3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	MPLETED
		245383	B. WING				/22/2013
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F 353	waiting. R3 verified when I soil my clot when I soil my clot R68 was admitted MDS dated 11/22/cognitively intact, of one staff for be personal hygiene transfers. During interview of indicated had not evidence by this right to the bathroom and had not come On 11/21/2013, a surveyor and state put your light on a the bathroom?" I times and it is minhappens a lot on sometimes only had R38 was admitted MDS dated 9/24/cognitively intact, independent with On 11/18/13, at 8 felt enough staff. During interview indicated had be over an hour. R (scale of 0 to 10 pain) located in Indicated in	dit doesn't make me feel good thing. on 10/22/13. The admission 13, identified R68 was required extensive assistance dimobility, dressing, toileting, and required two staff for an 11/19/13, at 9:01 a.m. R68 felt enough staff at facility as norning had to wait one hour to m-put call light on at 6:30 a.m. at 6:40 a.m., R68 approached ed, "What can you do when you and wait over an hour to go to Have wet myself a couple of serable to lay there in it." "It the night shift." "They have 2 staff on." d on 9/11/13. R38 's admission 13, identified R38 was able to communicate needs and activities of daily living. 5:29 p.m. R38 indicated had not was available at the facility. on 11//22/13, at 9:31 a.m. R38 en waiting for pain medication for 38 indicated his pain was a 6/10 with 10 being the most severe	d	353			neat Page 40 o
L	1 2 3	Event ID: 52W	/T11	F	acility ID: 00649	If continuation st	ieet Page 40 0

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY COMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING _

TEMENT O	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			11/22/2013	
) L) ((1 - 1		245383	B. WING		DDRESS, CITY, STATE	ZIP CODE		
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			F	353				
F 353	ago but was nei insulin on the ot	ping give residents who need her wing.						
	completed but v	ns MDS had not been fully were told by staff that R72 was when entered on first day.						
	evidence by he hours later star would like to semergency.	w on 11/19/13, at 11:27 a.m. R72 not felt enough staff at facility as e puts call light on and up to two ff will come help. R72 said he ee what they would do in an						
	During intervieus indicated had evidence by a night and wou medication. Few want to every here crying in was no one he waiting for he last night that	ew on 11/22/13, at 9:57 a.m. R72 not felt enough staff at facility as asked for pain medication during all not get it and felt terrible with R72 indicated the staff doesn't 't come back here. R72 indicated to pain at night. R72 indicated the nere last night and I wet myself lelp. R72 said the aide said to hirt they (NA) had 16 people to car	out I lay ere m re for.					
	R18 was add MDS identification required extending to the control of the control o	mitted on 10/10/13. R18's admis ed R18 was cognitively intact, ensive assistance with two staff view on 11/18/13, at 4:29 p.m. Fad not felt there was enough staff	for R18					
	the facility a incontinent the bathroomers the three transfers to the facility and the faci	because of not being able to ge om timely due to slow call light by staff. R18 verified it made him soil self. R18 indicated had waite bour and maybe longer to have	t to feel	1 Fac	cility ID: 00649	If con	tinuation sheet Pa	 ige 41

		AND HUMAN SERVICES				WO DATE	0938-0391
DEPARTME	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(VO) MILII	TIPLE CO	NSTRUCTION	COMF	PLETED
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OF DR	OVIDER OR SUPPLIER			201 5	MINI 55UDU		(X5)
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		44	F	= 353			
F 353	Continued From	page 41					
, ,	light answered.						
		MDS dated 10/3/13, identified ively intact and required extensi	ve				
	I DA2 WAS COULIN	IVOI) III- droceind					
	assistance from	n one staff with dressing, seenal hygiene and was able to		\			
	- bulation Dei	30(10.17)		1			
		10000		1			
	- :- intervie	w on 11/18/13, at 4:13 p.m. R13	5				
	During intervie	w on 11/18/13, at 4.13 p.m. not felt enough staff at facility as times waited ½ to one hour to	be				
1	ovidence by a	[[[IIICO West					
	accieted 10 DE	G.					
	\	- not- significant					
	R9 was admit	ted on 3/2/12. R9 s significant e MDS dated 11/4/13, identified cognitively intact and required					
	resident was	object of the staff will					
	transfers, be	d mobility, dressing, tolleding, giene and was able to communic	cate				
	personal nyg	giene and wa					
1	needs.	at 6:33 n m. F	२9				*
	During inter	view on 11/18/13, at 6:33 p.m. F	as				
	indicated ha	view on 11/18/13, at 6.33 p.m. of 6.33 p.m.	f times				
	evidence by	after put light on.		ĺ			
	a half hour	and par o	erly	\			
	R12 was a	dmitted on 6/12/13. R12's quart					
	MDS dated	dmitted on 6/12/13, 1(120) 1 9/4/13; identified resident was intact, able to communicate ne	eds and				
	:donande	ILL ANICLI CO.					
	During inte	erview on 11/18/13, at 6:02 p.m	lity as				
	- Licoton	HAU HOUSE	11116				
	ovidence	DV, Sulliculting and a whon my C	allinging				
	down for	nd would often get medication i	ale.				
	\	- 40 D4/9 3	1111133101	1			Leat Dage 42
	R47 was	admitted on 10/10/13. R47's at	ct, able t	.0	ID: 00649	If continu	uation sheet Page 42
	MDS ide	admitted on 10/10/13. R47 3 dentified R47 was cognitively inta-	vent ID: 52V	NT11	Facility ID: 00649		

EPARTMENT OF HEALTH AND TROMBERS OF THE PROVIDER SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCIES DEPARTMENT OF DEPARTM		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
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	ROVIDER OR SUPPLIER	245383	201 SOUTHWEST 18TH STREET		TREET ADDRESS, CITY, STATE, ZIP COD 01 SOUTHWEST 18TH STREET WATONNA, MN 55060	CODE	
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F 353	During interview indicated had not the facility as evin wait a long time after putting the after putting the farming the family 11:14 a.m. family concerns with st times when R22 bathroom and st take care of pathroom. F-1 st times while wait terrible and she going to the bather neck as a refew months bad discussed their and the facility the facility was concern. F-1 stabout how mustated being sl for the facility. have enough in residents. F-1 work and the facility have enough in the facility have enough in the facility. In the facility have enough in the facility have enough in the facility. In the facility have enough in the facility have enough in the facility have enough in the facility. In the facility have enough in the facility have enough in the facility have enough in the facility and the facility have enough in the facilit	eds and was independent in living. on 11/18/13, at 6:33 p.m. R47 if felt there was enough staff in dence by R47 identified had to for help, sometime half an hour	e e e e e e e e e e e e e e e e e e e	= 353			

OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING __ IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG F 353 Continued From page 43 verified had not felt there was enough staff. E-A F 353 indicated honestly they don't have enough staff and it is exhausting. There was an email about answering call lights we do the best we can. Nurses don't help with answering call lights. Supervisors 'don't normally answer call lights like they are this week. There are times we don't have enough staff to pass trays at meals. E-A indicated we are told we have to please everyone and how do you do that. E-A identified we had been working with two aides and management don't even care. The schedule was switch frequently by the director of nursing (DON) and don't tell the staff what was switch so staff don't show up. E-A indicated felt like the staff were being set up to fail. During interview on 11/20/13, at 11:53 a.m. E-B (who remained anonymous) indicated had not felt there was enough staff. E-B said we need more staff. E-B verified R29 waits for a long time because staff is down on 300 wing with all the lift residents. E-B verbalized felt burnt out it is non-stop here. E-B indicated was exhausted continuously trying to meet the resident's needs with current staffing. E-B identified was responsible for 9 residents on wing plus Hoyer transfer residents that required two staff, plus the Hoyer transfers and 2 people transfers on 100 wing. E-B indicated was responsible on all three wings. The nurses will come and say the residents need help and will explain will be there when able. Business office and activities use to assist with passing the trays and now nursing are supposed to pass the trays and can't always get to the dining room because residents were still in bed. E-B indicated had residents complain because they had to wait I apologize because I

DEPARTMENT OF HEALTH A	AND HUMAN SERVICES				FORM MB NO.	12/16/2013 APPROVED 0938-0391 E SURVEY
	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE C	ONSTRUCTION	COM	PLETED
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F 353 Continued From p	age 44	F	353			
(who remained and there are not endo come up and and bathroom that reshad heard from relong time. E-C stamore staff and becensus we can't take care of the been an increase because resident. During interview indicated the DC every two days a schedule had chaffects the care for falls. RN-C i person transfer on the floor. RN complained of answered time have the time to transfers and a supervisory stalights like this indicated the serious person transfer and control in the supervisory stalights like this indicated and the serious with recannot see if NA-A indicated meet resident.	ew on 11/21/13, at 10:44 a.m. Noncern with staffing related to the of resident rooms on a different esident care on the 100 wing I the call lights are on the 200 with the call light t	Ceengkonffineerysith		Facility ID: 00649	continuati	on sheet Page 45 o

DEPARTMENT OF HEALTH AND HUMAN SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES (X) (X) (X)		TON.	PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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F 353 Continued From page 45 audits were done randomly. The DON stated had audits were done randomly and overnights to a staying in the evenings and overnights to the resident and staff.	ı \		
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1 10 NOIL 600.	1		
to help each other. help answer call lights.	NC		
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During interview on 11/22/13, at 11:15 a.m. based indicated felt there was enough staff. DON said indicated felt there was enough to both census at the facility staffed according to census the facility staffed according to census and the property index. DON said been over staffed.	nd		
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they needed to five nursing dos	of three		
confirmed staff had come consistency needed more help. The DON indicates they needed as significant staffing was four to four the staff felt they were short staffed to four the staff felt they were short staffed to four the staff felt they were short staffed.	t.		
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indicated had never docume	n the		
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During interview of the residents were get	vs feel		
administrator administrator sais	naed t0		
care they have staff, do I feel the who	en our		
colling use it care less			
adjust to the low we call lot on	reside ء	ent	
case mix index is let verified had on different. Administrator verified had on different. Administrator verified had on different. Administrator verified had on different and different had on the di	t to be	raff	If continuation sheet Page
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says they			

PRINTED: 12/16/2013 FORM APPROVED
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		245383	B. WING			/22/2013
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F 353	indicated had obsolow, sitting and to staff had the potenthe staff would have the staff would have the staff would have the call light proportion of the call light proportion of the call light proportion attempting to transplan intervention attempting to transplan intervention attempting to transplan observation. The call light proportion of the chair alarm be hallway, wearing for the day and who the bathroom entered the dining room of the call the	served a lot of staff walking very alking. Administrator felt the ntial to get the work done but we to move quicker. Call light system policy revised ed the purpose of the call light oresident needs and requests. Sedure was to answer call lights of the resident needs and do not at feel you are too busy to help. Falls since admission and care included monitoring R22 when nesfer. However, staff not always to monitor residents activity falls. Fation on 11/21/13 between 7:15 m., R22 was observed sitting in a neck brace on. The resident elepherself in her wheelchair with eeping down the 200 wing her neck brace, was not dressed erbalized she needed help to go on a repetitive basis. R22 groom and continued to eded help to go to the bathroom injutes R22 was wheeled out of by another resident of the facility, a staff member to assist R22 to with initiated date of 11/18/13 in bed and WC [wheel chair].		953		

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		71DI 5	CONSTRUC	TION	(X3) DAT	E SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUC		COM	MPLETED
AND PLAN O	CORRECTION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,				44	12212043
		245383	B. WING		TET ADDRE	ESS, CITY, STATE, ZIP CODE	1 11/	/22/2013
NAME OF P	ROVIDER OR SUPPLIER					EST 18TH STREET		
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		- 47	F	353				
F 353	Continued From p	age 47 , staff provide weight-bearing						
	involved in activity	transfer and toilet use and						
	required one person	on assistance.						
	During an intervie	w on 11/22/13 at 12:22 p.m. the						
	director of nursing	(DON) indicated the preventive						
	intorvantions nut i	n place for RZZ had been						
	transfore in room	ntinue to monitor R22 for safe and bathroom and continue to						
	keen hed sensor	on at night. The DON committed						
	monitoring would	mean supervision would be or transfers and toileting and						
	Dog would not be	considered independent with						
	toileting The DO	N verified with the facility stairing	3					
	Luings and when r	sistant on each of the three nursing assistants are pulled to						
	other wings to pro	ovide assistance when residents	•					
	I pood two care div	ers their assigned wing is left				10.110.000.00		1-1-14
T 256		e assigned nursing assistant. ED NURSE STAFFING	F	356	SEE	Attachment		
F 356								
		post the following information or	n					
	a daily basis:	post the following imprime to						
	o Facility name.							
	o The current da	te. per and the actual hours worked						
	by the following (categories of licensed and						
	unlicensed nursi	ng staff directly responsible for						
	resident care per - Registered	r shift:						
	Licensed n	ractical nurses or licensed						
	vocational nurse	s (as defined under State law).						
	- Certified nu o Resident cens							
	The facility must	t post the nurse staffing data	a					
	specified above	on a daily basis at the beginning						hant Dogs 49 of 6
		F 4 ID: 52V	A/T11	F	acility ID: 006	if cor	itinuation sh	heet Page 48 of 6

NTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SED				NSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 356 Continued From pof each shift. Data or Clear and reada or In a prominent presidents and visit. The facility must, make nurse staffing for review at a constandard. The facility must staffing data for a required by State. This REQUIREM by: Based on observed daily basis. This 39 residents living initial tour, staff as Findings include on 11/18/13, at 25 to locate the staffing interview registered nurse location of the sof nursing (DON stated, "We do because we do During interview DON verified the staffing hours as a staffing hours as	age 48 a must be posted as follows: ble format. blace readily accessible to cors. upon oral or written request, ing data available to the public st not to exceed the community maintain the posted daily nurse minimum of 18 months, or as law, whichever is greater. ENT is not met as evidenced vation and interview, the facility uired staffing information on a had the potential to affect 39 of ing in the facility at the time of the and visitors. During observation of initial to con 11/18/13, at 2:07 p.m. (RN)-A was unaware of the taff posting and called the direct on 11/18/13, at 6:27 p.m. the facility had not posted the according to the regulation.	e ur ole	356				
daily staffing no	umbers revised August 2006,		Ea	cility ID: 00649	continuation	sheet Page 49 o	

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 PROVIDER'S PLAN OF CORRECTION (X5) OWATONNA CARE CENTER COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PREFIX TAG F 356 Continued From page 49 revealed the facility would post, on a daily basis F 356 1-1-14 for each shift, the number of nursing personnel F428 SEE Attachment responsible for providing direct care to residents. 483.60(c) DRUG REGIMEN REVIEW, REPORT F 428 IRREGULAR, ACT ON SS=D The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced Based on interview and document review the by: facility failed to ensure the consultant pharmacist identified parameters for use of an as needed (PRN) pain medication or offered non-pharmacological interventions prior to administering a PRN pain or document effectiveness of the PRN pain for 2 of 5 residents (R71 and R72) also R71 had not identified target behaviors or diagnosis/reason for receiving medications; and failed to assess and monitor for effectiveness of hypnotic medications used for 1 of 5 residents (R3) reviewed for unnecessary medications; and failed to identify specific behaviors/mood to determine the use of an antianxiety medication, or determine if the antianxiety medication was effective, or to attempt non-pharmacological interventions to manage anxiety/agitation before use of If continuation sheet Page 50 of

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES A. BUILDING _ 11/22/2013 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PRÉFIX TAG F 428 Continued From page 50 F 428 medications. Findings include: R71 had not had parameters identified for use of as needed (PRN) pain medication, had not had non-pharmacological interventions offered prior to administration of PRN pain medication, had not had effectiveness of PRN pain medication documented, had not had target behaviors identified and monitored for use of an anti-psychotic medication and had not had diagnoses identified for medications R71 had been receiving. On the Admission form it was learned that R71 had been admitted on 11/2/13. R71's admission Minimum Data Set (MDS) dated 11/8/13; identified brief interview of mental status (BIMS) had been 14 out of 15 and indicated cognitively intact, pain rarely and no behaviors. R71's care plan dated 11/20/13, identified use of psychotropic medication related to schizoaffective disorder, monitor/record occurrences of for target behavior symptoms and document per facility protocol. However, there were no specific behaviors identified to determine if antipsychotic was affective or not. Pain identified and directed staff to evaluate the effectiveness of pain

factors.

interventions and monitor/document relieving

R71's hospital dismissal summary dated 11/2/13, identified diagnoses of acute exacerbation of chronic COPD (chronic obstructive pulmonary disease), acute hypoxemic and hypercapnic respiratory failure due to chronic obstructive pulmonary disease (COPD), diabetes,

		D/IOEC				OMB NO.	0938-0391	
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TO THE O	E DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING			0/0043	
AND PLAN OF	CORRECTION	1000					22/2013	
		245383	B. WING	T OTE	EET ADDRESS, CITY, STATE, ZIP CODE			
				201	SOUTHWEST 18TH STREET			
NAME OF PE	ROVIDER OR SUPPLIER			201	14TONNA MN 55060		(VE)	
	NA CARE CENTER			100	PROVIDER'S PLAN OF CORRE	OULD BE	COMPLETION	
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TAG								
			F	F 428				
F 428	Continued From	page 51						
	with tongue rolling	g.						
		· aummary orders dated						
	R71's hospital di	d orders for the following						
	11/2/13, Identified	d orders for the following no corresponding diagnosis: anxiety medication) 30 mg						
	medications with	no corresponding diagrams anxiety medication) 30 mg times a day, aspiring 81 mg on	е					
	(milligrams) (WO	tillion and well tablet one time	,					
	time dally vilait	in Do ., medication	1)					
	daily, fluoxetine	(an and dop (60 mg) one time da	ıily,					
	20 mg capsule	5 Capación (1					
	lamotrigine (Lai	mictal) (an anti-seizure) mg tablet 3.5 tablets (350 mg) Tanamax (an anti-seizure	'					
	every hedtime,	Topamax (an anti-seizure mg tablet 2 tablets (50 mg) two	,					ĺ
	medication) 40	(Domadex) (1000						١
	times a day an	time daily	-					1
	digretic medica	ation) o medication						
	Document rev	record dated 11/2/13, indicated receiving the above medication	26					
	administration	record dated 11/2/10, included receiving the above medication	15					1
	since admissi	on.						
		orders dat	ed					1
	R71's hospita	l dismissal summary orders dat ified order for acetaminophen ma tablet one to two tablets ev						١
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	Dicherdal (al	111-psychiotis	eview					
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	of R71 'S M	edication data.	ne I					
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	Dain Manag	Jemeni Assessin and Tylenol (r	nain					
	identitied K	/ Had 100011	ablets					
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F 428	documented, 11/8 11/10 received two six and four, 11/11 documentation if re pain rate of five, 11 five, 11/20 two tab tablets pain rate of that non-pharmace attempted to relieve During interview or registered nurse (target behaviors in antipsychotic medicated for R71. Re order for Tylenol in when to give one stated the Tylenol the physician of w RN-B verified R7 Assessment Tool documentation of interventions bein of Tylenol and eff consistently. RN- had no diagnoses the medications is should have been diagnoses or indi medications. During interview director of nursin medications R71	two tablets pain rate of four, or tablets twice with pain rate of received Tylenol with no ecceived one or two tablets for 1/14 two tablets pain rate of lets pain rate of five, 11/21/ two f three. There was no indication ological interventions were	n	428			

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING __ STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PRÉFIX TAG F 428 Continued From page 53 behaviors to be identified and monitored for use F 428 of an anti-psychotic medication. Director of nursing stated PRN Tylenol order should have clarification from physician regarding when to give one tablet or two tablets and she would expect staff to offer non-pharmacological interventions prior to giving PRN Tylenol and staff should be following up within one hour maximum regarding effectiveness of PRN Tylenol. Document review of the facility Physician Medication Orders dated revised 4/10, read " Specifications for Drug Orders 6. Orders for medications must include: e. Reason or problem for which given. " Document review of the facility PRN Orders dated revised 4/10, read "Policy Statement PRN (on request or as needed) orders shall be used as little as possible. " PRN " orders must clarify the circumstances for offering or giving the medication. Policy Interpretation and Implementation 1. PRN orders or related documentation shall specify the circumstances under which the medication shall be offered or given, in as much detail as is needed to give the medication properly. 2. When PRN orders are implemented, nursing staff must monitor the use of such medication to determine: a. the nature of the problem and whether it persists; b. whether additional evaluation is needed; or c. whether the medication could be discontinued entirely because the problem is resolved. " Document review of the facility Psychotropic Review Committee (PRC) dated revised 6/13, read " POLICY: " Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions unless

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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eliminating medication. N. List of problem(s) identified on the Behavior behavior problem(s) identified on the Behavior Monitoring Sheet. 3. Residents with antipsychotic medication orders will be reviewed for the following: c. adequate monitoring of antipsychotic daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that		restorative, and	d behavior interventions restaurant					
problem(s) identified on the Behavior behavior problem(s) identified on the Behavior Monitoring Sheet. 3. Residents with antipsychotic medication orders will be reviewed for the following: c. adequate monitoring of antipsychotic daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that		participating in	to assist in decreasing					
behavior problem(s) Identified on the Monitoring Sheet. 3. Residents with antipsychotic medication orders will be reviewed for the following: c. adequate monitoring of antipsychotic daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that		eliminating me	entified on the care plan. I. List of	f				
Monitoring Sheet. 3. Residente medication orders will be reviewed for the medication orders will be reviewed for the following: c. adequate monitoring of antipsychotic daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that		problem(s) ide	lem(s) identified on the Behavior	ſ .:-				
medication orders will be revived antipsychotic following: c. adequate monitoring of antipsychotic daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that				Otic				
following: c. adequate monitoring daily or weekly behavioral charting. " R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted on 11/14/2013 with a diagnosis that		medication or	ders will be reviewed for the	otic				
R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that				Olic				
R72 had physician orders for as needed (PRN) pain medications, Tylenol, Tramadol, and Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that	1	daily or weekl	y behavioral charting.		١			
pain medications, Tyleriol, Training and Tyle				N)				
pain medications, Tyleriol, Training parameters for Oxycodone without identified parameters for when to use which medication for what pain intensity. Also non-pharmacological interventions intensity. Also non-pharmacological interventions were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted on 11/14/2013 with a diagnosis that		R72 had phys	sician orders for as needed (
when to use which medication with the state of the medication of the medications once given had effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted the sead fracture of humerus, atrial		pain medicati	ions, Tylenoi, Harristaneters for					
intensity. Also non-pharmacology were not always attempted and documented and effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted the local fracture of humerus, atrial		Oxycodone w	which medication for what pain					
were not always attempted and another effectiveness of the medications once given had not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted the lead fracture of humerus, atrial		when to use	o non-pharmacological interven	itions				
not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted the sead fracture of humerus, atrial		intensity. Als	avs attempted and documented	and				
not been assessed. Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted to the least of fracture of humerus, atrial		offectiveness	s of the medications once given	nau				
Review of the Admission form noted that R72 was admitted on 11/14/2013 with a diagnosis that admitted fracture of humerus, atrial		not been ass	sessed.					
admitted on 11/14/2013 with a diagnostic admitted on 11/14/2013 with a diagnos		1100 5001.	atod that R7	'2 was				
admitted on 11/14/2013 with a diagnostic admitted on 11/14/2013 with a diagnos		Review of th	e Admission form noted that Kr	at				
included closed the peart failure.			- ad tractille () Hullicias					
fibrillation, and congestive reactionship		fibrillation, a	nd congestive heart land.				If continue	ation sheet Page
Fixest ID: 52WT11 Facility ID: 00649	1			ID: 52\A/T11		acility ID: 00649	II Continue	auton entre e

DEPARTMENT OF HEALTH AND HOWARD SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			COM	(X3) DATE SURVEY COMPLETED		
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		11/22/2013			
		245383	B. WING	OTDEET AD	DDRESS, CITY, STATE, ZIP COI			
AME OF PI	ROVIDER OR SUPPLIER			201 SOUT	HWEST 18TH STREET			
OWATONNA CARE CENTER				OWATON	INA, MN 55060	DECTION	(X5)	
THENT OF DEFICIENCIES		ID PREF	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T			COMPLETION DATE		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	ATEMENT OF DELIGIED BY FULL BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CR	DEFICIENCY)	FICIENCY)		
	I France 15		F	428				
F 428	Continued From page 55 R72 's current physician orders, dated							
	11/14/2013 from the patient discharge							
	medications: ox	medications: oxycodone 5 miligrams overy						
	hours as needed 4 hours as neede							
	noon and supper, 25 mg as needed and acetaminophen 325 mg 2 tablets every 6 hours as needed for pain. There were no parameters for use identified in the order, nor on the medication should administration record, to determine which pain medication (Tylenol, Tramadol or Oxycodone) be used to treat R72's pain.							
		DRN medication sheets from						
	The state of the s							
	November 14, 2 revealed the following							
	(1) 11/15/2013, 11/16, 11/17, 11/15, 11/16, 11/17, 11/16,							
			the					
	hain medication	on the medication should	10					
		1/19-Tramadol 50 mg orally events are sold of the control of the resident's						
	pain level, where the pain was neither than non-pharmacological interventions attempted f nor effectiveness of the pain medication. (3) 11/15, 11/17, 11/18, 11/19, and 11/20/2013-Oxycodone 5 mg one table orally every 6 hours prn pain. No documentation wa evident of the resident's pain level, where the pain was neither located, non-pharmacological interventions attempted first nor effectiveness.							
	the pain medi	cation.	abs					
	(4) 11/18/2013	3-Acetaminophen 323 mg (2)	n.	`				
	by mouth eve	ation was evident of the reside	nt's		y ID: 00649	If continuation	sheet Page 56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
245383		B. WING			11/22/2013		
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHWEST 18TH STREET DWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428			F4	128			

AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	NG				PLETED
·	245383	B. WING				11/2	22/2013
NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER			201 SOUTHW OWATONNA	ESS, CITY, STATE, ZIP (VEST 18TH STREET A, MN 55060			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFII TAG	(EAC	ROVIDER'S PLAN OF CO CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	N SHOULD E		(X5) COMPLETION DATE
nursing was interview pain medication use. non-pharmacological and should follow up effectiveness of the a Should have specific needed pain medicat was on Tylenol, trama needed. R3 was prescribed Traileep; however R3 has comprehensively ass patterns. Review of the Admiss R3 was re-admitted of which included insom schizophrenia. A re-a Set (MDS) dated 10/moderate cognitive in dated 10/5/2013 and prescribed Trazodone every bedtime and Armouth every bedtime sleep cycle had not be re-admission back to On requesting inform to a sleep pattern and assessment a sleep a and dated 3/30/13 when and none was provide to the facility on 10/5/2013 at 12:	45 p.m., the director of ved regarding the as needed She would expect I interventions to be offered within one hour max for as needed medication. criteria for the use of the astion. Verified this resident adol, and Oxycodone as razodone and Ambien for ad not been sessed or monitored for sleep sion form it was noted that on 10/5/13, with diagnoses mia, bipolar disorder, and admission Minimum Data 18/13 identified R3 with mpairment. Physician orders 10/9/2013, identified R3 was a 75 milligrams by mouth mbien 12.5 milligrams by as needed. However, R3's been assessed upon the facility. The station from facility in regards a comprehensive sleep assessment was provided hich as not fully completed ed after R3's readmission	F 4	28				

		AND HUMAN SERVICES			UNID IVO:	SURVEY
)EPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	PLETED
SENTERS	FOR MEDICARE	& IVIEDICATO CELTO	(X2) MULT	IPLE CONSTRUCTION		1
O TURN	- DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG	1	
FATEMENT OF	DEFICIENCIES	IDENTIFICATION			11/	22/2013
ND PLAN OF	J-1		B. WING		ODE	
		245383	1	OFFICET ADDRESS, CITY, STATE, ZIT C	,052	1
			1	201 SOUTHWEST 18TH STREET		1
NAME OF PR	OVIDER OR SUPPLIER			ONATONNA MN 55060		
IAVAINIT O	OFNITED			PROVIDER'S PLAN OF CO	RRECTION	(X5) COMPLETION
OWATON	NA CARE CENTER		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO (EACH CORRECTIVE TO TH	N SHOULD BE	DATE
			PREF			
(X4) ID	SUMMART OF	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL L SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCY)		
PREFIX	REGULATORY OR	CY MUST BE PRECEDED BY 1 000 LSC IDENTIFYING INFORMATION)				
TAG	11200			1		
			F	428		
	. F	nage 58	1	1,20		
F 428	Continued From	page of	of			
	had been refusin	g the Trazodorio very often.				
	sleen) and didn't	take the Ambien very often. en patterns during the initial				1
	Only monitor sle	ep patterns during the initial and every quarter. No				
		ep patterns during the iod and every quarter. No coumented when the medicatio	n			
	assessment pon	iod and every quarter. It is cumented when the medication in the pharmacological intervention.				
	effective less do	cumented when the medical n-pharmacological intervention				
	was taken of no	11 buz				
	were attempted	•				
		the director of				
	On 11/21/2013	at 12:45 p.m., the am- was interviewed regarding loop patterns. She indicated th				
	nursing (DON)	was indicated the	iey	· ·		
1	monitoring of S	and the verified	the			
	do not monitor	SIOUP F	:U) \			
1	00 1101 11011100	n Trazodone at hs (hour of sick	eded			
1	resident was s	n Trazodone at hs (nour of sist n (as needed) for sleep. As ne gould have parameters for whe	n to			
1	and Ambien pr	hould have parameters for wile	11 10			
1	medications	n (as needed) for sleep. As no hould have parameters for whe aff should be attempting non	1			
1	use and the st	all street The stall				
	harmacologic	Jai littor voltas				
	abould he dov	,umona, a At 1.15	D.111			
	needed medic	Jaliulia Williamcoment/evali	uation			
	the DON prov	nueu a olosificat was the	mosi			
	dated 3/16/20)13 and indicated that was	ot had			
	recent one	on 3 and indicated that was the She verified the resident had no sement evaluation upon				
1	- cloop asset	sment evaluation upon to the facility 10/5/2013. The				
	a sleep asco	ssment evaluation upon to the facility 10/5/2013. The d ordered the Ambien medicati	on on			
1	re-admission	to the facility 10/5/2013. The d ordered the Ambien medicati he DON verified there was no	011 011			
	physician na	the DON verified there was no	·			
	10/9/2013.	d ordered the Ambien was no he DON verified there was no f sleep patterns for R3 evident	in the			
1	monitoring o	It sleep barren	1			
	medical reco	Jiu.				
			vever,			
	R3 received	l an antianxiety medication hov	e			
1	no non-nha	I an antianxiety medications rmacological interventions wer perfere the use of the antianxiet	v and			
	-ttompted t	rmacological interventions was before the use of the antianxiet as of the antianxiety was not	,			
1	attempted	pefore the use of the arm ss of the antianxiety was not determined.				
	effectivenes	, determined.				
1	consistently	y deterrimes	- 16			
1	\	t - facility on 10/5/2	2013			
	R3 was ad	mitted back to facility on 10/5/2)			
1	after being	HOSPitalizes and atrial fit	rillation.			
	10/10/2013	3 with pneumonia, and ather his	ler.		If continua	ation sheet Page 5
١	Other dian	3 with pneumonia, and data pnoses included: bipolar disorc		11 Facility ID: 00649	11 0011-111-1	
	Other diag	Ev	ent ID: 52WT	77		

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	REFICIENCIES RRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245383	B. WING			11/2	2/2013
	PROVIDER OR SUPPLIE			20	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHWEST 18TH STREET WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	cannabis depend dysphagia (difficulty personality, and seeds R3 had a physicia 6 hours as needs R3 used the as not 10/13 and 5 time. On 11/21/2013 at (RN)-B was interist to R3 for anxiety explain. If the RN-B verified the when to give the medication sheether medication sheether medication hon-pharmacological should be documeded Ativan medication should be documeded medication in to use and the stopharmacological should be documeded medication and the seeds of an asterior use of an as	ence diabetes, hypertension, alty swallowing), antisocial schizophrenia. an order for Ativan 0.5 mg every defended for agitation or for anxiety. eeded medication 8 times in		428			

		NID LILIMAN SERVICES					FORM OMB NO.	12/16/2013 APPROVED 0938-0391
DEPARTM	IENT OF HEALTH	AND HUMAN SERVICES		- 01107	PUCTION		(X3) DATI	E SURVEY PLETED
CENTERS	S FOR MEDICANE	T TO THE PLANT OF	(X2) MULTI	PLE CONST	RUCTION			
- TENT O	E DEFICIENCIES	(X1) PROVIDER/3011 CLEAN IDENTIFICATION NUMBER:	A. BUILDIN	IG			441	22/2013
AND PLAN OF	CORRECTION		B. WING _				1	2212013
		245383	B. WING _	CTREET A	DDRESS,	CITY, STATE, ZIP COD	E	
	== OD SLIPPLIER			201 SOU	THWEST	18TH STREET		
	ROVIDER OR SUPPLIER			OWATO	NNA. M	N 55060		(X5)
OWATON	NA CARE CENTER				PROVI	DER'S PLAN OF CORRI	HOULD BE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CO CROSS-RE	ORRECTIVE ACTION ST FERENCED TO THE AF DEFICIENCY)	PROPRIATE	
,,,,								
		nage 60		428		4		
F 428	Continued From	page 60 ypnotic use for 1 of 5 residents runnecessary medications.				4Huehment	_	1-1-14
	and monitor for it	r unnecessary medications.		131 SE	EE /	AHWERM		
	(R3) reviewed to	e) DRUG RECORDS, DRUGS & BIOLOGICALS	,	70.				
F 431	1 ABEL/STORE	DRUG & BIOLOGICALS						
SS=D		interior the services u	of					
	The facility must	employ or obtain the services of macist who establishes a system point and disposition of all	٦					
	a licensed phan	Tracist William of all						
	of records of rec	being and a detail to enable an						
	controlled drugs	s in sufficient detail to endough ciliation; and determines that dru ender and that an account of all	ug					
	records are in C	ciliation; and determined and of all or maintained and periodically						
	controlled arug	order and that all accounts of the state of						
	reconciled.		1					
	Drugs and biol	ogicals used in the facility must	be					
	labeled in acco	ogicals used in the facility was ordance with currently accepted						
	professional pi	and cautionary						
	appropriate ac	nd the expiration date when						
	applicable.							
	applicable.	LEadoral laws th	ne					
	In accordance	e with State and Federal laws, th						
	facility must s	tore all drugs amor temperat	ure					
	locked compa	artments under proper temporate permit only authorized personne to the keys.	el to					
	have access	to the keys.						
	nave access	to the looked						
	The facility m	nust provide separately locked,	ge of					
	permanently	affixed comparation cohedule II of the	-					
	controlled ar	ugs listed in the Brevention and						
	Comprehens	sive Diag, where drugs subject	tO unit					
	COULINI MOL	of 1976 and other drugs suspen opt when the facility uses single in distribution systems in which	the					
	package dru	ept when the facility uses single ug distribution systems in which rod is minimal and a missing do	se can					
	auantity Sto	led is itimines						
	be readily d	etected.						
								is a shoot Page 61 of
					::::: ID: 0	0649	If continua	tion sheet Page 61 o

CENTENT (RTMENT OF HEALTH AND FIGURE 4. MEDICAID SERVICES ERS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES IDENTIFICATION NUMBER: N OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			IPLETED		
PLANO			B. WING			22/2013
AME OF P	ROVIDER OR SUPPLIER	245383	B. WIIVE	STREET ADDRESS, CITY, STATE, ZI 201 SOUTHWEST 18TH STREET	P CODE	
WATON	NA CARE CENTER			OWATONNA, MN 55060 PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACT	THE APPROPRIATE	DATE
F 431	Continued From p		F	431		
	by: Based on observed documentation red document destrunarcotic used for of 2 medication rencourage divers residents and/or Findings include 8:38 a.m. register process was to a would throw into confirmed had rethrowing the fer container. During interview indicated the structure patches in the structure director of nurse this point had be toilet paper and indicated right.	ration, interview and eview, the facility failed to oction of fentanyl patches (a moderate to severe pain) for 2 ooms. This practice could sion of pain medications by staff visitors. During interview on 11/22/13, ered nurse (RN)-C indicated the remove the fentanyl patch and the sharps container. RN-C not had any other nurse sign what tanyl patch in the sharps of on 11/22/13, at 8:31 a.m. RN-A aff would throw the fentanyl sharps container. RN-A verified not signed when destroyed. W on 11/22/13, at 10:58 a.m. the sing (DON) identified the process of the	en A s at in			
	two signatures patches. The be no differen you would wa	from nurses when destroying DON confirmed the process wo t than any other narcotic destruint two nurse signatures. To destruction of medication por revealed narcotics were to be two licensed nurses.	uld ction			n sheet Page 62

CARNIT C	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDERSUPPLIER/CLIA	(XZ) MUL	ING	ONSTRUCT			COM	PLETED
PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD					11/	22/2013
		245383	B. WING	CTR	EET ADDRE	ESS, CITY, STATE	, ZIP CODE	<u> </u>	
ME OF PI	ROVIDER OR SUPPLIER			201	SOUTHWE	EST 18TH STRE	ET		
NATON	NA CARE CENTER			OW	OWATONNA, MN 5506		LAN OF CORRECTION		(X5) COMPLETION
X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG			H CORRECTIVE A B-REFERENCED DEFICII	O THE APPRO		DATE
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS		F	441	s FÆ	AHachme	nt		1-1-14
	Infection Control I	comfortable environment and edvelopment and transmission	n						
	Program under w (1) Investigates, in the facility; (2) Decides what should be applie (3) Maintains a r actions related to	establish an infection control /hich it - controls, and prevents infection t procedures, such as isolation, d to an individual resident; and ecord of incidents and correctiv o infections.							
	(1) When the Interpretation determines that prevent the spreisolate the resid (2) The facility recommunicable from direct contact w (3) The facility reached after each and washing in professional pressional pr	nust prohibit employees with a disease or infected skin lesions tact with residents or their food, will transmit the disease. The must require staff to wash their ch direct resident contact for whe indicated by accepted	if						
	(c) Linens Personnel mus transport linens infection.	st handle, store, process and s so as to prevent the spread o	F						

PRINTED: 12/16/2013 FORM APPROVED OMB NO. <u>0938-0391</u> DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 OWATONNA CARE CENTER PROVIDER'S PLAN OF CORRECTION COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG PREFIX TAG F 441 Continued From page 63 F 441 This REQUIREMENT is not met as evidenced Based on interview and document review the by: facility failed to develop and implement a functioning infection control program which at a minimum needs to include the necessary components to track, trend and analyze infections for residents and employee illness to determine infection cross contamination, train staff in infection control practices including tuberculosis control program, and in addition facility failed to implement proper infection control practices for 1 of 1 residents (R67) reviewed for infection control. Findings Include: The facility was requested to provide their infection control program and tracking system for the months of March 2013 through November 22, 2013. An infection control binder was provided that contained a surveillance log for the months of March 2013 through September 2013. No surveillance information was provided for the month of October 2013 through November 22, 2013. On asking for tracking and trending employee illnesses none was provided by the facility. Staff education for infection control was requested and a computer course was identified as an introduction to Infection Control. On review of the course it did not contain specific training toward Tuberculosis (TB) control program. Training data from 1/1/2012 through 11/22/2013 was provided. It listed only 3 staff as having the training for 2013. Twenty one staff had listed as having the training in 2012. During interview on 11/22/13, at 10:00 a.m. the director of nursing (DON) indicated she took over

the infection control tracking and trending since September 2013. The DON indicated there was

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 11/22/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245383 201 SOUTHWEST 18TH STREET NAME OF PROVIDER OR SUPPLIER OWATONNA, MN 55060 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OWATONNA CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DEFICIENCY) (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG F 441 Continued From page 64 program and she was currently working on the F 441 infection logs to prepare for quality assurance meeting and reported monthly. The information provided for October 2013 was a data count of each type of infection but no surveillance log of the infections were done for 10/13 or 11/13. Another nurse was going to be taking over the infection control program but had not yet started to implement it. For employee illness, if they call in, there is a form to fill out, which specifies symptoms. The forms are kept on a clipboard at the nurse's station. When the staff returns to work, the nurse fills out the bottom of the form. On 11/22/2013 at 4:55 p.m. the Administrator verified the TB training had not been completed and the infection control (IC) training had not been completed by all staff for 2013. After surveyor intervention, the administrator indicated staff would receive training at orientation and then annually. A policy dated 10/12 on Investigation, Control and Prevention of Infections was reviewed. Guidelines: It is the policy of the facility to maintain an Infection Prevention and Control Program in order to prevent recognize and control the onset and spread of infection within the facility. One of the components was identified as Education including training in infection prevention and control practices. A policy dated 2/2012 Infection Control Documentation-Monthly Infection Surveillance Report was reviewed. Guideline: To assist the facility in maintaining an infection control monitoring program designed to assure that the facility has an infection control program which is effective for investigating, If continuation sheet Page 65 of 69 The facility controlling, and preventing infection.

PRINTED: 12/16/2013 FORM APPROVED

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PARTMENT OF HEALTH AND TIONS OF MEDICARE & MEDICAID SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	NG	STRUCTION	COM	PLETED	
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	our hands. Technology before leaving no sink in the dispenser. The think she has	the room but because there wa room just use the alcohol e resident uses her wheelchair l a bottle of alcohol gel.	as				
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responsible. The Description of the Classific infection of communicated through and verified this would come ask and verified this would contaminated feed. The use of glove thorough hand wand affected residents. Resident washing momental washing momental washing by facilities resident Thorough bathroom contaminated worth washing to contaminated worth washing to contaminated washing and contaminated worth washing to contaminated washing and contaminated washing washing and contaminated washi	age 68 DON wants to implement a residents ' closet to explain and trash. Currently resider control needs are being rough 24 hour report and shift to as unsure infection control communicated to housekeeping she was not sure, " I guess the us when they see a red bag " was probably not the best way. Transmission: C. ften transmitted on the hands or residents after contact with ces or environmental surfaces. Is by facility personnel and resolved and demonstrate thorough and leave their room to enjoy of the facilityFrequent hand and items likely to be with fecesPrecautions will until course of treatment is rhea had resolved and negative.	of elland	441		

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F000 INTITIAL COMMENTS

MN Dept of Health

This plan of correction is submitted as required under State and Feder and Feder The submission of this Plan of Correction does not constitute an admission on the part of Owatonna Care Center LLC as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied.

Any changes to Facility policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure; and should be inadmissible in any proceeding in the basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility.

The Administrator will present this statement of deficiencies and plan of correction under the rules of confidentiality as applied, to the Facility's Quality Assurance/Assessment Committee for review and approval on Wednesday January 22nd, 2014.

F157

- 1. Resident R50 family has been notified of residents fall on 11/15/2013 and hospitalization on 11/16/2013.
- 2. The DON and/or designee will audit last 30 days incidents and hospitalizations of all residents to ensure that family notification has been completed and documented.
- 3. The DON/designee will educate nursing staff on the policy and procedure of notifying responsible party of resident changes.
- 4. The DON/designee will complete the nursing manager's task list 3 times a week to ensure that all resident changes have been completed to resident's responsible parties and documented in the medical record.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F225

- 1. Resident R20 allegation of abuse was reported to facility administrator and state agency. Investigation completed per facility policy and procedure.
- 2. The administrator/designee will complete an audit of last 30 days allegations of abuse/neglect to ensure timely reporting was completed to administrator and state agency.
- 3. The administrator/designee will educate all staff on the policy and procedure of reporting allegations of abuse/neglect to include timeliness of reporting.
- 4. The administrator/designee will log all allegations of abuse/neglect to ensure timely reporting has occurred.

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5. The facility will be in substantial compliance by January 1, 2014.

6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F226

- 1. Resident R20 allegation of abuse was reported to facility administrator and state agency.
- 2. The administrator/designee will interview all residents to ensure that mistreatment, neglect, abuse and/or misappropriation of resident property has not occurred in facility.
- 3. The administrator/designee will educate all staff on the policy and procedure for allegations of abuse/neglect.
- 4. The administrator/designee will log, investigate, and report all allegations of abuse/neglect within the facility per policy and procedure.
- 5. The facility will be in substantial compliance by January 1, 2014
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F272

- 1. Resident R68 initial comprehensive MDS has been completed to include care area assessments.
- 2. The case manager/designee will complete an audit of all resident's to ensure that an initial comprehensive assessment has been completed with care area assessments.
- 3. The case manager will be educated by the regional case manager/ designee on timely completion of comprehensive assessments to include care area assessments.
- 4. The regional case manager/designee will audit weekly the completion of comprehensive assessments and care area assessments.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F309

Resident R12 catheter site has been assessed with signs of complications noted. Resident R68
has had a dental appointment scheduled to fix broken dentures. Resident R23 has had a
complete head to toe skin assessment and an unusual occurrence investigation has been
completed.

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- 2. The DON/designee will complete an audit of all residents receiving dialysis to ensure that all areas are being monitored and treated per doctor order. The DON/designee will complete an audit of all residents' oral assessments to ensure accuracy of assessment and that areas of concerns are addressed with SSD/designee. The DON/designee will audit all residents skin to ensure that no unusual areas are found and if found will be compared to the weekly skin assessment and documentation to ensure accuracy and cause of area.
- 3. The DON/designee will educate nursing staff on the dialysis flow sheet and the importance of following doctor orders related to treatment of dialysis sites. The DON/designee will educate nursing staff on accuracy of oral assessments and notification of SSD when concerns have been identified. The DON/designee will educate all staff on the policy and procedure for reporting and documenting all unusual skin occurrences.
- 4. The DON/designee will use the nursing manager's daily task list to audit the completion of the dialysis flow sheet and treatments of dialysis sites. This audit will be completed three times a week. The cases manager/designee will review oral assessments for accuracy upon completion of comprehensive assessment. This will be completed upon admission, quarterly, annually and with significant change. The DON/designee will monitor areas of unusual skin occurrence during the skin and weight review meetings weekly.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F314

- 1. Resident R75 has been repositioned every two hours according to the plan of care.
- 2. The DON/designee will complete an audit of all residents that need assistance with repositioning to ensure that repositioning is being completed per each residents care plan.
- 3. The DON/designee will educate all nursing staff on the importance of repositioning residents according to care plan to prevent/heal pressure sores.
- 4. The DON/designee will complete an audit of all residents needing assistance with repositioning 3 times a week to ensure intervention is being completed per resident care plan. This audit will be completed for 4 weeks.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F315

1. Resident R62 has had a 3 day bowel and bladder diary completed and a toileting program has been established and care planned for resident.

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2. The DON/designee will complete and audit of all residents' bowel and bladderneeds to ensure proper toileting programs are in place and care plans are updated appropriately.

- 3. The DON/designee will educate nursing staff on importance of completing 3 day bowel and bladder diary so that appropriate toileting plans can be established and updated on the care plan and nursing assistances mini care plan.
- 4. The interdisciplinary team/designee will monitor the bowel and bladder function of all residents during each residents care conference using the care plan check off list upon admission, quarterly, annually and with significant change. The IDT/designee will update the residents care plan and the nursing assistance mini care plan at these times.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F323

- 1. Resident R3 has had a fall trend report completed, residents fall care plan has been reviewed and interventions updated accordingly. An alarm battery function log has been created and used daily to ensure all residents with personal alarms are functioning properly.
- 2. The DON/designee will complete an audit of the last 30 days falls to ensure that all fall interventions are in place, appropriate and effective.
- 3. The DON/designee will educate the nursing staff on updating the residents care plan with appropriate interventions after a fall. The DON/designee will educate the nursing staff on the alarm battery function log. The DON/designee will educate the nursing staff on the proper completion of the unusual occurrence report.
- 4. The DON/designee will audit the alarm battery function log three times a weekly using the manager's task list. The fall committee/designee will meet weekly to review all falls in the facility to ensure appropriateness and effectiveness of interventions that have been put in place and will complete a fall trend report when indicated per policy and procedure.'
- 5. The facility will be in substantial compliance by January 1, 2014
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F329

1. Resident R71 and R72 had parameters for PRN medication added to MAR, non-pharmalogical interventions have been offered to resident, and PRN effectiveness has been documented. R71 has had targeted behaviors identified and monitored, doctors clarification has been received on all medication diagnosis. Resident R3 has had a sleep assessment completed to identify resident sleep pattern, R3 has had non-pharmalogical interventions offered before PRN anti-anxiety given, and effectiveness of anti-anxiety PRN medication has been documented.

MN Dept of Health Rochester

- 2. The DON/designee will complete an audit of all PRN medications to include parameters, non-pharmalogical intervention use, and PRN medication effectiveness. The DON/designee will audit all residents using anti-psychotic medication to ensure all behaviors have been identified and monitored appropriately, that non-pharmalogical interventions have been identified and offered and effectiveness of PRN anti-anxiety medication has been documented and that all medications have appropriate DX. The DON/designee will audit all resident that currently take a sleep/hypnotic to ensure a sleep assessment has been completed to identify resident's sleep pattern.
- 3. The DON/designee will educate nursing staff on PRN/pain flow sheet, behavior monitoring flow sheet and ensuring appropriate medical diagnosis for all medications. The DON/designee will e3ducate nursing staff on completion of sleep assessment.
- 4. The DON/designee will audit the PRN/pain flow sheet and behavior flow sheet 3 times a week to ensure proper documentation is completed using the manager's task list. The case manager/designee will audit completion of sleep assessments and appropriate medication diagnosis upon admission, quarterly, annually and with significant change when completing comprehensive assessments.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F334

- 1. Resident R20, R16, R34 pneumococcal information has been obtained and place on the resident's medical record.
- 2. The medical records/designee will audit all residents' medical record to ensure that pneumococcal information has been obtained,
- 3. The DON/designee will educate nursing staff on policy and procedure of obtaining influenza and pneumococcal immunization information upon admission.
- 4. The medical records/designee will audit all admissions with the 48 hour check list to ensure that pneumococcal/influenza immunization information has been obtained and placed in the medical record.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F353

1.Department heads will monitor meals 5 days a week and assist with delivery of meal trays during meal times. A weekend manager will be in the facility during a minimum of one meal each day to assist with monitoring of dining room and delivery of meal trays.

- 2. The DON/designee will audit call light response time 5 times a week at random times to ensure efficient call light response time.
- 3. Education on appropriate call light response time will be completed to nursing staff by DON/designee. Department heads will monitor meals 5 days a week and assist with delivery of meal trays during meal times. A weekend manager will be in the facility during a minimum of one meal each day to assist with monitoring of dining room and delivery of meal trays.
- 4. The Administrator/designee will review call light audits weekly with DON/designee. The admin/designee will interview a minimum of 3 resident's weekly to ensure call light response is satisfactory to resident's.
- 5. The facility will be in substantial compliance by January 1, 2014
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F356

- 1. Nurse staffing information has been posted daily.
- 2. The Administrator/designee will complete audit to ensure that daily staffing sheet is completed, posted and filed.
- 3. The Administrator/designee will educate nursing staff on procedure for posting nurse staffing information.
- 4. The Administrator/designee will audit nursing staffing sheets weekly to ensure that nurse staffing forms are completed daily and filed appropriately.
- 5. The facility will be in substantial compliance by January 1, 2014
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F428

- 1, Use F329 number 1
- 2. Use F329 number 2 and add: pharmacist will review audits for accuracy.
- 3. The Administrator/DON/designee discussed with pharmacist the need to review all aspects of PRN medications, behavior flow sheets, and behavior monitoring and antipsychotic medications/assessments.
- 4. The pharmacist/designee will review all residents' medications monthly and report findings to administrator and DON before exiting facility.

5. The facility will be in substantial compliance by January 1, 2014'

MN Dept of Health Rochester

6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F431

- 1. Fentanyl patches are destroyed by two licensed professionals signing the reconciliation record and placing the patch in tissue and flushing down toilet
- 2. The DON/designee will audit the last 30 days of fentanyl patch destruction to ensure proper reconciliation has been completed.
- 3. The DON/designee will educate all nursing staff on the proper procedure of reconciliation of fentanyl patches.
- 4. The pharmacist/designee will audit monthly the destruction and reconciliation of all fentanyl patches in the facility and report finding to administrator/DON upon facility exit.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F441

- 1. Infection control program implemented per facility policy and procedure. Resident R67 is symptom free of clostridium difficile.
- 2. The DON/designee will complete an audit of all resident/employee infections to identify trends, and that sanitation and handling of equipment/personal items has been completed effectively.
- 3. The DON/designee will educate all staff on infection control policy and procedure to include tuberculosis control program. The Administrator/designee will educate all staff on addressing resident infection control needs when a resident is diagnosed with an infection that requires specific intervention.
- 4. The DON/designee will track and trend infections in the facility on a weekly basis and complete an infection surveillance report monthly to be reviewed at the Quality Assurance meeting.
- 5. The facility will be in substantial compliance by January 1, 2014.
- 6. Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Assessment Committee until lesser frequency is deemed appropriate.

F5383026

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245383 R WING 11/20/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHWEST 18TH STREET **OWATONNA CARE CENTER** OWATONNA, MN 55060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ΙD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 POCK 1-3-14 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey. Owatonna Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections MN DEPT. OF PUBE State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

ABORATOR DIRECTOR'S OR PROVIDER'S OFFICER REFRESENTATIVE'S SIGNATURE

administrator

-27-12

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245383	B. WING	_		11/3	20/2013
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060		
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K 000	By email to: Marian	.Whitney@state.mn.us	ΚŒ	000	0		
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	A description of v to correct the defici-	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	buildings. Owatonn- building with a parti constructed at 2 dif- building was constructed to be of 1966, addition was Wing, with a partial determined to be of Because the original are of the same typ	surveyed as two separate a Care Center is a 1-story al basement. The building was ferent times. The original ucted in 1958 and was Type II(222) construction. In constructed to the South basement and was Type II(111) construction. Al building and the 1 addition e of construction allowed for the facility was surveyed to a g.					
	alarm system with f and spaces open to	prinkled. The facility has a fire ull corridor smoke detection the corridors that is natic fire department					
	The facility has a cacensus of 39 at the	apacity of 55 beds and had a time of the survey.					

PRINTED: 12/16/2013 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245383 B. WING 11/20/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHWEST 18TH STREET **OWATONNA CARE CENTER** OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 | Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=D One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 18 out of 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 on 11/20/2013, observation revealed that the following was found: 1. Soiled utility room # 341, does not shut and latch 2. Soiled utility room in the 100 wing, does not

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245383	B. WING		11	/20/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060		
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K 029	shut and latch	ge 3 ctices were confirmed by the	K	029		
K 046 SS=D	Director of Mainten discovery. NFPA 101 LIFE SA	FETY CODE STANDARD of at least 1½ hour duration is	K	046	\ <u>\</u>	-14
	Based on documer and interview the fa of the emergency b signage as required	s not met as evidenced by: ntation review, observation cility failed to provide testing attery back up lighting and exit by 2000 NFPA 101, Section 17.10.9. The deficient t 39.				
	11/20/2013, the revenue and exit signage test past 12 months revenue. 1. The facility failed	to conduct the monthly 30		1		
	such 2. Found battery stafor (4) lights	90 minute test and document ation pack # 2 - does not work				

CLITICI	TO TOTAL MILEDION WILL	& MEDICAID SERVICES			OIVID INO. 0936-038	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245383	B. WING _		11/20/2013	
NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060			
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K 046	Continued From page 4 These deficient practices were confirmed by the		K 04	6		
K 050 SS=D	Director of Mainten discovery. NFPA 101 LIFE SA	ance (TH) at the time of	K 05	50	1-1-14	
	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2					
	Based on documer interview, the facility were conducted on staff under varying required by 2000 N	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 39				
	11/20/2013, the rev documentation for t 2013 to October 20 following shifts were	veen 8:30 AM and 11:00 on iew of the fire drill the past 12 months (February 13) revealed the drills for the e completed but did not times that the drills were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
245383		B. WING			11/20/2013		
NAME OF PROVIDER OR SUPPLIER OWATONNA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTHWEST 18TH STREET OWATONNA, MN 55060				
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K 050	Continued From page 5 Evening: 1425, 1423 and 1500 hours		KO	50			
	This deficient practi Director of Maintena discovery.	ce was confirmed by the ance (TH) at the time of					
	*TEAM COMPOSIT Gary Schroeder, Lif						
					æ (W)		

K 029

Soiled utility rooms # 341 and soiled utility room in the 100 wing were fixed so they shut and latch.

Maintenance Director is responsible for correction and monitoring to prevent reoccurrence

Date of completion: January 1st 2014

K 046

The monthly 30 second test, annual 90 minute test were completed and documented. The battery station pack #2 was fixed which impacted 4 lights. All emergency lighting was checked and cleared.

Maintenance Director is responsible for correction and monitoring to prevent reoccurrence.

Date of completion: January 1st, 2014

K 050 Bedg 1 + 2

Fire drills are now performed at least quarterly on each shift for all staff under various times and conditions and documented.

Maintenance Director is responsible for correction and monitoring to prevent reoccurrence.

Date of completion: January 1st, 2014

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - 1992 ADDITION

(X3) DATE SURVEY COMPLETED

245383

B. WING __

11/20/2013

NAME OF PROVIDER OR SUPPLIER

OWATONNA CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

201 SOUTHWEST 18TH STREET OWATONNA. MN 55060

OWATONNA CARE CENTER		OWATONNA, MN	55060		
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	FIRE SAFETY		ž.		
	THE FACILITY'S POC WILL SERVE AS ALLEGATION OF COMPLIANCE UPOI DEPARTMENT'S ACCEPTANCE. YOU SIGNATURE AT THE BOTTOM OF TH PAGE OF THE CMS-2567 WILL BE US VERIFICATION OF COMPLIANCE.	N THE JR IE FIRST		8	
	UPON RECEIPT OF AN ACCEPTABLE AN ON-SITE REVISIT OF YOUR FACIL BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH T REGULATIONS HAS BEEN ATTAINED ACCORDANCE WITH YOUR VERIFICA	LITY MAY THE DIN			
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	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFET DEFICIENCIES (K-TAGS) TO:	Y			
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or				
	By email to: Marian.Whitney@state.mn.	us	See bldg for signate	(X6) DATE	

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

TITLE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - 1992 ADDITION

(X3) DATE SURVEY COMPLETED

245383

B. WING.___

11/20/2013

NAME OF PROVIDER OR SUPPLIER

OWATONNA CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

		OWATONNA, MN	TONNA, MN 55060			
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K 000	Continued From page 1	K 000				
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:					
	1. A description of what has been, or will b to correct the deficiency.	e, done				
	2. The actual, or proposed, completion dat	e.				
	3. The name and/or title of the person responsible for correction and monitoring t prevent a reoccurrence of the deficiency.	o				
	This facility will be surveyed as two separabuildings. Owatonna Care Center, 1992 a is a 1-story building with no basement. The addition was determined to be of Type V (construction.	ddition e 1992				
	The 1992 addition building is fully sprinkler The facility has a fire alarm system with ful corridor smoke detection and spaces oper corridors that is monitored for automatic fir department notification.	I to the				
	The facility has a capacity of 55 beds and census of 39 at the time of the survey.	had a				
	The requirement at 42 CFR, Subpart 483.7 NOT MET as evidenced by:	70(a) is				
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDA	RD K 050	e			
	Fire drills are held at unexpected times unevarying conditions, at least quarterly on eashift. The staff is familiar with procedures aware that drills are part of established roundlessigned only to competent persons who a qualified to exercise leadership. Where driverying conditions are part of established roundlessing and conducting assigned only to competent persons who are qualified to exercise leadership.	ch and is utine. drills is are				

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(X5) COMPLETION

DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 02 - 1992 ADDITION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION 245383 B. WING 11/20/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 201 SOUTHWEST 18TH STREET OWATONNA CARE CENTER OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 050 K 050 Continued From page 2 see attached page for 1-1-14
blog/ conducted between 9 PM and 6 AM a coded announcement may be used instead of audible 19.7.1.2 alarms. This Standard is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 on

11/20/2013, the review of the fire drill documentation for the past 12 months (February 2013 to October 2013) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted:

Evening: 1425, 1423 and 1500 hours

This deficient practice was confirmed by the Director of Maintenance (TH) at the time of discovery.

TEAM COMPOSITION Gary Schroeder, Life Safety Code Spc.

If continuation sheet Page 3 of 3