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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 52WT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245383**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **01/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	12		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 03/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 03/31/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/24/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing, Program Specialist
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

MINNESOTA MDH DEPARTMENT OF HEALTH

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.

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245383	A. Building B. Wing	1/4/2014

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/01/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/01/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/01/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	03/21/2014	10160	01/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/22/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245383	A. Building B. Wing **01 - MAIN BUILDING 01**	3/4/2014

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed **02/28/2014**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027	
ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed **02/28/2014**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0064		Reg. # **NFPA 101** LSC K0147		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KFD	03/21/2014	25822	03/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/16/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 52WT

Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245383**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **11/22/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	12		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 01/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-245383

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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

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;

- 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

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:

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

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

DEC 31 2013
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157 1-4-14 GPN	SEE Attached	1-1-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brianne Ulell — TITLE: Administrator — (X6) DATE: 12-27-13

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

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

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	245383	A. BUILDING _____ B. WING _____ DEC 31 2013 MN Dept of Health Rochester	11/22/2013

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify a family when a resident was hospitalized after a fall for 1 of 1 resident (R50) reviewed for notification of change. Findings include: R50 experienced a fall and was hospitalized on 11/15/13, the resident's family was not notified until the afternoon of 11/16/15 of these events. On 11/19/13 at 2:37 p.m., family member (F)-4 requested to speak to a surveyor as she had concerns related to R50's cares. F-4 stated R50 had been transferred to the hospital on 11/15/13 and F-4 had not been notified until 11/16/13 around 3:00 p.m. by a nurse from the care center. R50's record was reviewed. According to documentation on the face sheet, R50 was admitted to the facility on 3/26/13 with diagnoses that included but were not limited to osteoporosis. Review of the nurse progress notes dated 11/15/13 revealed, " NAR [nursing assistant registered] reported at 8:15 p.m. that resident sounded "gurgled" writer was able to hear audible congestion, coughing, and noted res [resident] to have pitting edema bilateral feet. Res was very	F 157		

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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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 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have 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	F 225	SEE Attached	1-1-14

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

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DEC 31 2013
MN Dept of Health
Regulatory Div

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F 225	Continued From page 3 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report allegations of abuse/neglect immediately to the State Agency and immediately to the administrator for 1 of 4 residents (R20) reviewed for vulnerable adult protocol. Findings include: R20 had an allegation of rough treatment reported by staff on 10/7/13 however, the incident had not been reported immediately to the administrator or to the designated state agency but had been reported the day after the	F 225		

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Rochester

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F 225	Continued From page 4 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 Administrator of the facility, State Survey Agencies and Law Enforcement.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	SEE Attachment	1-1-14

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

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F 226	Continued From page 5 by: Based on interview and document review, the facility failed to implement their facility policy and procedure for reporting to the administrator and state agency immediately for 1 of 4 residents (R20) reviewed for Abuse Prohibition. Findings include: R20 had an allegation of rough treatment reported by staff on 10/7/13 however, the incident had not been reported immediately to the administrator or to the designated state agency but had been reported the day after the 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 Administrator of the facility, State Survey	F 226		

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

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F 226 F 272 SS=D	Continued From page 6 Agencies and Law Enforcement. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 226 F 272	SEE Attachment	1-1-14

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

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F 272	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive initial Minimum Data Set (MDS) assessment for 1 of 3 residents (R68) reviewed for resident assessments. Findings include: R68 had been admitted to the facility on 10/22/13. Record review revealed a PPS five day, PPS 14 day, and PPS readmission MDS had been documented, however no comprehensive initial assessment with care area assessments had been completed for R68. According to the PPS five day dated 10/24/13, R68 had diagnoses which included but were not limited to diabetes and a below the knee amputation. During interview on 11/20/13, at 3:30 p.m., the director of nursing verified R68 had not had an initial comprehensive MDS completed.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	SEE Attachment	1-1-14

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor dialysis catheter site for 1 of 1 resident (R12) reviewed for dialysis; failed to comprehensively assess dental needs and care plan according to these assessments for 1 of 1 resident (R68) who had broken teeth; facility failed to identify and investigate a bruise for 1 of 3 resident's (R23) reviewed for skin conditions. Findings include: R12's dialysis catheter site had not been monitored daily per physician orders. R12 had been admitted on 7/2/12. R12's quarterly Minimum Data Set (MDS) dated 8/27/13, identified diagnoses of chronic renal failure and renal dialysis status. R12's care plan dated 10/29/13, indicated hemodialysis related to chronic renal failure, risk for complications and infection in dialysis catheter. Monitor for signs and symptoms of infection to access site: redness, swelling, warmth or drainage. Dressing should remain dry, if becomes wet notify dialysis and replace dressing with a dry sterile dressing. Monitor for signs and symptoms of bleeding, hemorrhage. R12's physician orders dated 11/13, identified order to check change vent circuit catheter daily, monitor for infection. Do not get wet, notify dialysis if dressing gets wet, and replace with dry dressing. R12's treatment sheets dated 11/13, identified check change vent circuit catheter daily, monitor for infection. Do not get wet, notify dialysis if	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 309	Continued From page 9 dressing gets wet, and replace with dry dressing. 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 presents of the broken teeth visibly present in	F 309		

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

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F 309	Continued From page 10 R68 ' s upper teeth. During observation on 11/20/13, at 10:20 a.m., surveyor viewed R68 ' s teeth and noted R68 had two broken teeth on upper gum line. During interview on 11/20/13, at 2:48 p.m., R68 stated the two broken teeth had been broken before R68 had been admitted to the facility. R68 stated the two teeth had broken during the summer. During interview on 11/20/13, at 2:48 p.m., registered nurse (RN)-C verified R68 had two broken teeth on upper gum line and R68 had stated the two teeth had been broken prior to admission to the facility. RN-C verified R68's oral assessment dated 11/9/13 had not identified broken teeth. During interview on 11/20/13, at 3:30 p.m., director of nursing verified R68 ' s oral assessment dated 11/9/13 had not identified broken. Director of nursing stated they would expect staff to complete oral assessment accurately and if R68 needed a dental appointment, one should be made or if one not needed to re-check at a later date. On 11/22/13, at 9:45 a.m., director of nursing stated she had no policy for oral assessment. R23 was observed with a bruise on the back of the left hand with no documentation of finding, treatment, assessed if from possible abuse or possible cause so interventions could be determined to prevent further bruising and healing of this bruise. During document review R23 had diagnoses of	F 309		

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

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F 309	Continued From page 11 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 would begin. The physician, family and DON were	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 309	Continued From page 12 to be notified. If a bruise was missed would be caught on skin check every week. The DON there had not been a weekly skin assessment done since 11/1/13. Policy on bruising was requested and had not been provided by facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the temporary plan of care and document treatments for 1 of 1 resident (R75) reviewed for pressure ulcers. Findings include: R75 had not been repositioned for two hours and thirty minutes even though the temporary care plan states very two hours as R75 had a history of skin breakdown and currently had a stage II pressure ulcer. R75 ' s face sheet noted R75 had been admitted on 11/14/13 with diagnoses included but not limited to status post motor vehicle crash,	F 314	SEE Attachment	1-1-14

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 314	Continued From page 13 traumatic brain injury; loss of consciousness, diabetes, fractures (multiple). R75 ' s temporary care plan dated 11/19/13, identified at risk for skin breakdown, reposition every two hours in bed/chair. Bed mobility assist two staff, sometimes staff of three, wound care. R75 ' s hospital dismissal summary orders dated 11/14/13, identified pressure ulcer stage two coccyx, cleanse daily with normal saline (Anasept if stool) use friction to remove slough; apply nickel thick layer of Curafil and cover with Mepi border. Left heel, deep tissue injury, and hospital treatment 5x9 plus mist therapy. Left lateral foot, deep tissue injury, hospital treatment ace wrap plus mist therapy. R75 ' s admission/re-admission assessment dated 11/14/13 identified skin integrity; coccyx pressure stage two measures 2cm (centimeters) x1.5cm, left heel pressure, unstageable measures 3cm x 3cm and left toe pressure, unstageable measures 2cm x 2cm. During observation on 11/21/13, at 7:10 a.m., R75 had been laid on back in bed, left leg and foot floated on pillow. At 7:15 a.m., registered nurse (RN)-B entered R75 room and repositioned R75's legs and feet up on pillows and covered R75 with a blanket. R75 remained laid on back. At 7:19 a.m., RN-B had entered room to raise head of bed and had given R75 medications, R75 remained laid on back. At 7:27 a.m., nursing assistant (NA)-C had entered room and brought R75 cold juice and walked back out of room, R75 remained laid on back. At 8:24 a.m., RN-B entered room and asked R75 about pain and delivered breakfast tray, R75 remain laid on back.	F 314		

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

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F 314	Continued From page 14 At 8:36 a.m., RN-B entered room to give R75 medications, R75 remained laid on back. At 8:40 a.m., R75 remained laid on back, R75 had lowered head of bead. At 8:51 a.m., staff person had entered to remove breakfast tray out of room, R75 remained laid on back. At 9:03 a.m., R75 remained laid on back in bed, sleeping. At 9:22 a.m., R75 remained laid on back in bed, sleeping. At 9:40 a.m., R75 remains same. At 9:43 a.m., R75 remains same. Continuous observation by surveyor revealed R75 had not been repositioned off back for a total of two hours and thirty three minutes, at which time surveyor informed staff. During interview on 11/21/13, at 9:43 a.m., NA-C verified had not repositioned R75 since started shift at 6:00 a.m. NA-C stated R75 will normally ask to be repositioned once R75 gets pain pills. During interview on 11/21/13, at 9:47a.m., RN-B stated R75 should be repositioned at least every two hours. RN-B stated she had gone in R75 ' s room and the only thing had repositioned, had been legs and feet. During interview on 11/21/13, at 9:50 a.m., director of nursing stated she would expect staff to reposition R75 every one and one half hours to two hours. Director of nursing stated she would expect staff to keep track of last time R75 had been repositioned and be prompt to reposition. Director of nursing stated verbal report is given between shifts to know last time a resident is repositioned.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	SEE Attachment	1-1-14

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 315	Continued From page 15 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess a change in urinary continence status for 1 of 1 resident (R62) reviewed who had a change in continence status. Findings include: R62 had a decline in continence and had not been reassessed to determine interventions to restore or prevent further loss of continence. R62 ' s face sheet noted R62 had been admitted on 8/8/13 with diagnoses that included but were not limited to late effect intracranial injury without mention of skull fracture, Alzheimer's disease, post- polio syndrome with left leg weakness. R62's quarterly Minimum Data Set (MDS) dated 11/3/13 indicated R62 was always incontinent (this was a decline for R62) of urine, was not on a toileting program and required extensive assistance to toilet. The MDS assessment of 11/3/13 indicated that a toileting program was not being used to manage urinary incontinence. However, the previous admission MDS dated 8/19/13, included R62 was frequently incontinent	F 315		

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F 315	Continued From page 16 of urine, but was not on a toileting program. Urinary Continence Evaluation dated 11/2/13 indicated R62 was unable to determine when she needed to go to the bathroom and had a history of incontinence since admission. Indicated R62 was incontinent of bladder due to Alzheimer's dementia. Indicated R62 could use the call light however usually already had a wet pad had. Indicated R62 required an assist of 1 for all cares and required to be checked and changed every 2 hours and as needed. Urinary Continence Evaluation dated 8/22/13 indicated R62 was admitted to facility on 7/31/13 with a Foley catheter with no orders to remove. The doctor was faxed and order was received to remove catheter and document urinary output. Indicated R6 was transferred to emergency department on 8/4/13 due to increased confusion, concentrated urine and lethargy. R62 was diagnosed with a urinary tract infection and the Foley catheter was removed. R62 had some occasional incontinence of bladder when first returned from hospital. Nursing assistants reported that R62 was incontinent during the nocturnal and early morning but continent throughout the day. Nursing assistants reported R62 requested to go to the bathroom after every meal. Staff was to continue to offer R62 the commode before and after meals. The care plan problem for toileting dated 8/13/13 indicated that R62 was incontinent of bowel and bladder, and directed staff to check and change every two hours or assist to commode. The care plan goal was for R62 to be clean, dry and free of odor. Nursing assistant/registered (NAR) care guides in place for R62 at the time of the survey included	F 315		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 315	Continued From page 17 the following information: -undated Re-admission Awareness Communication form, " Incontinent of bowel and catheter. " -11/5/13 MDS Kardex Report for Owatonna Care Center, " occasional incontinent of bowel and frequently incontinent of urine. " The care plan problem for toileting dated 8/16/13 indicated that R62 was incontinent of bowel and bladder, and directed staff to toilet resident upon rising before and after meals and every evening. The care plan goal was for R62 to be clean, dry and free of odor. During an interview on 11/20/13 at 1:14 p.m. nursing assistant (NA)-A stated R62 had been incontinent of bladder. Stated R62 was to be toileted upon rising, before and after meals and in the evening or upon R62's request. NA-A stated there have been shifts when she cared for R62 when she had not been incontinent of bladder. During an interview on 11/21/13 at 9:46 a.m. registered nurse (RN)-A stated R62 displayed a decline in incontinence and verified according to the bladder diary, urinary continence evaluation and MDS assessment the current toileting plan was not effective for R62. RN-A verified the facility did not fully assess R62 ' s toileting plan to prevent further decline in incontinence or to maintain optimal bladder function. RN-A stated the facility should have implemented hourly continence checks and attempted toileting to determine if there was a pattern to R62 ' s incontinence to maximize R62's plan of care related to her incontinence to help prevent further decline or complications. RN-A verified the care	F 315		

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

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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 regarding a change in R62's incontinence and toileting needs.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 323	SEE Attachment	1-1-14

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 323	Continued From page 19 facility failed to complete a comprehensive fall assessment following a fall to determine possible root cause/s of the fall in order to develop interventions to prevent further falls from occurring for 1 of 4 residents (R3) who were reviewed for frequent falls. Findings include: R3 had history of falls and recent falls while in the facility without thorough investigation of causal factors, interventions implemented, and effectiveness of the intervention evaluated. R3 was re-admitted on 10/5/2013 after hospitalization of pneumonia (9/26/2013 to 10/5/2013) with diagnoses included: bipolar disorder, diabetes, and high blood pressure. Admission fall risk assessment dated 10/6/2013 was reviewed. It identified R3 at high risk of falls with a score of 30. R3 had a history of falls in the last 90 days with 2 in 9/2013 and 2 in 10/2013. R3's cognitive status had changed over the past year and the resident had behaviors of periods of altered perception or awareness of surroundings, mental function varies over the course of the day, abusive and was resistive to cares. The resident was identified with moderately impaired vision, confined to wheelchair, always needed physical support, had psychiatric or cognitive factors, and perceptual factors (impaired hearing, dizziness/vertigo). The resident's re-admission MDS dated 10/11/2013 identified the resident as having moderate cognitive impairment and required extensive assist of one staff for activities of daily living. An accident/incident report dated 10/10/2013 was reviewed. The resident was found sitting on the	F 323		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 323	Continued From page 20 floor and stated, " I don't know what happened." The intervention was the malfunctioning bed pressure alarm replaced with new alarm pad. Tested and found to be working properly. Resident confused. Impaired decision making, incontinent, recent change in condition, weakness/fainted, gait imbalance. Improper foot wear and ambulating without assist. No injury. Although the alarm was replaced, there was no system in place to monitor the function of the alarms routinely to reduce the occurrence of a malfunction. An accident/incident report dated 10/25/2013 was reviewed. The staff responded to bed pressure alarm to find resident on floor. The resident stated, "I wanted to get up. I had to go to the bathroom," no injury. The report identified clutter in room, drowsy, impaired decision making, and poor lighting. No interventions were identified after the fall and no actual causal factors were identified. R3's care plan date of 3/30/2013 noted: I am a high risk of fall related to unsteady gait, and history of falls: Interventions include: call light within reach. participate in activities that promote exercise, follow facility fall protocol, gripper stops on floor next to bed, physical therapy evaluate and treat as ordered or as needed. Determine cause of falls record possible root causes. Educate family, caregivers as to causes. The care plan was not updated to address the use of the alarms. On 11/22/2013 at 10:30 a.m., the director of nursing (DON) was interviewed on how the staff is monitoring the alarms for proper functioning. She indicated when the staff takes care of the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 323	Continued From page 21 resident; they are to check the alarms. At 2:30 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 form did not include or identify checking and maintaining resident alarms. No further information or auditing of the alarms was provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	SEE Attachment	1-1-14

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F 329	Continued From page 22 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify 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 medications.	F 329		

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F 329	Continued From page 23 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 interventions and monitor/document relieving factors. 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, schizoaffective disorder, obstructive sleep apnea, pain, diabetic nephropathy, tardive dyskinesia with tongue rolling.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 R71's hospital dismissal summary orders dated 11/2/13, identified orders for the following medications with no corresponding diagnosis: Buspar (an anti-anxiety medication) 30 mg (milligrams) two times a day, aspiring 81 mg one time daily, vitamin D3 1,000 unit tablet one time daily, fluoxetine (an anti-depressant medication) 20 mg capsule 3 capsules (60 mg) one time daily, lamotrigine (Lamictal) (an anti-seizure medication) 100 mg tablet 3.5 tablets (350 mg) every bedtime, Topamax (an anti-seizure medication) 25 mg tablet 2 tablets (50 mg) two times a day and torsemide (Demadex) (loop diuretic medication) 5 mg tablet one time daily. Document review of R71's medication administration record dated 11/2/13, indicated R71 had been receiving the above medications since admission. R71's hospital dismissal summary orders dated 11/2/13, identified order for acetaminophen (Tylenol) 500 mg tablet one to two tablets every six hours as needed for pain, and order for Risperdal (anti-psychotic medication) 3 mg tablet 2 tablets (6 mg) every bedtime. Document review of R71 ' s medication administration record dated 11/2/13, indicated R71 had been receiving the above medications since admission on a routine basis. Document review of DESERT HEALTH GROUP Pain Management Assessment Tool dated 11/13, identified R71 had received PRN Tylenol (pain medication) for pain on dates of 11/5 two tablets for pain rate (rating of 0 to 10 with 10 being the worst) of six , 11/6 two tablets for pain rate of nine, 11/7 two tablets with no pain rate documented, 11/8 two tablets pain rate of four,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 329	Continued From page 25 11/10 received two tablets twice with pain rate of six and four, 11/11 received Tylenol with no documentation if received one or two tablets for pain rate of five, 11/14 two tablets pain rate of five, 11/21/ two tablets pain rate of three. There was no indication that non-pharmacological interventions were attempted to relieve pain. During interview on 11/21/13, at 12:02 p.m., registered nurse (RN)-B verified R71 had not had target behaviors identified whole receiving an antipsychotic medication, had no monitoring being done for use of anti-psychotic medication use and RN-B stated the facility used a target behavior sheet for behaviors but had not been started for R71. RN-B verified R71's physician order for Tylenol had no parameters identified of when to give one or two tablets for pain and stated the Tylenol order should be clarified with the physician of when to give one or two tablets. RN-B verified R71's Pain Management Assessment Tool dated 11/13 had no documentation of non-pharmacological interventions being offered prior to administration of Tylenol and effectiveness had not been consistently. RN-B verified R71's physician orders had no diagnoses/indication for use for some of the medications R71 is receiving and stated a fax should have been sent to physician requesting diagnoses or indications for use of these medications. During interview on 11/21/13, at 12:13 P.M., director of nursing stated diagnoses for medications R71 was receiving should have been obtained upon admission but had not been done. Director of nursing stated she expected target behaviors to be identified and monitored for use	F 329		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 329	Continued From page 26 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 clinically contraindicated in an effort to	F 329		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 329	Continued From page 27 discontinue these drugs. PROCEDURE: 2. PRC will discuss appropriateness of therapy based on OBRA requirements regarding: d. quantitative documentation of appropriate target behaviors. " Document review of the facility Nursing Documentation Antipsychotic Medication Monitoring dated revised 6/13, read " POLICY: To assist the facility in assessing and monitoring residents who require the use of antipsychotic medications. PROCEDURE: 2. All residents who require antipsychotic medication will have the following information documented on the Antipsychotic Medication Log: j. List interventions, restorative, and behavior interventions resident is participating in to assist in decreasing and eliminating medication. k. List of behavior problem(s) identified on the care plan. l. List of 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 included closed fracture of humerus, atrial fibrillation, and congestive heart failure. R72 ' s current physician orders, dated	F 329		

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F 329	Continued From page 28 11/14/2013 from the patient discharge 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. No documentation was evident of the resident ' s pain level, where the pain was neither located,	F 329		

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 329	Continued From page 29 non-pharmacological interventions attempted first nor effectiveness of the pain medication. On 11/20/2013 at 11:13 a.m. ., a registered nurse (RN)-C was interviewed on which as needed pain medication to give R72. She indicated there were no criteria to follow. They would assess the pain and documented how the resident rated the pain. On 11/21/2013 at 6:55 a.m., RN-D indicated she gave the resident oxycodone 5 mg at night when wanted something for pain because R72 rated the pain at 8 of 10 and that seemed more appropriate than Tylenol. RN-D indicated there were no specific criteria on which medication to give but usually give R72 the oxycodone at night. On 11/21/2013 at 7:00 a.m., RN-B was interviewed regarding as needed pain medication to give to R72. She stated she went by the pain rating and how severe the pain is. Can usually give the resident something else if has had the Tramadol medication. She indicated she tried to stagger R72's as needed pain medications. RN-B verified there were no specific criteria for each medication. However R72 did have a scheduled order for Tramadol three times a day and as needed at bedtime. At 8:40 a.m., RN-B was interviewed regarding documentation of effectiveness of the as needed pain medication and use of non-pharmacological interventions before giving them. She indicated they should be documenting on the back of the medication sheet the effectiveness and there was a form to document use of non-pharmacological interventions. She verified none of that has been documented since admission of this resident. However, the staff should be doing that.	F 329		

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 329	Continued From page 30 On 11/21/2013 at 12:45 p.m., the director of nursing was interviewed regarding the as needed pain medication use. She would expect non-pharmacological interventions to be offered and should follow up within one hour max for effectiveness of the as needed medication. Should have specific criteria for the use of the as needed pain medication. Verified this resident was on Tylenol, tramadol, and Oxycodone as needed. R3 was prescribed Trazodone and Ambien for sleep; however R3 had not been comprehensively assessed or monitored for sleep patterns. Review of the Admission form it was noted that R3 was re-admitted on 10/5/13, with diagnoses which included insomnia, bipolar disorder, and schizophrenia. A re-admission Minimum Data Set (MDS) dated 10/18/13 identified R3 with moderate cognitive impairment. Physician orders dated 10/5/2013 and 10/9/2013, identified R3 was prescribed Trazodone 75 milligrams by mouth every bedtime and Ambien 12.5 milligrams by mouth every bedtime as needed. However, R3's sleep cycle had not been assessed upon re-admission back to the facility. On requesting information from facility in regards to a sleep pattern and comprehensive sleep assessment a sleep assessment was provided and dated 3/30/13 which as not fully completed and none was provided after R3 ' s readmission to the facility on 10/5/13. On 11/21/2013 at 12:20 p.m., a registered nurse (RN)-B was interviewed and stated the resident had been refusing the Trazodone at hs (hours of	F 329		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 329	Continued From page 31 sleep) and didn't take the Ambien very often. Only monitor sleep patterns during the initial assessment period and every quarter. No effectiveness documented when the medication was taken or non-pharmacological interventions were attempted. On 11/21/2013 at 12:45 p.m., the director of nursing (DON) was interviewed regarding monitoring of sleep patterns. She indicated they do not monitor sleep patterns and she verified the resident was on Trazodone at hs (hour of sleep) and Ambien prn (as needed) for sleep. As needed medications should have parameters for when to use and the staff should be attempting non pharmacological interventions first. The staff should be documenting effectiveness of as needed medications within an hour. At 1:15 p.m., the DON provided a sleep assessment/evaluation dated 3/16/2013 and indicated that was the most recent one. She verified the resident had not had a sleep assessment evaluation upon re-admission to the facility 10/5/2013. The physician had ordered the Ambien medication on 10/9/2013. The DON verified there was no monitoring of sleep patterns for R3 evident in the medical record. R3 received an antianxiety medication however, no non-pharmacological interventions were attempted before the use of the antianxiety and effectiveness of the antianxiety was not consistently determined. R3 was admitted back to facility on 10/5/2013 after being hospitalized from 9/27/2013 to 10/10/2013 with pneumonia, and atrial fibrillation. Other diagnoses included: bipolar disorder, cannabis dependence diabetes, hypertension,	F 329		

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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 should be documenting effectiveness of the as needed medications within an hour.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334	SEE Attachment	1-1-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 334	Continued From page 33 (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	F 334		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 334	Continued From page 34 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the 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. R16 was admitted on 10/10/2013 and had no pneumococcal information identified in the chart	F 334		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 334	Continued From page 35 to determine whether or not the resident had been immunized or needed to be immunized. On 11/22/2013 at 2:30 p.m., the director of nursing (DON) verified that pneumococcal immunization information had not been obtained for R34, R20, and R16 otherwise it would be in the medical record or located in the binder with the immunization forms. The facility Immunization Program Implementation Guidelines, with revised date of 2/2012, was reviewed and read, "The facility will ensure recommended immunizations as applicable are offered or available for administration to all facility residents and employees and that accurate documentation of such immunizations are maintained. Immunization requirement: (1) All facility residents over 65 years of age or those with high risk conditions will be offered the Pneumococcal Polysaccharide Vaccine upon admission. Document administration on the Vaccine Administration Record for Adults. If the vaccination is refused by the resident, the Immunization Waiver will be required. The waiver will be maintained in the resident chart or employee's file. "	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	SEE Attachment	1-1-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 353	Continued From page 36 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 by: 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	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 353	Continued From page 37	F 353		

had turned the call light on at 8:42 a.m. and was still waiting to get out of bed. R29 put call light on again at 9:22 a.m., at 9:26 a.m. registered nurse (RN)-A went into R29's room and shut off light and immediately came out of the room. At 9:29 a.m. surveyor asked resident if needs were met and resident indicated staff were looking for someone to help me that does not exist. At 9:31 a.m. RN-A again had entered and left the room. NA-C walked past resident room (call light had been shut off previously by RN-A). At 9:35 a.m., RN-A walked into room with medication. At 9:41 a.m. NA-E came into resident room and asked what resident needed (the other time they just shut off light and left the room), R29 indicated needed to use commode. NA-E indicated they would need to get nurse to assist. At 9:42 a.m. RN-A and NA-E went into room and assisted resident to the commode. From 8:42 a.m. until 9:42 when RN-A and NA-E physically assisted resident to commode the residents request had not been responded to for 60 minutes even though the RN and NA went into room and shut off call light but immediately left looking for help.)

R29 was admitted on 11/5/13. R29 had a significant status change Minimum Data Set (MDS) completed on 11/21/13, identified R29 was cognitively intact, was able to communicate needs and required extensive assistance with bed mobility and transfers with two staff, extensive assistance with one staff with toileting, dressing and personal hygiene.

During interview on 11/18/13, at 4:59 p.m. R29 indicated had not felt there was enough staff in the facility as evidence by having to wait a half hour or more for call light to be answered. R29 indicated they treated nursing assistants very

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 353	Continued From page 38 nicely so they treat me well. R29 revealed they had accidents (incontinence) due to having to wait for call light to be answered. R74's quarterly MDS with assessment reference date of 11/11/13, identified R74 was cognitively intact and required extensive assistance with bed mobility, transfers, toileting, dressing and personal hygiene with one to two staff. R74 was identified as being able to communicate needs. During interview on 11/18/13, at 4:41 p.m. R74 indicated had not felt enough staff at facility as evidence by at times needed to wait an hour for staff to answer call light. R74 was interviewed again on 11/22/13, at 9:44 a.m. and said they were depended on staff for assistance. R74 indicated staff says they are understaffed and busy helping others as to why they wait so long to get light answered. R74 indicated they felt some of the staff are burnt out and revealed had waited up to an hour and half to get help some days. R74 said,"I feel like I don't matter, like they don't give a [curse word]." R3's admission MDS dated 10/29/13, identified R3 had mild cognitive impairment and required extensive assistance with bed mobility, transfers, toileting, personal hygiene and was able to communicate needs. During interview on 11/18/13, at 4:30 p.m. R3 indicated had not felt enough staff at facility as evidence by sometimes had to wait an hour. During interview on 11/22/13, at 10:06 a.m. R3 indicated last night in the dining room drank lots of fluids and had to go down by therapy to go to the bathroom. R3 stated staff was just not available and they soiled their clothing while	F 353		

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F 353	Continued From page 39 waiting. R3 verified it doesn't make me feel good when I soil my clothing. R68 was admitted on 10/22/13. The admission MDS dated 11/22/13, identified R68 was cognitively intact, required extensive assistance of one staff for bed mobility, dressing, toileting, personal hygiene and required two staff for transfers. During interview on 11/19/13,a t 9:01 a.m. R68 indicated had not felt enough staff at facility as evidence by this morning had to wait one hour to get to the bathroom-put call light on at 6:30 a.m. and had not come to help until 7:30 a.m. On 11/21/2013, at 6:40 a.m., R68 approached surveyor and stated, "What can you do when you put your light on and wait over an hour to go to the bathroom?" "Have wet myself a couple of times and it is miserable to lay there in it." "It happens a lot on the night shift." "They sometimes only have 2 staff on." R38 was admitted on 9/11/13. R38 ' s admission MDS dated 9/24/13, identified R38 was cognitively intact, able to communicate needs and independent with activities of daily living. On 11/18/13, at 5:29 p.m. R38 indicated had not felt enough staff was available at the facility. During interview on 11//22/13, at 9:31 a.m. R38 indicated had been waiting for pain medication for over an hour. R38 indicated his pain was a 6/10 (scale of 0 to 10 with 10 being the most severe pain) located in ribs. During interview on 11/22/13, at 9:38 a.m. registered nurse (RN)-C verified resident had	F 353		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 353	Continued From page 40 requested pain medication at least a half hour ago but was helping give residents who need insulin on the other wing. R72's admissions MDS had not been fully completed but were told by staff that R72 was interview able when entered on first day. During interview on 11/19/13, at 11:27 a.m. R72 indicated had not felt enough staff at facility as evidence by he puts call light on and up to two hours later staff will come help. R72 said he would like to see what they would do in an emergency. During interview on 11/22/13, at 9:57 a.m. R72 indicated had not felt enough staff at facility as evidence by asked for pain medication during the night and would not get it and felt terrible without medication. R72 indicated the staff doesn't ' t want to ever come back here. R72 indicated I lay here crying in pain at night. R72 indicated there was no one here last night and I wet myself waiting for help. R72 said the aide said to him last night that they (NA) had 16 people to care for. R18 was admitted on 10/10/13. R18's admission MDS identified R18 was cognitively intact, required extensive assistance with two staff for toileting. During interview on 11/18/13, at 4:29 p.m. R18 indicated had not felt there was enough staff in the facility as evidence by R18 had been incontinent because of not being able to get to the bathroom timely due to slow call light response by staff. R18 verified it made him feel terrible to soil self. R18 indicated had waited as long as ½ hour and maybe longer to have call	F 353		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 41 light answered. R13's quarterly MDS dated 10/3/13, identified R13 was cognitively intact and required extensive assistance from one staff with dressing, ambulation, personal hygiene and was able to communicate needs. During interview on 11/18/13, at 4:13 p.m. R13 indicated had not felt enough staff at facility as evidence by at times waited ½ to one hour to be assisted to bed. R9 was admitted on 3/2/12. R9's significant status change MDS dated 11/4/13, identified resident was cognitively intact and required extensive assistance from one staff with transfers, bed mobility, dressing, toileting, personal hygiene and was able to communicate needs. During interview on 11/18/13, at 6:33 p.m. R9 indicated had not felt enough staff at facility as evidence by had to wait a long time most of times a half hour after put light on. R12 was admitted on 6/12/13. R12's quarterly MDS dated 9/4/13; identified resident was cognitively intact, able to communicate needs and independent with cares. During interview on 11/18/13, at 6:02 p.m. R12 indicated had not felt enough staff at facility as evidence by, sometimes staff does not come down for long periods of time when my call light was on and would often get medication late. R47 was admitted on 10/10/13. R47's admission MDS identified R47 was cognitively intact, able to	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 353	Continued From page 42 communicate needs and was independent in activities of daily living. During interview on 11/18/13, at 6:33 p.m. R47 indicated had not felt there was enough staff in the facility as evidence by R47 identified had to wait a long time for help, sometime half an hour after putting the call light on. During the family council interview on 11/21/13 at 11:14 a.m. family member (F)-1 shared family concerns with staffing. F-1 stated there were times when R22 had to wait at times to go to the bathroom and stated there was not enough staff to take care of people that need assist with the bathroom. F-1 stated R22 had been incontinent at times while waiting for help and it made her feel terrible and she cried. F-1 stated R22 ended up going to the bathroom by herself and had broken her neck as a result of a fall in the bathroom a few months back. F-1 stated their family had discussed their staffing concern with the facility and the facility had a " deaf ear " and did not feel the facility was paying attention to the family concern. F-1 stated the facility was just worried about how much money they will make. F-1 stated being short staffed was not a new concern for the facility. F-1 stated the facility just doesn't have enough help to meet the needs of the residents. F-1 stated staff doesn't show up for work and the facility doesn't get replacements or can't find replacements. F-1 stated this was a huge problem and shared the facility has had a huge turnover of help. F-1 stated the facility did have some really good people working there but they are just worked to death. During interview on 11/20/13, at 11:21 a.m. employee (E) -A (who remained anonymous)	F 353		

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	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 353	Continued From page 43 verified had not felt there was enough staff. E-A 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 do not want to anger the residents anymore.	F 353		

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F 353	Continued From page 44 During interview on 11/22/13, at 12:30 p.m. E-C (who remained anonymous) indicated some days there are not enough staff. E-C verbalized things come up and another resident has to go to the bathroom that resident had to wait. E-C verified had heard from residents that they have to wait a long time. E-C stated the staff had asked for more staff and because of case mix index or census we can't have more staff but we need to take care of the residents. E-C indicated had been an increase in incontinence and falls because residents had to wait for help. During interview on 11/20/13, at 2:15 p.m. RN-C indicated the DON would print off new schedule every two days and staff would not realize schedule had changed and not show up. Staffing affects the care and residents are at higher risk for falls. RN-C indicated if a resident was a two person transfer there may not be any other staff on the floor. RN-C verified residents had complained of having to wait for call lights to be answered timely. RN-C indicated doesn't always have the time to help the nursing assistants with transfers and call lights. RN-C verbalized supervisory staff had not routinely answered lights like this week. During interview on 11/21/13, at 10:44 a.m. NA-A identified a concern with staffing related to the responsibility of resident rooms on a different hall. If busy with resident care on the 100 wing I cannot see if the call lights are on the 200 wing. NA-A indicated felt not always enough staff to meet resident needs. During interview on 11/22/13, at 11:06 a.m. the director of nursing (DON) indicated call light	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 45 audits were done randomly. The DON stated had been staying in the evenings and overnights to monitor interactions with the resident and staff. The expectation from the DON would be that staff would answer the call lights within 5 minutes. The DON said had sent out a couple of notes to staff to help each other out. All staff was responsible to help answer call lights. During interview on 11/22/13, at 11:15 a.m. DON indicated felt there was enough staff. DON said the facility staffed according to both census and case mix index. DON said according to census and case mix the facility had been over staffed for nurses by four hours a day. The DON indicated had talked with administrator and have justified going over the four hours for admission and resident care. DON verbalized nursing assistants are staffed the same but identified trying to restructure the nursing assistant staffing. DON confirmed staff had come to the DON and said they needed more help. The DON indicated the staffing was four to five nursing assistants for the same census so now with the restructure of three to four the staff felt they were short staffed. During interview on 11/22/13, at 2:09 p.m. DON indicated had never documented call light audits. During interview on 11/22/13, at 2:37 p.m. the administrator felt the residents were getting the care they need. Administrator said always feel could use more staff, do I feel the staff need to adjust to higher acuity care "Yes." When our case mix index is low we cannot staff any different. Administrator verified had one resident complaint of having to wait for call light to be answered and confirmed 75 percent of the staff says they are short staffed. Administrator further	F 353		

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F 353	Continued From page 46 indicated had observed a lot of staff walking very slow, sitting and talking. Administrator felt the staff had the potential to get the work done but the staff would have to move quicker. During review of call light system policy revised on 5/2012, revealed the purpose of the call light was to respond to resident needs and requests. The call light procedure was to answer call lights promptly, listen to the resident needs and do not make the resident feel you are too busy to help. R22 had several falls since admission and care plan intervention included monitoring R22 when attempting to transfer. However, staff not always available on wing to monitor residents activity status to prevent falls. During an observation on 11/21/13 between 7:15 a.m. and 7:30 a.m., R22 was observed sitting in a wheelchair with a neck brace on. The resident was not to propel herself in her wheelchair with the chair alarm beeping down the 200 wing hallway, wearing her neck brace, was not dressed for the day and verbalized she needed help to go to the bathroom on a repetitive basis. R22 entered the dining room and continued to verbalize she needed help to go to the bathroom and after a few minutes R22 was wheeled out of the dining room by another resident of the facility, who then located a staff member to assist R22 to the bathroom. R22's care plan with initiated date of 11/18/13 reads, "Alarms on bed and WC [wheel chair]. Continue to monitor for falls. Recent cervical neck fx [fracture]. High risk of falls" Quarterly MDS dated 10/09/13 reads under section G-functional Status Activities of daily living assessment, " Extensive assistance-resident	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 47 involved in activity, staff provide weight-bearing support " for both transfer and toilet use and required one person assistance. During an interview on 11/22/13 at 12:22 p.m. the director of nursing (DON) indicated the preventive interventions put in place for R22 had been nursing was to continue to monitor R22 for safe transfers in room and bathroom and continue to keep bed sensor on at night. The DON confirmed monitoring would mean supervision would be provided to R22 for transfers and toileting and R22 would not be considered independent with toileting. The DON verified with the facility staffing of one nursing assistant on each of the three wings and when nursing assistants are pulled to other wings to provide assistance when residents need two care givers their assigned wing is left unattended by the assigned nursing assistant.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356	SEE Attachment	1-1-14

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

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F 356	Continued From page 48 of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post required staffing information on a daily basis. This had the potential to affect 39 of 39 residents living in the facility at the time of the initial tour, staff and visitors. Findings include: During observation of initial tour on 11/18/13, at 2:05 p.m. surveyors were not able to locate the staff posting of hours. During interview on 11/18/13, at 2:07 p.m. registered nurse (RN)-A was unaware of the location of the staff posting and called the director of nursing (DON) according to RN-A the DON stated, "We do not have the hours posted because we do not have the new form." During interview on 11/18/13, at 6:27 p.m. the DON verified the facility had not posted the staffing hours according to the regulation. During review of policy titled posting direct care daily staffing numbers revised August 2006,	F 356		

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F 356	Continued From page 49 revealed the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.	F 356		1-1-14
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the 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	F 428	SEE Attachment	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 50 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 interventions and monitor/document relieving factors. 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, schizoaffective disorder, obstructive sleep apnea, pain, diabetic nephropathy, tardive dyskinesia	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

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F 428	Continued From page 51 with tongue rolling. R71's hospital dismissal summary orders dated 11/2/13, identified orders for the following medications with no corresponding diagnosis: Buspar (an anti-anxiety medication) 30 mg (milligrams) two times a day, aspiring 81 mg one time daily, vitamin D3 1,000 unit tablet one time daily, fluoxetine (an anti-depressant medication) 20 mg capsule 3 capsules (60 mg) one time daily, lamotrigine (Lamictal) (an anti-seizure medication) 100 mg tablet 3.5 tablets (350 mg) every bedtime, Topamax (an anti-seizure medication) 25 mg tablet 2 tablets (50 mg) two times a day and torsemide (Demadex) (loop diuretic medication) 5 mg tablet one time daily. Document review of R71's medication administration record dated 11/2/13, indicated R71 had been receiving the above medications since admission. R71's hospital dismissal summary orders dated 11/2/13, identified order for acetaminophen (Tylenol) 500 mg tablet one to two tablets every six hours as needed for pain, and order for Risperdal (anti-psychotic medication) 3 mg tablet 2 tablets (6 mg) every bedtime. Document review of R71 ' s medication administration record dated 11/2/13, indicated R71 had been receiving the above medications since admission on a routine basis. Document review of DESERT HEALTH GROUP Pain Management Assessment Tool dated 11/13, identified R71 had received PRN Tylenol (pain medication) for pain on dates of 11/5 two tablets for pain rate (rating of 0 to 10 with 10 being the worst) of six , 11/6 two tablets for pain rate of nine, 11/7 two tablets with no pain rate	F 428		

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F 428	Continued From page 52 documented, 11/8 two tablets pain rate of four, 11/10 received two tablets twice with pain rate of six and four, 11/11 received Tylenol with no documentation if received one or two tablets for pain rate of five, 11/14 two tablets pain rate of five, 11/20 two tablets pain rate of five, 11/21/ two tablets pain rate of three. There was no indication that non-pharmacological interventions were attempted to relieve pain. During interview on 11/21/13, at 12:02 p.m., registered nurse (RN)-B verified R71 had not had target behaviors identified whole receiving an antipsychotic medication, had no monitoring being done for use of anti-psychotic medication use and RN-B stated the facility used a target behavior sheet for behaviors but had not been started for R71. RN-B verified R71's physician order for Tylenol had no parameters identified of when to give one or two tablets for pain and stated the Tylenol order should be clarified with the physician of when to give one or two tablets. RN-B verified R71's Pain Management Assessment Tool dated 11/13 had no documentation of non-pharmacological interventions being offered prior to administration of Tylenol and effectiveness had not been consistently. RN-B verified R71's physician orders had no diagnoses/indication for use for some of the medications R71 is receiving and stated a fax should have been sent to physician requesting diagnoses or indications for use of these medications. During interview on 11/21/13, at 12:13 P.M., director of nursing stated diagnoses for medications R71 was receiving should have been obtained upon admission but had not been done. Director of nursing stated she expected target	F 428		

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F 428	Continued From page 53 behaviors to be identified and monitored for use 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	F 428		

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F 428	Continued From page 54 clinically contraindicated in an effort to discontinue these drugs. PROCEDURE: 2. PRC will discuss appropriateness of therapy based on OBRA requirements regarding: d. quantitative documentation of appropriate target behaviors. " Document review of the facility Nursing Documentation Antipsychotic Medication Monitoring dated revised 6/13, read " POLICY: To assist the facility in assessing and monitoring residents who require the use of antipsychotic medications. PROCEDURE: 2. All residents who require antipsychotic medication will have the following information documented on the Antipsychotic Medication Log: j. List interventions, restorative, and behavior interventions resident is participating in to assist in decreasing and eliminating medication. k. List of behavior problem(s) identified on the care plan. l. List of 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 included closed fracture of humerus, atrial fibrillation, and congestive heart failure.	F 428		

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F 428	Continued From page 55 R72 ' s current physician orders, dated 11/14/2013 from the patient discharge 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. No documentation was evident of the resident ' s	F 428		

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F 428	Continued From page 56	F 428		

pain level, where the pain was neither located, non-pharmacological interventions attempted first nor effectiveness of the pain medication.

On 11/20/2013 at 11:13 a.m. ., a registered nurse (RN)-C was interviewed on which as needed pain medication to give R72. She indicated there were no criteria to follow. They would assess the pain and documented how the resident rated the pain.

On 11/21/2013 at 6:55 a.m., RN-D indicated she gave the resident oxycodone 5 mg at night when wanted something for pain because R72 rated the pain at 8 of 10 and that seemed more appropriate than Tylenol. RN-D indicated there were no specific criteria on which medication to give but usually give R72 the oxycodone at night.

On 11/21/2013 at 7:00 a.m., RN-B was interviewed regarding as needed pain medication to give to R72. She stated she went by the pain rating and how severe the pain is. Can usually give the resident something else if has had the Tramadol medication. She indicated she tried to stagger R72's as needed pain medications. RN-B verified there were no specific criteria for each medication. However R72 did have a scheduled order for Tramadol three times a day and as needed at bedtime. At 8:40 a.m., RN-B was interviewed regarding documentation of effectiveness of the as needed pain medication and use of non-pharmacological interventions before giving them. She indicated they should be documenting on the back of the medication sheet the effectiveness and there was a form to document use of non-pharmacological interventions. She verified none of that has been documented since admission of this resident. However, the staff should be doing that.

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F 428	Continued From page 57 On 11/21/2013 at 12:45 p.m., the director of nursing was interviewed regarding the as needed pain medication use. She would expect non-pharmacological interventions to be offered and should follow up within one hour max for effectiveness of the as needed medication. Should have specific criteria for the use of the as needed pain medication. Verified this resident was on Tylenol, tramadol, and Oxycodone as needed. R3 was prescribed Trazodone and Ambien for sleep; however R3 had not been comprehensively assessed or monitored for sleep patterns. Review of the Admission form it was noted that R3 was re-admitted on 10/5/13, with diagnoses which included insomnia, bipolar disorder, and schizophrenia. A re-admission Minimum Data Set (MDS) dated 10/18/13 identified R3 with moderate cognitive impairment. Physician orders dated 10/5/2013 and 10/9/2013, identified R3 was prescribed Trazodone 75 milligrams by mouth every bedtime and Ambien 12.5 milligrams by mouth every bedtime as needed. However, R3's sleep cycle had not been assessed upon re-admission back to the facility. On requesting information from facility in regards to a sleep pattern and comprehensive sleep assessment a sleep assessment was provided and dated 3/30/13 which as not fully completed and none was provided after R3 ' s readmission to the facility on 10/5/13. On 11/21/2013 at 12:20 p.m., a registered nurse (RN)-B was interviewed and stated the resident	F 428		

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F 428	Continued From page 58 had been refusing the Trazodone at hs (hours of sleep) and didn't take the Ambien very often. Only monitor sleep patterns during the initial assessment period and every quarter. No effectiveness documented when the medication was taken or non-pharmacological interventions were attempted. On 11/21/2013 at 12:45 p.m., the director of nursing (DON) was interviewed regarding monitoring of sleep patterns. She indicated they do not monitor sleep patterns and she verified the resident was on Trazodone at hs (hour of sleep) and Ambien prn (as needed) for sleep. As needed medications should have parameters for when to use and the staff should be attempting non pharmacological interventions first. The staff should be documenting effectiveness of as needed medications within an hour. At 1:15 p.m., the DON provided a sleep assessment/evaluation dated 3/16/2013 and indicated that was the most recent one. She verified the resident had not had a sleep assessment evaluation upon re-admission to the facility 10/5/2013. The physician had ordered the Ambien medication on 10/9/2013. The DON verified there was no monitoring of sleep patterns for R3 evident in the medical record. R3 received an antianxiety medication however, no non-pharmacological interventions were attempted before the use of the antianxiety and effectiveness of the antianxiety was not consistently determined. R3 was admitted back to facility on 10/5/2013 after being hospitalized from 9/27/2013 to 10/10/2013 with pneumonia, and atrial fibrillation. Other diagnoses included: bipolar disorder,	F 428		

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F 428	Continued From page 59 cannabis dependence diabetes, hypertension, 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 should be documenting effectiveness of the as needed medications within an hour. parameters for use of an as needed (PRN) pain medication for 1 of 5 resident ' s (R71); failed to identify offer of non-pharmacological interventions prior to administering a PRN pain and anti-anxiety medication and failed to identify documenting of effectiveness of PRN pain and anti-anxiety medications for 2 of 5 residents (R3, R71);failed to identify and monitor target behaviors and failed to obtain diagnoses for medications administered for 1 of 5 residents (R71) and failed to assess	F 428		

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F 428	Continued From page 60 and monitor for hypnotic use for 1 of 5 residents (R3) reviewed for unnecessary medications.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	SEE Attachment	1-1-14

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

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F 431	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to document destruction of fentanyl patches (a narcotic used for moderate to severe pain) for 2 of 2 medication rooms. This practice could encourage diversion of pain medications by staff, residents and/or visitors. Findings include: During interview on 11/22/13, at 8:38 a.m. registered nurse (RN)-C indicated the process was to remove the fentanyl patch and would throw into the sharps container. RN-C confirmed had not had any other nurse sign when throwing the fentanyl patch in the sharps container. During interview on 11/22/13, at 8:31 a.m. RN-A indicated the staff would throw the fentanyl patches in the sharps container. RN-A verified two nurses had not signed when destroyed. During interview on 11/22/13, at 10:58 a.m. the director of nursing (DON) identified the process at this point had been wrap the fentanyl patch up in toilet paper and flushed in the toilet. The DON indicated right now the facility had not had two nurses' sign when destroying fentanyl patches. The DON verified in other facilities worked had two signatures from nurses when destroying patches. The DON confirmed the process would be no different than any other narcotic destruction you would want two nurse signatures. During review of destruction of medication policy dated 2/2012, revealed narcotics were to be destroyed by two licensed nurses.	F 431		

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

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	SEE Attachment	1-1-14

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F 441	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on interview and document review the 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 not a lot of time to focus on infection control	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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F 441	Continued From page 64 program and she was currently working on the 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, controlling, and preventing infection. The facility	F 441		

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F 441	Continued From page 65	F 441		

had several different policies taken from the computer and combined for the infection control program. The policies provided did not include any information regarding employee illness and tracking.
R67 lived in room 103 on unit 100 which had two hallway bathrooms for residents to use as no room had attached bathroom facilities. Room 103 lacked in room sink access for resident or staff to wash their hands with soap and water when resident had an active clostridium difficile (c-diff an infection of the colon). The sink with soap for staff and resident use was located in the hallway. Resident was treated with antibiotics for a c-diff from 10/30/13 to 11/11/13. However, the lack of soap and water access in R67 ' s room increased the chance of spreading C-Diff to staff, visitors and other residents who used the common bathroom and sink.

Review of the admission Minimum Data Set (MDS) assessment dated 10-8-13 indicated R67 was frequently incontinent of bowel and required extensive assist of one for toileting and personal hygiene needs.

During an interview on 11/22/13 at 7:51 a.m. R67 stated she used the Purell hand sanitizer (alcohol based sanitizer) in her room and sometimes used wet-wipes to wash her hands after having bowel movements. R67 staff educated her on the importance of good hand washing after having loose stools related to c-diff. R67 stated the facility staff did not instruct her on how to wash her hands as resident's room does not have a sink for washing her hands. R67 stated she had not had loose stools for about two weeks. R67 verified she did use the sink in the hallway or common area resident bathrooms to wash her

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F 441	Continued From page 66 hands. R67 stated did use the sink in the hallway to rinse out her drinking cup. During an interview on 11/22/13 at 8:21 a.m. a housekeeping staff member (H)-A stated he was unaware R67 had c-diff during her stay at the facility and stated she did not have a red sign on her door to alert him. Stated there was a red container in the room, but did not know what R67 had " No one told me " he said. H-A verified he wore gloves and used bleach to clean in her room. H-A stated if it looked like it needs to be cleaned he cleaned it. H-A stated he did the best he could within his time constraints and having to be out of work on time. HA-A stated he gloved when go into the room, took gloves off when he left the room and in between rooms cleaned his hand with hand sanitizer. H-A stated he did not wash his hand with soap and water after cleaning her room on a consistent basis. During interview on 11/22/13, at 8:22 a.m. NA-B indicated staff used the alcohol (Purell) in the room than go to the sink in the hallway to wash our hands. Technically staff should wash hands before leaving the room but because there was no sink in the room just use the alcohol dispenser. The resident uses her wheelchair I think she has a bottle of alcohol gel. During interview on 11/22/13, at 8:33 a.m. RN-A indicated resident went down to the sink in the hallway to wash her hands and so do staff. Best practice would be not to use the alcohol as does not kill the spores. Staff needed to wash hands at least 20 seconds of actually washing hands. Housekeeping was responsible for cleaning the sink and the room.	F 441		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 67 During interview on 11/22/13, at 8:39 a.m. RN-C verified when staff leave the rooms they are to go down and wash hands in sink located in hallway. RN-C confirmed there was no sink in residents' room. Ideally she should have a room with a sink. During an interview on 11/22/13 at 8:52 a.m. nursing assistant (NA)-F stated she washed her hands with soap and water in the sink in the hallway after providing cares for R67. NA-F stated residents like R67 with c-diff who were mobile and did not have a sink in their room would wash their hands with soap and water in the sink in the 100 wing hallway. NA-F verified the sink in the hallway would not be disinfected after staff washed their hands with soap and water after proving cares for a resident with c-diff or after a resident with c-diff used the sink to wash their hands. During interview on 11/22/13, at 10:48 a.m. the director of nursing (DON) stated as far as both good washing after assisting her with personal cares and toileting. Staff should go to the closest sink. It is not acceptable practice. Stated R67 did not come in with c-diff and developed the c-diff and is hospice and hospice is on the 100 unit. The DON thought it was better for R67 to have private room than to move to a room with a sink. It was discussed that she did not have sink thought about bringing in basin each time she would need to wash her hands. The DON stated for the most part R67 had completed her antibiotics. The DON was not sure if R67 continued to have any loose stools. The DON stated she did not feel R67 had active c-diff at this time. The DON stated housekeeping was responsible for cleaning the room with bleach and in between the nursing assistants are	F 441		

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F 441	Continued From page 68 responsible. The DON wants to implement a check list inside of residents ' closet to explain how to handle linens and trash. Currently resident specific infection control needs are being communicated through 24 hour report and shift to shift. The DON was unsure infection control needs are being communicated to housekeeping. The DON stated she was not sure, " I guess they would come ask us when they see a red bag " and verified this was probably not the best way. Review of the Clostridium Difficile Infection Guidelines dated 8/12 read, "Transmission: C. Difficile is most often transmitted on the hands of facility personnel or residents after contact with contaminated feces or environmental surfaces. The use of gloves by facility personnel and thorough hand washing by both facility personnel and affected residents is crucial." "Prevention and Control: Contact precautions for symptomatic residents. Residents who are continent of stool and who understand and demonstrate thorough hand washing may leave their room to enjoy common areas of the facility...Frequent hand washing by facility personnel and the infected resident ...Thorough cleaning of the resident room, bathroom and items likely to be contaminated with feces ...Precautions will remain in place until course of treatment is completed, diarrhea had resolved and negative culture preferred."	F 441		

F000 INTITIAL COMMENTS

This plan of correction is submitted as required under State and Federal law. 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.

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

1. 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.

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.

2. The DON/designee will complete and audit of all residents' bowel and bladder needs 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.

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'

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.

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

F5383026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2013**

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OWATONNA CARE CENTER	**201 SOUTHWEST 18TH STREET** **OWATONNA, MN 55060**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok JB 1-3-14 RECEIVED DEC 3 1 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-1-14
Exit: 11-27-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dianne Wood
TITLE: Administrator
(X6) DATE: 12-27-13

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	**201 SOUTHWEST 18TH STREET** **OWATONNA, MN 55060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Owatonna Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1958 and was determined to be of Type II(222) construction. In 1966, addition was constructed to the South Wing, with a partial basement and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed to a Type II (111) building. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 39 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2013**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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	K 029	1-6-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2013**

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K 029	Continued From page 3 shut and latch These deficient practices were confirmed by the Director of Maintenance (TH) at the time of discovery.	K 029		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on documentation review, observation and interview the facility failed to provide testing of the emergency battery back up lighting and exit signage as required by 2000 NFPA 101, Section 19..2.9.1, 7.9.3, and 7.10.9. The deficient practice could affect 39. Findings include: On facility tour between 8:30 AM and 11:00 on 11/20/2013, the review of the emergency lighting and exit signage testing documentation for the past 12 months revealed the following: 1. The facility failed to conduct the monthly 30 second test, annual 90 minute test and document such 2. Found battery station pack # 2 - does not work for (4) lights NOTE: Check ALL emergency lights	K 046	1-1-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 046	Continued From page 4 These deficient practices were confirmed by the Director of Maintenance (TH) at the time of discovery.	K 046		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 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:	K 050	1-1-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 5 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.	K 050		

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 re-occurrence

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 re-occurrence.

Date of completion : January 1st, 2014

K 050 Bldg 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 re-occurrence.

Date of completion: January 1st, 2014

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING **02 - 1992 ADDITION** B. WING _____	**11/20/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	See bldg 1 for signature	

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

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

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

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K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		

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K 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 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.	K 050	see attached page for bldg 1 1-1-14	