CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 531Z

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

	PAR	RT I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	F	acility ID: 00343
1. MEDICARE/MEDICAID PRO (L1) 245228 2.STATE VENDOR OR MEDIC. (L2) 019545601		3. NAME AND ADI (L3) AVERA MOH (L4) 300 SOUTH I (L5) MARSHALL	RNINGSIDE HEI BRUCE STREET	IGHTS CAI		56258	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	
5. EFFECTIVE DATE CHANGE (L9) 11/02/2009	E OF OWNERSHIP	7. PROVIDER/SUP	<u> </u>	Y 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
DATE OF SURVEY ACCREDITATION STATUS: Unaccredited AOA	03/14/2017 ^(L34) — (L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
	76 (L18) 76 (L17)	B. Not in Compli	nce With quirements		2. Techn3. 24 He4. 7-Day5. Life \$	nical Personnel our RN y RN (Rural SNF) Safety Code A EETS	Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12) (L15)	or
16. STATE SURVEY AGENCY 17. SURVEYOR SIGNATURE Lois Boerbo	nemarks (if applicable	Date :	05/09/2017	(L19)		EY AGENCY APP	PROVAL Enforcement Special	Date: ist 05/09/2017 (L20)
	PART II - TO	D BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	INGLE STAT	E AGENCY	
19. DETERMINATION OF ELI 1. Facility is Elig 2. Facility is not	ible to Participate		IPLIANCE WITH C	CIVIL	2. O		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1979 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEI BEGINNING (L41) 27. ALTERNATI A. Suspensio	G DATE	24. LTC AGREEME ENDING DATI (L25)		26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction 03-Risk of Involun 04-Other Reason for	e W/ Reimbursementary Termination	INVOLUNT. 05-Fail to Me 06-Fail to Me OTHER 07-Provider S	ARY eet Health/Safety et Agreement Status Change
(L27) B. Rescind S	uspension Date:	(L44) (L45)				00-Active	
28. TERMINATION DATE:	:	29. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	(L32)	32. DETERMINATION (OF APPROVAL DAT	ΓΕ (L33)	DETERMINA	TION ADDOO	5/A I	
	(1.54)			(درس)	DETERMINA	TION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245228

May 9, 2017

Ms. Doris Derynck, Administrator Avera Morningside Heights Care Center 300 South Bruce Street Marshall, MN 56258

Dear Ms. Derynck:

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 March 8, 2017 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 9, 2017

Ms. Doris Derynck, Administrator Avera Morningside Heights Care Center 300 South Bruce Street Marshall, MN 56258

RE: Project Number S5228027

Dear Ms. Derynck:

On February 13, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective February 18, 2017. (42 CFR 488.422)

Also, on February 13, 2017 we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Futhermore, as we notified you in our letter of February 13, 2017, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 27, 2017.

This was based on the deficiencies cited by this Department for an extended survey completed on January 27, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On March 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 27, 2017, as of March 8, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 8, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing	Υ	/2	3/14/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
AVERA MORNINGSIDE HEIGH	ITS CARE CENTER	300 SOUTH BRUCE STREET			
		MARSHALL, MN 56258			

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).

ITEI Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.12(a)(3)(4)((c)(1)-(4)	Completed	Reg. #	483.12 483.95	(b)(1)-(3), (c)(1)-(3)	Completed	Reg. #	483.21(b)(3)(ii)		Completed
LSC			03/08/2017	LSC			03/08/2017	LSC			03/08/2017
ID Prefix	F0309		Correction	ID Prefix	F0312		Correction	ID Prefix	F0318		Correction
Reg. #	483.24, 483.25(k)(l)	Completed	Reg. #	483.24	(a)(2)	Completed	Reg. #	483.25(c)(2)(3)		Completed
LSC			03/08/2017	LSC			03/08/2017	LSC			03/08/2017
ID Prefix	F0497		Correction	ID Prefix	F0520		Correction	ID Prefix			Correction
Reg. #	483.35(d)(7)		Completed	Reg. #	483.75 (h)(i)	(g)(1)(i)-(iii)(2)(i)(ii)	Completed	Reg. #			Completed
LSC			03/08/2017	LSC			03/08/2017	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix	_		Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
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LSC				LSC				LSC			
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REVIEWS CMS RO	ED BY	REVIEW (INITIAL:		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/27/2017			ETED ON			R ANY UNCORRECTED DEFICIENCIE				☐ YE	s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

FOLLOW		Y COMPLETED ON			CORRECTED DEFICIEN CIENCIES (CMS-2567)				-
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REVIEWI	ED RV	REVIEWED BY	DATE	SIGNATI	RE OF SURVEYOR	LUU		DATE	
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Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
LSC	K0918	02/15/2017	LSC			LSC			
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
LSC	K0351	01/31/2017	LSC	K0711	02/15/2017	LSC	K0781		02/15/2017
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed
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program corrected provision the surve	, to show thosed and the date number and ey report form)		reported ovas accompode previou	on the CMS-256 plished. Each d	7, Statement of Defici eficiency should be fune CMS-2567 (prefix of	encies and Illy identifie codes show	Plan of Correct d using either th	ion, that ie regula	have been tion or LSC uirement on
	F FACILITY MORNINGSID	E HEIGHTS CARE CEN	TER		STREET ADDRESS, C 300 SOUTH BRUCE S MARSHALL, MN 5625	TREET	, ZIP CODE		
245228		Y1 B. Wing					Y2	3/6/201	7 _{Y3}
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 9, 2017

Ms. Doris Derynck, Administrator Avera Morningside Heights Care Center 300 South Bruce Street Marshall, MN 56258

Re: Reinspection Results - Project Number S5228027

Dear Ms. Derynck:

On January 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 14, 2017, with orders received by you on February 20, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

		STAT	E FORM: RE\	/ISIT REPORT				
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00343	MULTIPLE CON A. Building B. Wing	ISTRUCTIO	DN			Y2	DATE OF RE	EVISIT Y3
NAME OF FACILITY AVERA MORNINGSIDE HEIG								
This report is completed by a corrective action was accomp identification prefix code prev report form).	lished. Each def	iciency sh	ould be fully ident	tified using either the	e regulation	or LSC provision	n number and	d the
ITEM	DATE	ITEM	1	DATE	ITEM		DA	TE
Y4	Y5	Y4		Y5	Y4		Y	' 5
ID Prefix 20255 Reg. # MN Rule 4658.0070 LSC	Correction Completed 03/08/2017	ID Prefix Reg. # LSC	20565 MN Rule 4658.040 Subp. 3	Correction Completed 03/08/2017	ID Prefix Reg. # LSC	20830 MN Rule 4658.05 Subp. 1	520 Con	rection npleted 8/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 531Z

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

		PART I - TO B	E COMPL	ETED BY T	HE STATI	E SURVEY AC	GENCY	F	acility ID: 00343
1. MEDICARE/MEDICAID PRO (L1) 245228 2.STATE VENDOR OR MEDICA (L2) 019545601		(L3) AVI (L4) 300	ERA MORN	ESS OF FACILITINGSIDE HEILUCE STREET	GHTS CAI		56258	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9) 11/02/2009		7. PROV	/IDER/SUPPL	IER CATEGORY	09 ESRD	<u>02</u> (L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
	01/27/2017 (L (L: 1 TJC 3 Other	34) 02 SNF/NF 10) 03 SNF/NF 04 SNF		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
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17. SURVEYOR SIGNATURE Holly Kranz	, HFE NE II		Date : 02/2	22/2017	(L19)		vey agency app	PROVAL ogram Specialis	Date: t 03/17/2017 (L20)
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19. DETERMINATION OF ELIC 1. Facility is Eligi 2. Facility is not leading to the second sec	ble to Participate	L21)	20. COMPLI RIGHTS	IANCE WITH C	IVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1979 (L24)		GREEMENT NNING DATE	24.	LTC AGREEME ENDING DATE (L25)		VOLUNTARY 01-Merger, Close 02-Dissatisfaction	n W/ Reimbursemen		eet Health/Safety
25. LTC EXTENSION DATE:	A. Susp	NATIVE SANCTIO pension of Admission and Suspension Date	ns:	(L44) (L45)		04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider 5 00-Active	Status Change
28. TERMINATION DATE:	(L28)	29. INTERME		RIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(I 22)	32. DETERMI	NATION OF A	APPROVAL DAT	_	DETERM (C)	ATION ADDOS		
	(L32)				(L33)	DETERMIN	ATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted February 13, 2017

Ms. Doris Derynck, Administrator Avera Morningside Heights Care Center 300 South Bruce Street Marshall, MN 56258

RE: Project Number S5228027

Dear Ms. Derynck:

On January 27, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 26, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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 Email: gary.nederhoff@state.mn.us

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

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective February 18, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 27, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 April 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

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 July 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 02/22/2017 FORM APPROVED OMB NO. 0938-0391

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245228	B. WING		01	/27/2017		
	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 000	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substates	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will	F 00	00				
	your verification. A survey was conducted by the survey w	ucted by the Minnesota Ith on January 23, 24, 25, 26, rvey resulted in an Immediate 09 related to the facility's failed timely emergent care after an olus obstruction which resulted I for harm or death. The IJ 16, was identified by survey 4:15 p.m., and was removed a.m. y was conducted by the						
F 225 SS=D	26, & 27, 2017. 483.12(a)(3)(4)(c)(1 ALLEGATIONS/INI (a) The facility mus (3) Not employ or o who-		F 22	25		3/8/17		

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

(X6) DATE

Electronically Signed

02/20/2017

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 225	(ii) Have had a find nurse aide registry exploitation, mistremisappropriation of (iii) Have a disciplin or her professional body as a result of exploitation, mistremisappropriation of (4) Report to the St licensing authorities actions by a court of which would indicate nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, expincluding injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cau abuse and do not reto officials (including the administrator of officials (including the administration in longer the ad	propriation of property, or court of law; Ing entered into the State concerning abuse, neglect, atment of residents or their property; or eary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. ate nurse aide registry or any knowledge it has of a flaw against an employee, are unfitness for service as a		25		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ITS CARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 800 SOUTH BRUCE STREET MARSHALL, MN 56258	01/21/	2011	
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F 225	thoroughly investigation (3) Prevent further exploitation, or missinvestigation is in percentage (4) Report the result administrator or his representative and with State law, including Agency, within 5 weight in the alleged violatic corrective action matched to impotential neglect of reviewed for abuse experienced an escobstruction on 6/17 transferred to the eprimary physician, limplement the physician implement the physician document reviewed for a base and document reviewed for a base and document reviewed for the physician for the residents (R66, R1 transferred from the room department with the state of the state	that all alleged violations are ated. potential abuse, neglect, treatment while the rogress. Its of all investigations to the or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced or, and document review, the nediately report and investigate care for 1 of 8 incidents (R66) reporting requirements. R66 ophageal food bolus /16 and was ordered to be mergency department by her nowever nursing staff failed to	F 225	,	or usions ncies. encies n. This or ly ly with latory cility's u. HFC OHFC en by		
	R66, who experiend	ced actual harm due to for an esophageal obstruction		and DON will review all QM's daily, working day, to assess for potential	each		

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED	
		245228	B. WING		01/:	27/2017
	PROVIDER OR SUPPLIER	HTS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
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F 225	aspiration pneumor as actual harm for cardiac disease an treatment for sever. A facility email, date director of nursing not been taken to timmediately as peresophageal food be primary physician (conferred with the subsequently contact review. A repto the state agency and an internal investincluding all relevant completed at the time. When interviewed director of nursing was not reported to incident of abuse and director had completed at the time. When interviewed director had completed at the time. The DON stated "lobeen reportable, cobeen a bad outcombeen." The facility's Vulner Plan, last revised 1 Avera Marshall will patient, resident, clanyone including sivisitors, or family mathed the provisitors of some six visitors, or goods or staker, or goods or staker, or goods or staker.	sophageal irritation and risk of nia/airway compromise as well R116, who had a history of d experienced delayed re chest pain. ed 6/21/16 indicated the (DON) was informed R66 had he emergency room physician's orders after an olus obstruction by R66's MD-B). The DON then administrator (A), who acted the medical director for a port was not immediately made of (SA) regarding the incident, restigation into the incident estigation into the incident not staff members was not me. on 1/27/17, at 8:16 a.m. the (DON) stated R66's incident of the SA since there was not an or neglect, rather the medical eted his own internal review. Tooking back on it, it might have be retainly if there would have not a possible Adult Abuse Prevention	F 225	situations. Nursing staff to subrin condition form to the DON on residents who require physician intervention or show a change in condition. Don will review for appropriateness of care. These be reviewed with the medical din weekly. Summaries of the finding reported monthly to the LTC Quality Committee meeting. Education will be provided to all reporting obligations and proceduring March staff meetings. Ald receive annual education on VA and procedures via CBL (compulearning), and upon hire. Nurses will be provided education completing a change in condition form/transfer form for all resider require physician intervention or Tracking tool will be used to mo immediate reporting of VA's. All reports will be reviewed at mont Quality Committee meetings.	all forms will rector ngs will be ality staff on dures I staff will policies uter based on on n ts who transfer. nitor for VA	

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 225	residents, irrespect condition, cause phanguish. Abuse incabuse, physical abuse, physical abuse of technology. The policy defined Failure of the facilit providers to provide resident that are netharm, pain, mental distress. All health reporters. A report believe that abuse Immediately means minutes of knowled to incidents of neglect agency. Taking all in Analyzing the occurchanges are needed occurrences. Keep The policy directed incidents of alleged report should be file be made immediate incident. Review of to the Vulnerable A identifies that once are aware of a incidentifies that once (investigation) is conditioned in the condition of the c	reing. Instances of abuse of all ive of any mental or physical pysical harm, pain or mental ludes verbal abuse, sexual use and mental abuse silitated or enabled through the	F 22					

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	(X3) DATE SUR\ COMPLETE	
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F 226 F 226 SS=D	483.12(b)(1)-(3), 48 DEVELOP/IMPLMB POLICIES 483.12 (b) The facility mus written policies and (1) Prohibit and pre exploitation of resident property, (2) Establish policies investigate any successive successi	and exploitation. In addition to buse, neglect, and exploitation. In addition to buse, neglect, and exploitation as required at paragraph	F 22 F 22	26	3/8/1	17
		or reporting incidents of abuse, n, or the misappropriation of				
CORM CMS 25	prevention. This REQUIREMED by: Based on interview	NT is not met as evidenced V, and document review, the lement the Vulnerable Adult CObsolete Event ID:531Z1		VA report filed on 1/30/17 received from OHFC on 2 Facility ID: 00343		6 of 50

l l	
245228 B. WING 01/27	7/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AVERA MORNINGSIDE HEIGHTS CARE CENTER 300 SOUTH BRUCE STREET MARSHALL MN 56259	
MARSHALL, MN 56258	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 Continued From page 6 Abuse Prevention Plan to ensure immediate reporting of allegations of potential neglect to the State Agency (SA) for 1 of 8 incidents reviewed (R66) who experienced a decline in health status without being transferred to the emergency room immediately as ordered by her primary physician. Findings include: Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal irritation and risk of aspiration pneumonia/ainway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. The facility's Vulnerable Adult Abuse Prevention Plan, last revised 1/2017 indicated: Avera Marshall will not condone abuse of any patient, resident, client and/or participant, by anyone including staff, physicians, volunteers, visitors, or family members. Definition of abuse: the deprivation by an individual, including a care taker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, and mental abuse	

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F 226	use of technology. The policy defined Failure of the facilit providers to provide resident that are ne harm, pain, mental distress. All health reporters. A report believe that abuse Immediately means minutes of knowled to incidents is initial investigation of the incidents of neglect agency. Taking all ranalyzing the occur changes are needed occurrences. Keep The policy directed incidents of alleged report should be filled be made immediate incident. Review of to the Vulnerable A identifies that once are aware of a incidentifies of health facili immediately. Once (investigation) is consubmitted to OHFO. A facility email, dated director of nursing the not been taken to the immediately as per esophageal food be		F 2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY PLETED
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F 226 F 282 SS=D	subsequently contachart review. A rep to the state agency and an internal inversional including all relevancempleted at the tire. When interviewed a director of nursing (was not reported to incident of abuse nedirector had completed to have nedirector had completed have nedificated have nedif	administrator (A), who cted the medical director for a ort was not immediately made (SA) regarding the incident, estigation into the incident at staff members was not me. On 1/27/17, at 8:16 a.m. the (DON) stated R66's incident at the SA since there was not an or neglect, rather the medical eted his own internal review. Toking back on it, it might have etertainly if there would have the for the patient it would have the PLAN are Plans are already by the facility, comprehensive care plan, and document and the follow the plan of care es related to shaving for 1 of 3 iewed for activities of daily failed to ensure a splint was urther development of a f1 resident (R45) reviewed	F 28	Therapy recommendations for RO splint placement will be posted (pri protected) in residents room as a communication tool for staff to assicorrect procedure and placement of and ROM activities. Resident groowill be completed to remove unwar	vacy ure of splint oming	3/8/17
	for grooming servic residents (R54) rev living (ADL's), and f applied to prevent f	es related to shaving for 1 of 3 iewed for activities of daily ailed to ensure a splint was urther development of 1 resident (R45) reviewed		protected) in residents room as a communication tool for staff to assicorrect procedure and placement of and ROM activities. Resident groot	ure of splint oming	

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	PROVIDER OR SUPPLIER	ITS CARE CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 SOUTH BRUCE STREET MARSHALL, MN 56258	•	
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F 282	seated in recliner in unshaven facial ne on the right side of approximated 1/4-1 hair continued to be from 1/23/17 through The care plan revision personal care active noted: It is very imputed interventions included Interventions included Interventions included Interventions included Interview for Mental indicating severe correquired extensive hygiene. R54's dial (paralysis on one second corresponding assistant (Interviewed of the interviewed of	e. p.m. R54 was observed in her room. R54 had long ar her chin along the jawline her face. The hairs were 1/2 inch in length. The facial expresent all days of the surveying 1/27/17. The ded 1/7/17, for R54 identified a aity of daily living (ADL) goal as cortant to my mental health is ed/groomed daily. The ded requiring assist of staff for the degree of the last o	F 282	obtained for resident. On-going compliance: resident carplanning process will be reviewed revised as appropriate for each resident care sheets will be updat reflect resident us of splints or bradall residents. Staff education will be provided at staff meetings on care planning and dignity. Expectation will be that all residents have grooming and facial removed as residents condition in Nurse managers will monitor comp with care plan by monitoring 10 peresidents on a monthly basis for us splints/braces and appropriate grooming/cleanliness. Tracking tool will be used for monit Results of monitoring activities will recorded on facility quality scorecare ported at monthly LTC Quality Committee meeting	and sident. ed to ces for March id lair dicates. bliance rcent of se of toring. be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
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F 282	to be shaved; howe stated R54 did not desired to have one purchase a shaver. preferred to look ninecklace daily) and Monday after her broom with the surve whether she preferremoved if a shave R54 responded, "Yand down. After leapproached adminifront desk to inform personal shaver. Vresponsible for acq R54's family would approval was given personal funds acc shaver. When interviewed clinical manager (Crequired to have the past the facility available for reside always thoroughly cinfection if not thorowere required to pushavers. CM-B als extra shavers avail time. CM-B verified meet R54's groomi When interviewed confirmed the beau available for reside personal shaver to	ever, R54 declined. NA-A also a personal shaver and if she e, the family would need to NA-A verified that R54 ce (requested to wear a had a hair appointment every ath. Upon entering R54's eyor present, NA-A asked R54 red to have her facial hair r was purchased for her use. Yes" and nodded her head up aving the room, NA-A istrative assistant (AA)-A at the AA-A of R54's need for a Yhen questioned who was uiring the shaver, AA-A stated have to purchase unless to use funds from R54's ount for staff to purchase a con 1/27/17, at 11:27 a.m. EM)-B verified residents were eir own razor. CM-B stated in had community shavers nt use but they were not cleaned. Due to the risk of oughly cleaned, residents archase their own personal o confirmed there were no able for resident use at this did the facility was responsible to ng needs per the plan of care. On 1/27/17, at 11:50 a.m. AA-A atty shop did have a shaver nts who did not have their own meet their grooming needs. Set revised 1/16/17, identified	F 28	2		

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F 282	R45 wore a hand shours per day and a hand. The care platherapy directions is splints/braces. R45 stated: right hand fhours per dayon Review of R45's que (MDS) assessment as comatose with a injury (TBI). It furth impairment on both with functional limit On 1/24/17, at 9:32 in bed with a carrot splint was on right has assistant (NA)-B states splint to his left hand any other splint dev. On 1/24/17, at 2:06 (LPN)-A was obserright hand. LPN-A have splint on and on R45 earlier, indimorning cares by the During interview on and NA-D both states as a carrot aware of any other hand. On 1/26/17, at 10:1 completed to both in NA-D with carrot specific parts of the carrot specific parts and specific parts.	plint in right hand/arm 6-8 a carrot splint at all times in left in further directed staff to see in R45's room for 5's current undated splint order forearm splint/brace on for 6-8 6:00 a.m. off at 2:00 p.m. Parterly Minimum Data Set adated 1/11/17, identified R45 a diagnosis of traumatic brain her identified R45 as having a sides of upper extremities ation in range of motion. Pa.m. R45 was observed lying splint in place to left hand. No hand at this time. Nursing atted R45 only wore a carrot and, and did not wear or utilize vices for right hand. P.m., licensed practical nurse wed to apply a splint to R45's stated R45 was suppose to NA-B must have forgot to put it cating it was to be applied with	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309 SS=J	dressed and groom 9:21 a.m. NA-G ver place on left hand, worn by resident. A indicated R45 did not applied as ordered not been posted in plan of care. During interview on director of nursing (expected staff to fo verified R45 was to 6-8 hours per day a 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of lift Quality of life is a fuapplies to all care a residents. Each residents. Each residents. Each residents on practicable physical well-being, consisted comprehensive assistances. The facility must entry the services to attain or practicable physical well-being, consisted comprehensive assistances. The facility must entry the services to attain or practicable physical well-being, consisted comprehensive assistances.	a.m. R45 was laying in bed ed, no splint to right hand. At ified R45 had carrot splint in and stated no other splint is at 9:27 a.m. NA-F also ot wear a right hand splint. 1/27/17, at 10:22 a.m. LPN-C have a right hand splint and that splint instructions had the room as directed on the 1/27/17, at 10:23 a.m. the DON) confirmed she llow the plan of care and have a right hand splint on s ordered. PROVIDE CARE/SERVICES ELL BEING e undamental principle that and services provided to facility sident must receive and the ethe necessary care and maintain the highest l, mental, and psychosocial ent with the resident's ressment and plan of care.	F 28			2/17/17
	provided to residen	sure that pain management is ts who require such services, essional standards of practice,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	and the residents' g (I) Dialysis. The factoresidents who requiservices, consistent of practice, the compared care plan, and their preferences. This REQUIREMENT by: Based on observatoreview, the facility for treatment was proved the facility for the emerging acute changes in the immediate jeopardy actual harm due to esophageal obstruction pneumonia/airway of harm for R116, who disease and experies evere chest pain. The immediate jeopardy harm for R116, who disease and experies evere chest pain. The immediate jeopardy administrator was the direction and was identified of director of nursing a quality were notified 1/25/17, at 4:15 p.m. was removed on 1/2 remained at the low	person-centered care plan, loals and preferences. cility must ensure that re dialysis receive such the with professional standards prehensive person-centered residents' goals and of the interview and document alled to ensure timely medical ided to 2 of 12 residents (R66, or were transferred from the ency room department with eir condition. This resulted in a for R66, who experienced delayed treatment for an extinguished to a single promise as well as actual or had a history of cardiac enced delayed treatment for an experienced delayed treatment for experienced dela	F 3	Policy and process map revieupdated to reflect current representations, definitions added what constitutes as an emergisituation requiring emergency transfer (chest pain, cardiac stroke symptoms, seizure act choking, and intractable pain) Services and Resident Care previewed and updated to refleeLTC services. Process map for non-emergent resident trasituations and for physician/mservices provided in LTC. On-going compliance: 1:1 ed 100% of licensed nurses on semergencies requiring immediate transfer on 1/26/17. eLTC use and endefinitions and process maps new licensed nurse orientations taff to submit change in conditions to DON on 100% of all reside require physician intervention change in condition. DON will forms for appropriateness/tim care. Forms will be reviewed	orting to reflect ency room symptoms, ivity, . Physician colicies ect use of s developed nsfer redical ucation to ituations of diate transfer tuations completed nergency added to all n. Nursing dition forms nts who or show a ll review eliness of		

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F 309	orders signed 4/25/stricture, chronic of (COPD), asthma, of gastroesophageal redementia. R66's annual Minimassessment dated Interview for Menta indicating moderate MDS also indicated independently, had mechanically altere or choking during medications. Review of a Care A 8/23/16, related to had swallowing prodiet or altered cons R66 had experienc transfer to the Emeron R66's care plan Up "Self-Feeding: I am setup." R66's care authored by registe "Diet: NDD3 with grant Also included "My of dysphagia diet and had an instance of in the dining room. esophagus in the pefore. It is safer to ground up to not early as the stricture of the safer to ground up to not early stricture.	entified on the physician (16, included: esophageal ostructive pulmonary disease ysphonia, dysphagia, reflux disease (GERD) and (GER	F3	009	director weekly. Summaries of the findings will be reported monthly to LTC Quality Committee meetings a reviewed at monthly licensed staff meetings.	the	

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F 309	snacks between me watch for symptom esophageal strictur mealtimes, more di notify my Dr. and S pathologist] per Dr. According to the repathologist (SLP) s 12/30/16. On 1/24/pathologist (SLP) d currently receiving a voice and to evalua increased coughing. During observation was having a speed room. At that time, was working on voiobserved to be actisession. During an interview p.m., having had we with assistance, an addition, R66 stated discomfort at this till. On 1/26/17 at 12:32 have eaten her entithe liquids R66 couraction. A preoperative histogauthored by MD (m6/17/16 at 3:30 p.m. information in regar of chicken and needs.)	eals Staff and nurses should in increasing related to my e such as coughing at fficulty swallowing, so they can LP [speech language order." cord, speech language ervices had been initiated on 17 the speech language ocumented, "the resident is speech therapy to strengthen the a report from staff of a during eating." on 1/24/17 at 2:25 p.m., R66 och therapy session in her the SLP acknowledged R66 och therapy session in the surface strengthening. R66 was vely participating in the with R66 on 1/26/17 at 12:10 alked out to the dining room distated it felt good to walk. In dishe was having no pain or me.	F 3	09		

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F 309	last EGD, (Esophage procedure during we endoscope is introduced through the stomach, and/or durin April of last year doing exceedingly with she took her first birth and it apparently go nursing home tried water, tried to cough regurgitate the piecedid not work. They them to send the part of th	ge 16 own peptic acid stricture. Her gogastroduodenoscopy, a hich a small flexible luced through the mouth and he pharynx, esophagus, odenum), and dilatation was (2015) and she has been well since then. Today at lunch te of her chicken sandwich of stuck. The staff at the to get her to take sips of h, they even tried to get her to es of chicken up but that all contacted me and I asked atient to the emergency room. It ill do not quite understand the er to the emergency room as I stated "she needed to have a st". I explained to the nurse all emergency and that she hergency room directly and I he was waiting for her in the just notified shortly ago that and for me to come to the n brought the patient over, [FM-1] present. The patient ten stuck in her throat. She is the has not been able to be regurgitating into any on her spit and secretions. any pain except she states is full" PAST SURGICAL is had multiple EGDs, as well RESSION: 1. Acute impaction of lunch todayPLAN: Urgent foreign body. More than only have to stretch or dilate here an ear future, probably within an emergent EGD."	F 30	09		

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F 309	Report dated 6/17/ Dysphagia in responsimpactionThe gas great difficulty throw visualization and according of the duodenum. The mucosa was catesophagus: A large the middle third of the centimeters (cm) from the middle third of the middle third of the struction in the mass removed with a Stenosis was found obstruction in the mass removed (laying according to the middle third of the esophasis of the middle third of the esophasis of the middle third of the esophasis of the middle the following the typical present a food bolus impactions are accupant, are immediated the following the middle the stomach or by the programment of the stomach or by the programment of the stomach or by the programment of the medical attention. It is ensation of squeen the middle the stomach or squeen the middle the stomach or squeen the middle the stomach or by the programment of the middle the stomach or by the programment of the middle the stomach or squeen the middle the stomach or squeen the middle the stomach or squeen the middle the stomach of the stomac	roduodenoscopy Procedure 16, included: "Indications: onse to solids, causing acute stroscope was passed with ugh the mouth under direct dvanced to the second portion The scope was withdrawn and arefully examinedFindings: e quantity of food was found in the the esophagus, 30 om the entry site. The food a basket, with success. If to be causing a moderate hiddle third of the esophagus, ry site. The obstruction was cross). Moderately hess of skin secondary to hucosa was found in the middle gus" Interology & Hepatology, The Reviewed Journal, ol (NY) 2007 Feb; 3(2): 85-86	F 309			

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F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH COROSS-REFERENCED TO THE APPROPRIES OF THE A			
	the "backyard basurprisingly, impact patients are eating do not chew their conditions could be dentures, the use to eat too quickly, foods are beef, chedente-cooked veg. Review of the nurs as List Resdent (s. 6/26/16 revealed to the cooked by regist reported to RN that at lunch time and be this nurse found reholding an emesis	rbeque syndrome. "Not ctions occur more often when meat and generally when they food sufficiently. Contributing e poor dentation, illfitting of alcohol, or a predisposition. The most commonly impacted icken, pork, and alletables. Sing progress notes identified ic) Notes from 6/17/16 to the following documentation: ring occurred at 1230 (12:30 I at 2000 (8:00 p.m.) 6/18/16, ered nurse (RN)-A: "Staff					

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F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3	09			

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F 309	saturation) 94%, R 6/19/16 at 6:00 p.m "Resident continues eat regular meals th weekend with no di throughout weeken Lungs clear all field signs of aspiration." 6/28/16 at 10:07 a.r (LPN)-D documents from same day surg dilatation by her son breakfast at this tim 174/77. Denies any feel like I have to be MD-B was interview regarding the incide became lodged in h the noon meal. MD doctor on call that of local clinic located 8 home. MD-B said th the nursing home to on chicken, and has some of the meat. I RN-A an order to se stated he had proce for the ER, a surgic anesthesia, to be re ER and that the nur to bring her immedi to explain that R66 surgical procedure in her esophagus. N	sure) 110/63, O2 sat (oxygen (respirations) 20." ., RN-A documented, so to be free of pain and able to proughout the rest of the efficulty. Vitals normal range do after return from procedure. so will continue to monitor for end. [Incensed practical nurse end, "Resident brought back gery post endoscopy with the [FM-1], resident is eating the end, "Temp 97.2, pulse 71, B/P en pain. Done eating states, "I	F3	09			

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F 309	check on the status got to the ER, R66 area. On further in told that R66 was s MD-B stated he the to speak with him. It that R66 had to be visit by a doctor or and determine if she emergency room. It that, he immediatel (connected to the E emesis bag while in had spoken to RN-"should have been "did not order telem had asked, "What remergency?" MD-ERN-B's question by drooling, spitting ar putting your airway this type of medical patient comfort, prothere was an increase pneumonia. MD-B nursing home had the ER in accordant to requiring a "face before a resident cosaid that must be a MD-B said that after staff about not havi immediately he had ER himself. He statisting R66 at the term ER. MD-B stated a immediate assessing mediate assessing the stated as immediate assessing the stated as immediate assessing the ER. MD-B stated a immediate assessing the ER. MD-B	age 21 one to the hospital's ER to of R66. MD-B said when he was not in the ER or surgical vestigation, he said he'd been till over at the nursing home. In had a phone call from RN-B MD-B was informed by RN-A first seen for a "face to face" telemedicine to assess her see should be seen in the MD-B stated when he heard y went to the nursing home ER) and found R66 holding an her room. MD-B stated he B and informed her R66 seen in the ER" and that he nedicine!" MD-B said RN-B makes this a medical as said he had responded to a saying, "When you are not not able to swallow, you are not not able to swallow, you are not at risk." MD-B then said that a seed risk for aspiration said he was in "Awe" that the not immediately sent R66 to one with his orders. In regards to face" and or telemedicine and be seen in the ER, MD-B apolicy of the nursing home are talking to the nursing home and taken R66 to the ER deproceeded to take R66 to the telement and preparation for a not remove the lodged	F3	309		

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F 309	MD-B further state of nursing (DON) involving R66 not be ER as he had order looked into by the five been informed by the trying to prevent ure MD-B explained furthe DON was that on call medical system he'd told the DON, not call the telement me!" MD-B said the makes this a medical explained what emergency, and we emergency based told the DON, "This MD-B further state with the DON, he is facility would look it resident's care. However, the food of aspiration increase unnecessary discounted to the food removed. In the face of the food removed in the face of the food removed. The food removed in the face of the food removed.	age 22 de resident's esophagus. It he had spoken to the director by phone following the incident being taken immediately to the red and wanted this to be racility. MD-B said he had he DON, that the facility was inecessary visits to the ER. It wither his understanding from the nursing home is using an item called e-LTC. He stated "They [nursing home staff] did dicine this time, they called be DON had asked him "What cal emergency?" and that he is constitutes a medical on this incident. He said he'd is was an emergent EGD." If that during the phone call had been assured that the into his concern regarding the wever, MD-B said there had received concerning R66's all concern. MD-B again said atteintervention for R66 to be struction, the risk for ind, and R66 experienced in more more more more more more more more	F3	09			

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F 309	1/25/17 at 4:36 p.m emergency on 6/17 come to visit his mand that she "was in FM-1 said, "I remein handled very good assistant (NA) was he'd arrived. He say encouraging his more food stuck in her thagain stated, "She stated staff called the e-Care-Long Term service) and had his something soft, and maneuver. FM-1 say eaten came back to blocked. FM-1 said doctor had said the (several hours awand chicken would reso the arring that, he'd in doctor. RN-A called said that he would emergency room (I be prepared for his surgical intervention confirmed staff had the ER immediately "we were on our way when [RN-A] got a was off and then say nursing home." FM back to his mother'he would work on it was another 2 hour miserable until MD-	Age 23 M)-1 was interviewed on a., in regards to R66's medical 7/16. FM-1 stated that he had other after lunch on 6/17/16, miserable" and not feeling well. Imber the day, it was not "FM-1 stated a nursing in the room with R66 when aid the NA had been other to cough, but she had aroat and kept spitting up. FM-1 was pretty miserable." He then he doctor at the Avera Care (eLTC a telemedicine is mother drink water, eat defined to do the Heimlich aid, it seemed like all that she'd up, but her throat was still I he was told by RN-A that the early to see if the stuck piece of olve by itself. FM-1 said on equested RN-A to call another different medical doctor (MD)-B, who immediately notify the ER) and surgery so they would a mother who might require in to remove the food. FM-1 if been told to bring R66 over to by by MD-B. FM-1 then stated, any over to the emergency room phone call that the transfer aid we had to return to the left said when they returned it and get it worked out, but it are of watching my mother be B came in personally and took and 5 p.m. FM-1 said when	F3	109			

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F 309	"he was not very had upset then I was." If upsetting to watch I was mom and I. The times and the nurse one seemed to do a discomfort then add the whole thing him handled." FM-1 als ER, MD-B had his in the piece of chicker time they'd waited the piece of chicker time they'd waited the did not blame R something else in the FM-1 further stated had problems, espeand that her esophathen once before. Fa very narrow pass required. When FM followed up with hir stated the 'foundation head the into and had been again to his mother FM-1 was asked if the eLTC service, he telemedicine Dome about that." FM had intervened and concerned about a	saw R66 was still in her room appy, I think he was more FM-1 added that it had been his mother suffer stating, "it he NA came into the room two e once." FM-1 said when no anything to relieve her ded, "[MD-B] ended up doing self, and he got the situation to stated once she got to the mother go into surgery to have no removed, and that the entire of be seen in the ER, his mome and had filled three [emesis] is she'd spit up. FM-1 stated N-A because "it was netween, he was caught." In his mother had previously exially when eating too fast agus had been stretched more fM-1 explained that there was age way, and a softer diet is lated the way the situation had been he had been told by the at the matter would be looked assured it would not happen for any other resident. When he was knowledgeable about the stated. "I was not aware of the none has ever talked to the control on the lates of the lates." I was not aware of the none has ever talked to the stated. "I was not aware of the none has ever talked to the lates." I was not aware of the lates of the lates. The lates of the lates. The lates of the la	F 36	09			

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F 309	1/25/17 at 8:17 a.m happened on 6/17/RN-A was asked at protocol the nursing "On weekends, bas from Avera is here see the patient [fac can use eLTC syste contact with the doc is always an option confirmed eLTC ha R66's choking epise eLTC doctor had or soft food to try to di of meat. RN-A state not work, he called send R66 to the EF not able to see the before the transfer, facility's policy that affiliated community versus Avera the M to the nursing home complete a "face to emergency situation attack, the nurse casend the resident d room. After reviewing choking event on 6 was coughing up so obstruction did not RN-A further stated would have thought RN-A confirmed that facility, and added the policy regarding RN-A further stated	ige 25 RN)-A was interviewed on an interviewed in regards to the events that 16 with R66's choking episode. Out the "face to face" eLTC and if they are not available to be to face/in person], the nurse em. If the nurse cannot make cotor [on call], use of the eLTC for the nurse." RN-A is deen contacted regarding ode on 6/17/16. He verified redered small sips of water, or slodge the partial obstruction ed, when the interventions did MD-B, who gave the order to an interviewed in	F 3	09			

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F 309	the ER, the nurse in to do a "face to face path that is on ever to be used to deterror not. When asked been reviewed with stated the incident is clinical manager (C "I remember that C current protocols in paths." RN-A also is started to use eLTC in from Sioux Falls, nursing staff about Medical Director (M 1/25/17 at 11:55 a.i. that occurred on 6/2 episode. MD-A state program was for the timely. The eLTC protelephone, or came medications, intrave that can be completexplained that the fatrying to utilize the saccess to the MD, a use of the emergen MD-A continued to not appropriate whe such as if the reside impaired airway, strained. MD-A explained the units in the follow. MD-A added are non-emergent."	their family member to go to nust contact the resident's MD e" first. RN-A referred to a care y care center unit in a binder, mine if eLTC should be used I if the incident on 6/17/16 had him by administration, RN-A nad been reviewed with him by M)-A. RN-A continued to say, M-A reminded us to review the place, including the care aid that before the facility had a services, trainers had come South Dakota to talk with the	F3	09			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245228	B. WING			01/2	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH BRUCE STREET IARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	said that utilization they occur for his p whether he was aw emergency on 6/17 reviewed the situati was reviewed previ and himself, and th was handled correct patient was miseral resident did not have airway obstruction a or speak." MD-A state ER nothing cousending the patient appropriate. MD-A worked as the ER facility and do a fact then send to endos doctor could have gothe ER and/or hosp reviewed the incide had not been award seen the patient "fact assessment, since been turned on. ME had not been evaluvideo as that was the stated there possib response if R66 had In addition, in an enfacility to surveyors from MD-A to the n MD-A had written, "camera so technicate consult was made [and he said he had not. MD-A reports are emailed to him as atients. MD-A was asked are of R66's medical /16, and he said he had on. MD-A stated the event ously between administration at in his opinion, the situation of the signs of an as evidenced by "can't breathe ated if R66 had been sent to lid have been done however, for an endoscopy was explained that when he MD he would come to the eto face with the patient and copy. He stated the eto face with the patient and copy. He stated the ethat the eLTC given an order to send R66 to ital. MD-A stated when he'd not regarding this patient, he ethat the eLTC MD had not ce to face" to conduct an the video equipment had not D-A could not explain why R66 ated 'face to face' by eLTC per ne facility's protocol. MD-A ly would have been a different d been seen by the eLTC MD. nail document provided by the dated 6/29/16 at 2:55 p.m., ursing home administrator, ELTC was called but not on ally no F2F (face to face) for R66]." The email was part case MD-A had conducted in	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245228	B. WING		01	/27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	1/24/17 at 5:07 p.m acute medical condithey are seen emer was unaware of an to be seen face to room transfer and pseen in the emerge long-term care cen. On 1/25/17 at 8:34 conducted with the manager. The ED precall the incident of the ED manager statell the nurse at the present a resident are trusted to deterneded to be seen further verified that require being seen CMS (Centers for Mederal regulation of utilized to determinish immediately without confirmed that in the an order for patient expectation would be residents to get as possible while in the non-emergent situation aware of a facility patient face to face visit the emergency room to the seen emergency	sing (DON) was interviewed on a., the DON stated that for ditions, "if it is an emergency, regently in the ER." The DON by requirements for a resident face prior to an emergency provided a list of residents ency department from the ter within the last 12 months. a.m., an interview was emergency department (ED) manager stated she could not for R66 on 6/17/16. However, ated the eLTC doctor would enursing home when to to the ER, and that they (eLTC) mine when the resident in the ER. The ED manager a life threatening crisis would immediately and referenced a Medicare/Medicaid Support, a division) guideline that is erif a resident is seen the first utilizing eLTC. The EDM are instance of a provider giving the seen in ER, "the poer for immediate transport." The anager (NM)-A, was for the eLTC program was for much workup done as	F 30	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER MORNINGSIDE HEIGH	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	educated/oriented to charge nurses. In a eLTC had been conthere was "chicken FM-1 was with R66 stable. NM-A also here is not going to work." NM-A confir a higher risk of asp. The administrator v 3:21 p.m., regardin. R66 on 6/17/16. The situation was "emethave gone immedia. The administrator swhether a medical non-emergent was assessment of the informed him that a completed by eLTC it was an option to than by video. The expectation for RN-when given an order the correct protocol MD-B had refused is an algorithm for the did not know why FER when there was MD-B. When prese aspiration, airway in the ADM stated she and had not seen the During a follow up in at 8:22 a.m., RN-A	dically, and that nurses are to eLTC processes by other addition, NM-A recalled that intacted when R66 felt like stuck in throat." NM-A said and her vital signs had been stated, "if a simple intervention work, the telemonitor wouldn't med the food bolus put R66 at iration. The was interviewed on 1/25/17 at g the medical incident with the administrator stated if the regent" for R66 than she would ately to the emergency room. The administrator is emergent or determined by the nurse's resident. When the surveyor is face to face had not been the Ato ask for a face to face visit for by MD-B would have been at the ADM indicated that if to do a face to face visit, there the nurse to follow. The ADM indicated that if to do a face to face visit, there the nurse to follow. The ADM indicated that if to do a face to face visit, there is an order from to do so by inted with potential issues of management, and discomfort, and not been in the facility	F 3	09		

-	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3	OMPLETED
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	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIAT	COMPLETION DATE
F 309	with R66 on 6/17/10 call had been from been directed not to had returned R66 to On 1/26/17 at 9:24 had worked on 6/17 called RN-A to stop hospital. On 1/26/17 at 10:03 and stated eLTC was provider from Avera stated that if the resclinic's physicians, was called first. RN provider group, the the staff to use eLT On 1/26/17 at 10:20 conducted with CM on 6/17/16. CM-A awith directions to reconducted with GM on 6/17/16. CM-A awith directions to reconducted with GM on 6/17/16. CM-A awith directions to reconducted with GM on 6/17/17 at 11:23 administrator stated surrounding the incomplete of the surrounding the incomplete of the conducted with GM or 1/27/17 at 11:23 administrator stated given the eLTC or implemented, and so orientation checklis stated she felt the reference of the administrator stated or the administrator had been actively conducted with CM or 1/27/17 at 11:23 administrator stated given the eLTC or implemented, and so orientation checklis stated she felt the reference of the administrator stated or the administrator stated or the administrator stated she felt the reference of the administrator stated or the administrator stated she felt the reference of the administrator stated or the administrator stated she felt the reference of the administrator	6. RN-A stated he thought the the DON, and stated he had take R66 to the ER, so he her room at the facility. a.m., the DON confirmed she 7/16 however, denied having the transfer of R66 to the B a.m., RN-B was interviewed as used when a resident's a was not available. RN-B sident used one of the other the outside provider ACMC -B said that with either doctor did a workup or told C, depending on the situation. D a.m., an interview was -A who verified having worked also denied having called RN-A thurn the resident to the facility. If, "there was discussion ident after it had occurred and its was completed. The I not feel there was risk of at discussion and I did not feel		309		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	` '	ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECONDS - REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	for eLTC process tr RN-A. However, no was found in RN-A' reviewed. Registered nurse (F 1/27/17 at 12:33 p.I RN-A said he had r change in the proto system the prior ev had been informed R66's 6/17/16 incid Review of a docum Agreement (undate sign to be designate physician for each in the medical care of will: [bullet six] Cor before ordering that an Emergency Dep non-life threatening An Avera Marshall Inconsent form, was authorization of eLT not provided. A policy for manage and a policy for the requested during the was made by e-mathat the facility did r choking resident, of maneuver.	irector of nursing were asked raining was requested for one was provided and none is personal record when and regarding eLTC education. eceived training regarding a col for when to use the eLTC ening, 1/26/17 after the facility of the serious concern about	F 3	09		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		,,_
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F 309	had a previous me hypertension, atria placement, and art further identified a amyloidosis (a dise substance known a heart, which cause deteriorates the pu and poor appetite, code for resuscitat R116's admission a Brief Interview for indicating R116 has expressed verbal solook back. A substance of her printension of the purindesignee. An Urgent Care Te 12/23/16, indicated due to moderate to started around 3:30 indicated R116 has could beunstable as segment elevated addition, the note in BNP (lab used to cheart failure), give diuretic) intravenous metolazone (anoth tramadol (a pain retroponin level (labor proteins integral to	atted 12/21/16, indicated R116 dical history including: I fibrillation, pacemaker hritis. The discharge summary primary problem of cardiac ease that occurs when a as amyloid builds up in the est it to get increasingly stiff and imping function), hyperkalemia and indicated R116 was a full	F 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245228	B. WING _	·····		01/27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 300 SOUTH BRUCE STREET MARSHALL, MN 56258	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	control. The note for was planning on har nursing home but he the emergency roor discussed with the physician. The diagpain, unspecified. R116's nursing proof following entries: On 12/23/16 a notate p.m.: R116 had contain the pain and the	rin or morphine for pain arther indicated R116's family aving the resident stay at the lad decided to transfer her to m so her case had been local emergency room gnosis was listed as chest gress notes revealed the lition was entered by RN-A 5:24 mplained of epigastric/chest moon around 3:30 p.m. She lat an 8 on a 10 point scale (10 lere pain). R116 had been lox (an antacid) and Zofran (a losea) by RN-A. After 20 let o be reached. As a result, the service) had been let to be reached. As a result, the service) had been let to be reached. As a result, the service) had been let to be reached. As a result, the service had been let to be reached. As a result, the service had been let to be reached. As a result, the service had been lettered and family wished to lettered and family	F 30	09		

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	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	milligrams orally on reflect any intravendany further medicate treat chest pain. A subsequent nursi On 12/23/16 at 7:42 documented by lice Family requested Remergency room at doctor. R116 was the R116's ED nursing arrived in the ER at having only been at days. The notes fur R116 was found to (indicative of heart cardiac risk). The pR116 and her family family indicated the transferred to an outreatment. R116's emergency dated 12/23/16, aut (MD)-G indicated Repigastric pain at 22 and family and the of a possible MI (mheart attack) so R1 evaluation and mar of pain rated at a 10 which was substerr were not tried includaspirin, breathing, of lying down, movem oxygen, palpation and R116's laboratory we metabolic panel (m	m. and Tylenol tablets, 650 12/23/16. The MAR did not bus Lasix administration, nor ion being given to R116 to ang progress note indicated: 2 p.m. a notation was used practical nurse (LPN)-E: 116 be transferred to the 6:00 p.m. RN notified eLTC ransferred at 6:10 p.m. progress notes indicated she'd 6:26 p.m. on 12/23/16 after the nursing home a couple of ther revealed that at 7:09 p.m. have a troponin level of 0.159 muscle damage or increased lan of care was discussed with y and at 7:49 p.m., R116's y wanted R116 to be utside facility for further department (ED) visit note hored by medical doctor 116 had started having 00 p.m. after physical therapy, E care doctor were concerned yocardial infarction, a term for 16 had been sent to the ED for lagement. R116 complained 0 out of 10 upon ED admission tal. Modifying factors that ded analgesics, antacids, coughing, eating, exercise, ent, nitroglycerin, other,	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245228	B. WING		01	/27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZII 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	collected until 6:26 transferred to the e A follow up nursing indicated the follow On 12/24/16 at 4:18 LPN-F included: At R116's family came belongings, stating to the hospital in Si Family stated this wheart damage and family, as R116 was decisions at this tim R116's Avera Heart history and physical listed a chief compl had been admitted concerns of an elevelectrolyte imbalance milligrams of morph with a heparin bolus a nitroglygerin drip Dakota. Lasix was fluid overload state down. A follow-up visit not indicated R116 was to decrease her poid discharge was antichome as family was During interview on nursing home DON to use eLTC. The Demergency, they ar The DON was unaversident to be seen emergency room transidents seen in the residents	p.m., after R116 had been mergency room. home progress note entry ing information: 3 a.m. documentation by 8:00 p.m. (on 12/23/16), back to her room to get her R116 was being transported oux Falls to receive treatment. It was due to R116 sustaining a bed hold was signed per se too upset to make any	F3	009		

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245228	B. WING		01/	27/2017
	PROVIDER OR SUPPLIER	HTS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	verified the facility of weekends and after stated that if the result and they were unawaseen, then eLTC with further stated "if yo someone's provide RN-A stated signs would warrant nursing directly to the ED. In Italian I	_	F 309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245228	B. WING			01/	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTER		300	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTH BRUCE STREET ARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	experiencing chest unaware her mothe ED right away. F-2 herself why her moright away, and that family was presented Additionally, F-2 stago to the ED, and hochest discomfort during interview on RN-B stated eLTC provider from Averaused one of the Affic Clinic (ACMC) doct was called first. Eit workup or told the son the situation. The nursing station with computers as well. During interview on nurse manager (NN program was for redone in the nursing situations, not sympindicated serious chas an emergent situin immediately to the lany facility policy that to face visit with a croom transportation of clinical conditions warranting transportusing eLTC for and reviewing R116's cl NM-A reviewed the	r at the time she started pain. F2 stated she was r could have been sent to the stated she was not sure ther had not been sent over a basically as soon as the ed with this option they did so. Ited her mother had wanted to ad experienced very severe	F3	009			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		245228	B. WING _			01/27/2017	
	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (300 SOUTH BRUCE STREET MARSHALL, MN 56258	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	(X5) COMPLETION DATE	
F 309	During interview on medical director (M the eLTC program eLTC providers were camera, and could intravenous lines at the facility had a grautilize the service to the doctor. MD-A renot appropriate if the care, or the resident airway obstruction, arrest. MDS explair pathways on the unstated that "a lot of nonemergent." Who of a patient exhibiting as chest pain rated within the hour to 10 for indigestion, and of Tylenol for pain, the quickest person they wanted to go to then it would be apperent in the patient (R1 stronger medication had been hard feeling home and one of the resulting in some less the patient of the puring interview on the patient of the patien	arrant immediate ED transfer thway. 1/25/17, at 11:55 a.m. the D-A) stated that the goal of was to see a provider timely. The available via telephone, or order labs, tests, medications, and x-rays. MD-A explained that ant, and they were trying to expect that the service was ere was an acute change in thad an emergency, with breathing difficulty or cardiace and that there were protocols, its for the nurse to follow, and the situations are en presented with an example and signs of a heart attack such at 8 out of 10, escalating 0/10, who was given maalox 20 and the explained that he would get at there. "If the person indicated to the emergency room (ER), propriate to send them to the aid that the doctor must do a explained that he was disappointed that he was disappointed that he was disappointed that he was disappointed to the engine the nursing e other medical providers	F 30	09			

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 39 appropriate for someone reporting severe chest	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AVERA MORNINGSIDE HEIGHTS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 39 appropriate for someone reporting severe chest			245228	B. WING _		01	/27/2017
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 39 appropriate for someone reporting severe chest	_				300 SOUTH BRUCE STREET		
appropriate for someone reporting severe chest	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
pain rated a 10 out of 10 and was unable to state what would constitute an emergent versus non-emergent situation in which eLTC would not be used and the resident brought directly to the ED. During additional interview on 1/25/17, at 1:41 p.m. MD-A (the medical director and also R116's primary physician), stated R116 had an unusual cardiac condition and had been admitted late in the day on 12/21/16 to the facility. R116 had a pacemaker inserted which was not working effectively and was very weak. The medical director stated he had not had time to fully discuss R116's condition with family and had not found out about her episode of chest pain as he had a day off on 12/23/16 until he returned back on duty. The medical director stated the eLTC providers were used after hours for on-call coverage for his residents. The medical director indicated R116's condition was terminal, however wished someone had called him on 12/23/16 and that she "probably should have" gotten pain control from the eLTC physician such as morphine or nitroglycerin on board right away. The medical director stated he did not feel the visit had been very effective in managing R116's symptoms. A facility policy entitled Physician/Medical Services LTC (long term care), Effective: 11/2011 and Expiration: 11/2017 (page 1 of 4) included: "F. Complete a face to face visit before ordering a resident to be transferred to an Emergency Department or to a hospital. This requirement is for acute changes in medical condition of a	F 309	appropriate for sor pain rated a 10 out what would constit non-emergent situs be used and the re ED. During additional ir p.m. MD-A (the me primary physician) cardiac condition at the day on 12/21/1 pacemaker inserte effectively and was director stated he discuss R116's cor found out about he had a day off on 12 on duty. The medic providers were use coverage for his reindicated R116's cowished someone hit hat she "probably control from the eL morphine or nitrog. The medical direct visit had been very symptoms. A facility policy entity services LTC (long and Expiration: 11/1"F. Complete a fact resident to be trans Department or to a service of the control o	meone reporting severe chest to f 10 and was unable to state ute an emergent versus ation in which eLTC would not esident brought directly to the otherwise on 1/25/17, at 1:41 edical director and also R116's, stated R116 had an unusual and had been admitted late in 6 to the facility. R116 had a ed which was not working as very weak. The medical had not had time to fully endition with family and had not er episode of chest pain as he 2/23/16 until he returned back cal director stated the eLTC end after hours for on-call esidents. The medical director ondition was terminal, however and called him on 12/23/16 and should have" gotten pain LTC physician such as lycerin on board right away. For stated he did not feel the or effective in managing R116's effective in managing R116's et of face visit before ordering a sferred to an Emergency a hospital. This requirement is		9		

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	appointment, and/o procedure, or if goind department] for an condition (as specific The Physician/Med page 1. (Undated) is medical condition, referred to next box) medical condition?" "Resident taken to for evaluation" (if Not consent to utilize electrical contacted." The immediate jeon was removed on 1/ implemented the form Reviewed and revised diet order information with esophageal nate records of all resided department (ED)/howhich were unplanted use of eLTC; Upprocess procedure Implemented a log and changes of restresident records for prior to hospital/ED staff had been education.	a hospital for a scheduled or a scheduled out patient ing to the ED [emergency emergency, life threatening fied later in this policy)." ical Services LTC algorithm on included "Change in resident's requiring physician intervention "Emergency, life threatening (If Yes arrow to next box) ED [emergency department] o arrow to next box) "Resident LTC present on resident's to next box) "eLTC pardy that began on 6/21/16, 26/17, when the facility allowing interventions: sed R66's care plan to include on and precautions associated arrowing/stricture; Reviewed ent transfers to the emergency ospital/same-day surgery ned in the previous 12 months; of affected residents wed and revised their physician esident care policies regarding podated their resident transfer and process maps; to track unplanned transfers ident conditions; Audited which eLTC had been utilized visits; and verified all licensed cated regarding these	F 30	09		
F 312	changes. 483.24(a)(2) ADL C	CARE PROVIDED FOR	F 31	12		3/8/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER	HTS CARE CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 SS=D	DEPENDENT RES (a)(2) A resident whactivities of daily live services to maintain personal and oral hactivities of daily lives and oral hactivities of daily lives and oral hactivities and oral hactivities and oral hactivities and oral hactivities are living (ADL's). Findings include: On 1/23/17, at 4:22 seated in recliner in unshaven facial neon the right side of approximated 1/4-1 hair continued to be from 1/23/17 through R54's annual Minin assessment dated Interview for Mentaindicating severe or required extensive hygiene. R54's dia (paralysis on one sexpersonal care actives noted: It is very imputat I look well dressing the daily lives and the daily lives are plan revisional care actives the daily look well dressing the daily lives are plan revisional care actives the daily lives are planted to the daily lives are plante	no is unable to carry out ring receives the necessary in good nutrition, grooming, and aygiene. NT is not met as evidenced tion, interview, and document alled to provide facial shaving re grooming needs for 1 of 3 riewed for activities of daily 2 p.m. R54 was observed in her room. R54 had long ar her chin along the jawline her face. The hairs were 1/2 inch in length. The facial represent all days of the survey gh 1/27/17. num Data Set (MDS) 1/4/17, included a Brief all Status (BIMS) score of 6/15, ognitive impairment, and assistance with personal gnoses included hemiplegia ide of the body) following CVA occident/stroke) affecting the	F 312	ADL cares for identified residents reviewed with assigned care givers On-going compliance: staff educat provided on resident care planning grooming processes including the appropriateness of hygiene cares fresidents who are unable to carry trand are required to receive necess services to maintain good nutrition, grooming, and personal and oral hyduring the March staff meetings. Tracking tool will be used to monitor track residents on a monthly basis appropriate hygiene and grooming practices. Results of monitoring active will be added to the LTC quality scand reviewed at monthly LTC quality committee meetings.	or and or and or any ygiene or and for attivities precard	

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F 312	all grooming needs When interviewed on ursing assistant (It have their own shat NA-A confirmed R5 nor had asked to be when interviewed of confirmed R54 had mainly on the right was aware of the fa R54 approximately desired to be shave NA-A also stated R shaver and if she dwould need to pure that R54 preferred a necklace daily) are every Monday after R54's room with the asked R54 whether facial hair removed her use. R54 responsible for acq head up and down approached adminificant desk to inform personal shaver. Versponsible for acq R54's family would approval was given personal funds acc shaver. When interviewed of confirmed R54's family would approval was given personal funds acc shaver.	on 1/26/17, at 2:37 p.m. NA)-A stated residents need to vers if wanting to be shaved. 4 did not have her own shaver	F3	12			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
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F 312	cleanable razor whi without a personal shavers by beauty shop. When interviewed of clinical manager (Corequired to have the the past the facility available for resider always thoroughly of infection if not thorowere now required personal shavers. Were no extra shave at this time. CM-B responsible to meet the plan of care. When interviewed of confirmed the beau available for resider personal shaver to the plan of care. The policy titled, Ref. 1/2016, included: Coand obtain resident wishes to be groom following: Facial has	ge 43 ch was used for resident's shaver. but was unaware current option. AA-A stated ere admitted with their own ut she would follow up with the on 1/27/17, at 11:27 a.m. M)-B verified residents were eir own razor. CM-B stated in had community shavers in use but they were not cleaned. Due to the risk of bughly cleaned, residents to purchase their own CM-B also confirmed there ers available for resident use verified the facility was t R54's grooming needs per on 1/27/17, at 11:50 a.m. AA-A ty shop did have a shaver into who did not have their own meet their grooming needs. Pesident Quality of Life dated Grooming: staff will recognize preference as to how resident tied. Grooming includes the air: how resident likes to be in, does resident like to have	F 312			
F 318 SS=D	483.25(c)(2)(3) INC DECREASE IN RA		F 318	3		3/8/17
	(c) Mobility.					

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245228	B. WING			01/2	27/2017	
	AME OF PROVIDER OR SUPPLIER VERA MORNINGSIDE HEIGHTS CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			30	REET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BRUCE STREET ARSHALL, MN 56258			
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 318	(2) A resident with receives appropria increase range of redecrease in range (3) A resident with appropriate service to maintain or impropriate service to maintain or impropracticable independent of the independent of independent of the independent of independen	limited range of motion te treatment and services to motion and/or to prevent further of motion. limited mobility receives es, equipment, and assistance ove mobility with the maximum ndence unless a reduction in trably unavoidable. NT is not met as evidenced tion, interview, and document ailed to ensure a splint was hand to prevent further ntractures (permanent scle or joint preventing normal of 1 resident (R45) reviewed for OM). Luarterly Minimum Data Set to dated 1/11/17, identified R45 a diagnosis of traumatic brain and mobility, transfers, and hygiene. It further aving impairment on both emities with functional	F3	:18	Splint application for identified resireviewed with assigned staff. On-going compliance: Staff educate be provided during Marsh staff meet on care planning policies including ensuring residents with limited rang motion receives appropriate treatm and services to increase range of nand or to prevent further decrease range of motion. Staff care sheets updated to reflect splint or brace not 100% of residents who have orders splints or braces. Nurse Mangers of monitor 10% of residents monthly following of care plans including us splints, braces, and/or ROM. Track care plan compliance including use splints, braces, ROM exercises will added to department quality scored and reported and reviewed at mont LTC Quality Committee meetings.	tion will etings ge of ent notion in will be eeds of s for will or e of king of be eards		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	` '	NG		COMPLETED	
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	a.m. off at 2:00 p.m. On 1/24/17, at 9:32 in bed with a carrot splint was on right hassistant (NA)-B stasplint to his left hanany other splint dev. On 1/24/17, at 2:06 (LPN)-A was observight hand. LPN-A shave the splint on bto apply earlier with staff. During interview on NA-E and NA-D sta R45 wearing a carro of any other devices On 1/26/17, at 10:1 completed to both to NA-D with a carrot shave the splint on both and following the Fon 1/27/17, at 8:07 dressed and groom 9:21 a.m. NA-G verplace on left hand both to R45. At 9:27 a.m. Not wear a right hard When interviewed of LPN-C verified R45.	a.m. R45 was observed lying splint in place to left hand. No hand at this time. Nursing ated R45 only wore a carrot d, and did not wear or utilize ices for right hand. p.m. licensed practical nurse ared to apply a splint to R45's stated R45 was suppose to ut NA-B must have forgotten morning cares by the nursing 1/24/17, at 2:07 p.m. both ted they were only aware of ot splint to left hand; not aware as or splints for right hand. 2 a.m. ROM exercises were upper extremities by NA-C and splint placed to the left hand. was applied to R45's right ROM. a.m. R45 was lying in bed ed; no splint to right hand. At ified R45 had a carrot splint in out no other splint was worn by NA-F also indicated R45 did	F3	18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
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F 318	director of nursing (expected staff to fo verified R45 was to 6-8 hours per day and During interview on certified occupation stated splints are of further contractures recommendations at they expect nursing A facility policy relatives requested but 483.35(d)(7) NURS REVIEW-12 HR/YF (d)(7) Regular In-Set The facility must coof every nurse aide months, and must peducation based or reviews. In-service requirements of §44 This REQUIREMENT by: Based on interview facility failed to compare the service of the service	1/27/17, at 10:23 a.m. the DON) confirmed she flow the plan of care and wear a right hand splint on sordered. 1/27/17, at 11:33 a.m. the al therapist assistant (COTA) redered for residents to prevent and when therapy gives and schedules for splint use to follow it. 1/27/17 to 11:33 a.m. the all therapist assistant (COTA) redered for residents to prevent and when therapy gives and schedules for splint use to follow it. 1/27/17 to 11:33 a.m. the all therapist assistant (COTA) redered for residents to prevent and when therapy gives and schedules for splint use to follow it. 1/27/17 to 11:33 a.m. the all therapist assistant (COTA) redered for residents to prevent and when therapy gives and schedules for splint use to follow it.	F 318	3	will be	3/8/17
	(NA-H, NA-I) perso to ensure at least 1 had been complete (NA-F, NA-H, NA-I)	nnel files reviewed and failed 2 hours of in-service training d for 3 of 7 nursing assistant training records reviewed d survey. This had the		policy on performance reviews will reviewed and updated to reflect expectations of timely performance reviews for all employees. Educati leaders on policy expectations (lea	be e ion to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•		
AVERA I	MORNINGSIDE HEIGH	HTS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258			
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F 497	Findings include: Nursing assistants reviewed on 1/26/1 10/9/15. The perso any performance e conducted. In addit 1/1/16 through 12/3 NA-H had complete education hours du NA-I's personnel file indic performance evalu 12/4/15 (13 months evaluation had bee addition, a review of 1/1/16 through 12/3 completed 9.04 hor 2016 instead of the NA-F's Training Ref 12/31/16, noted NA hours of continuing The file lacked evic completed twelve hin the last year. When interviewed acquisition specialiand NA-I did not had completed at least	(NA)-H personnel file was 7, and indicated a hire date of nnel file lacked evidence that valuation had not been tion, the Training Records from 31/16, lacked evidence that ed any in-service/continuing	F 4	assigned to complete perforeviews). Process placed in managers, director and adwith overdue performance. Overdue evaluations will be reminder on a daily basis we valuations are completed by employee and manager placed to update managers for staff who are overdue in mandatory and required explain the second of the completion. Untimely comperformance reviews will be the leader's respective manup. Managers will track encompliance with completion education and will follow upemployees during monthly Employees who are unable mandatory education will be link to complete the online and will be paid for their times.	to update ministration evaluations. e sent as a ia email until and signed off (s). Process is via email alert in completing flucation. In the mance timely pletion of the forwarded to mager for follow in ployee in of mandatory o with rounding. It is to complete e offered the CBL's remotely		

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F 497	NA-H and NA-I did continuing education	ge 48 stant (AA)-A verified that NA-F, not have 12 hours of on from 1/1/16 through	F 4	97			
F 520 SS=F	12/31/16. 483.75(g)(1)(i)-(iii)(i COMMITTEE-MEM QUARTERLY/PLAN	IBERS/MEET	F 5	20		3/8/17	
	(g) Quality assessn	nent and assurance.					
		naintain a quality assessment nmittee consisting at a					
	(i) The director of n	ursing services;					
	(ii) The Medical Dire	ector or his/her designee;					
	staff, at least one o	er, a board member or other					
	(g)(2) The quality a committee must:	ssessment and assurance					
	coordinate and eva identifying issues w	arterly and as needed to luate activities such as ith respect to which quality ssurance activities are					
		plement appropriate plans of entified quality deficiencies;					
	Secretary may not	formation. A State or the require disclosure of the mmittee except in so far as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 520	such committee wit section. (i) Sanctions. Good committee to identified deficiencies will not sanctions. This REQUIREMENT by: Based on interview facility failed to ensure and assurance (QA evaluated and deveroncerns with regal (a telemedicine ser and face to face visemergent acute characteristic of the factoristic	elated to the compliance of h the requirements of this faith attempts by the fy and correct quality be used as a basis for NT is not met as evidenced and document review, the cure the quality assessment and to protocols for use of eLTC vice available in the facility sits being conducted for langes in condition. This and the potential to affect all 72	F 52	Change in condition events add Quality Committee and scorecar On-going compliance: education to nursing staff on completion of in condition/transfer form to be con 100% of residents who prese change in condition or those requtransfer to ED/hospital/SDS. For forwarded to DON or designee to reviewed for appropriateness of later than the next business day, in condition forms/transfer forms reviewed by DON and LTC medical director each week for appropriation and timeliness of care. Summar findings will be reported on a mobasis to the LTC Quality Commitmeetings.	d. provided change completed nt with a uiring a ms be care no Change will be cal teness y of nthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245228	B. WING		01	/27/2017
	PREFIX TAG (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 520 Continued From page 50 Morningside Heights Care Center for the dates 5/2016 through 12/2016 showed a total for this six month period of 37 urgent care video encounters, with a large percentage of telephor and video encounters occurring between the hours of 9:00 a.m. and 3:00 p.m. During interview on 1/25/17, at 11:55 a.m. the medical director (MD)-A for Morningside Care center, stated the goal of the eLTC program wa for residents to see a provider timely. eLTC providers were available via telephone, or camera, and could order labs, tests, medicatior intravenous lines and x-rays. MD-A explained the facility had a grant and were trying to utilize the service to support immediate access to the doctor. MD-A revealed the service was not appropriate if there was an acute change in car or the resident had an emergency; with airway	ITS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258	·	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	Morningside Height 5/2016 through 12/2 six month period of encounters, with a land video encounter hours of 9:00 a.m. and video encounter hours of 9:00 a.m. and During interview on medical director (Macenter, stated the growing for residents to see providers were avaicamera, and could intravenous lines are facility had a grant a service to support indoctor. MD-A revea appropriate if there or the resident had obstruction, breathing MDS explained the on the nursing units stated that "a lot of non-emergent." Where we want to the example of a patier attack such as cheen escalating within the given Maalox for inconsusea, one dose or esponded that he withere, "If the person to the emergency reappropriate to send further stated the deand he "believed" the CMS, but was not confirmed he was obeen administered.	s Care Center for the dates of 2016 showed a total for this 37 urgent care video arge percentage of telephone ers occurring between the and 3:00 p.m. 1/25/17, at 11:55 a.m. the D)-A for Morningside Care oal of the eLTC program was a provider timely. eLTC idable via telephone, or order labs, tests, medications, and x-rays. MD-A explained the and were trying to utilize the mmediate access to the led the service was not was an acute change in care, an emergency; with airwaying difficulty or cardiac arrest. The were protocols, pathways as for the nurse to follow, and	F 5			

-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ID PLAN OF CORRECTION 245228 IAME OF PROVIDER OR SUPPLIER AVERA MORNINGSIDE HEIGHTS CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	HTS CARE CENTER		STREET ADDRESS, CITY, STATE 300 SOUTH BRUCE STREET MARSHALL, MN 56258	E, ZIP CODE		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 520	the facility three dameetings. MD-As system had not be meetings and wish he could be aware providers were sta. During interview or administrator (who primary QA comming emergent situation directly to the ER program requirement assessment, howe experienced emergadministrator state reviewed upon initial been training in 8/2 program requirement appropriately for not be regard to whether appropriately for not be antipsychotic medial recommendations. Physician services within the last year monitoring being under the emergency roopersent during this not feel anything heregard to R66 and	lys/week and attended the QAA tated improper use of the eLTC en reviewed at the QAA ed staff would call him more so of what medications the eLTC ring on his residents. In 1/25/2017, at 3:21 p.m. the was identified as the facility's ttee contact) stated for some the resident should go prior to a face to face were did not feel R66 or R116 gent health conditions. The douse of the eLTC system was all orientation and there had ents that had been added. In a QA review specifically with the system was being used on-emergent situations. In 1/27/17, at 11:23 a.m. the (DON) stated sources of the ideas included previous enavioral management issues, cation reduction and incident reports. In the late the electron and incident reports. In the ented the eLTC as a method to transfers and repeat trips to m. The administrator was also interview, and stated she did ad been done wrong with her incident of a food bolus.	F 5	520			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 520	been taken to the edirected by her primhad not been address rather MD-A had do administrator further breathing there wou analysis done. The facility policy end Heights Care Center Performance Improduced the program and Scope indicated the program comprehensive, and transitions, aiming further while emphasizing alife for residents. The facility policy endicated the program committee for the The facility policy endicated the Center and Scope or Servithe LTC (long-term committee. The cordeficiencies and deaction to correct the Quality Committee Committee of the Breedback, Data Sy indicated the committee and servariety of sources. staff, patients, famili performance indicated the committee indica	mergency department (ED) as nary physician, the concern essed via the QA committee, one a chart review. The er stated if R66 had not been all have been an event er Quality Assurance and evement (QAPI) Committee or Service, last revised 4/15 am would be ongoing and diaddress resident care for safety and high quality autonomy and choice in daily he policy indicated the Vice ent care Services will be	F 5	20			

F135 9005

PRINTED: 02/23/2017 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - NEW BUILDING AND RENOVATED **EXISTING BLD** 245228 B. WING 01/24/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 SOUTH BRUCE STREET AVERA MORNINGSIDE HEIGHTS CARE CENTER MARSHALL, MN 56258 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Avera Marshall Regional Medical Center Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or

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

Electronically Signed

(X6) DATE

TITLE

02/22/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD EXISTIN	E SURVEY PLETED					
		245228	B. WING			01/2	4/2017	
	NAME OF PROVIDER OR SUPPLIER AVERA MORNINGSIDE HEIGHTS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258				
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K 351 SS=D	NOT MET as evide NFPA 101 Sprinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automati accordance with N Installation of Sprin In Type I and II commeasures are permisprinkler protection or local regulations In hospitals, sprink closets of patients of the closet does a sprinkler coverage required by NFPA Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This STANDARD Based on observatiled to ensure the kept in the sprinkler.	r System - Installation nstallation d hospitals where required by are protected throughout by an esprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. Hers are not required in clothes leeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 2.7, 9.7.1.1(1) s not met as evidenced by: tion and interview, the Facility at spare fire sprinklers were r box at the sprinkler riser in FPA 13. This deficient practice		351	Contacted Building Sprinkler on 1 Informed him that we needed two type of sprinkler heads in the sprin box. Personnel came added requ sprinkler heads on 1/31/17. Labe to front of box with a list of the rec heads for quick reference.	of each nkler iired I added	1/31/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 02 - NEW BUILDING AND RENOVAT IG BLD	1` ′ 004	E SURVEY MPLETED
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K 711 SS=F	on 01/24/2017, ob 2 replacement fire that is in service a Replacement Spri This deficient prac Maintenance Dire NFPA 101 Evacuation and R There is a written patients and for than emergency. Employees are personners are presented to the service of	tween 10:00 AM and 1:00 PM eservation revealed, that at least esprinkler heads for each style at the facility were not in the nkler Head Box. Stice was verified by the Facility ector. Stice and Relocation Plan		711		2/16/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - NEW BUILDING AND RENOVATED EXISTING BLD		(X3) DATE SURVEY COMPLETED	
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K 711	copy of the plan is operator or with se basic response red and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 this STANDARD Based on docume the Facility failed to Relocation Plan ac Code. This deficient 72 residents Evacuation and Retermination of the patients and for the an emergency. Employees are perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components. The perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 asafety plan components.	readily available with telephone curity. The plan addresses the quired of staff per 18/19.7.2.1.2 I of the fire safety plan 8/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, is not met as evidenced by: entation review and interview, or maintain a Evacuation and ecording to the 2012 Life Safety it practice could affect 72 of the elocation Plan colar for the protection of all eir evacuation in the event of riodically instructed and kept in duties under the plan, and a readily available with in or with security. The plan ic response required of staff and provides for all of the fire nents per 18/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, DE: ween 10:00 AM and 1:00 PM cumentation review revealed the Plan needs to be updated to direments of the 2012 Life ddressed, specificly, to include feel will call 911 in the event of	K	711	Updated Fire Response and Evac plan for Morningside Heights. Pla copy of updated plan in the Book of Business. Added item 6 to processection of plan: staff member to confirm fire call has been received.	ced a of lure all 911	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	STING BLD		PLETED	
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K 781 SS=E	This deficient prac Maintenance Direc NFPA 101 Portable		K.	781			2/15/17
30-L	prohibited in all he unless used in nor areas where the he 212 degrees Fahre 18.7.8, 19.7.8 This STANDARD Based on docume the Facility failed to	ating devices shall be alth care occupancies, except, asleeping staff and employee eating elements do not exceed enheit (100 degrees Celsius). is not met as evidenced by: entation review and interview, o provide a written and current cy. This deficient practice could idents.			New policy on space heater use i Morningside Heights Care Center developed. Copy of new policy pla Book of Business		
	Portable space he prohibited in all he unless used in nor areas where the h 212 degrees Fahre 18.7.8, 19.7.8	ating devices shall be alth care occupancies, except, asleeping staff and employee eating elements do not exceed enheit (100 degrees Celsius).					
	on 01/24/2017, do that the Facility do	tween 10:00 AM and 1:00 PM recumentation reviewed revealed research have a written Space is specific to the Avera					5
	Maintenance Dire	ctice was verified by the Facility ctor. cal Systems - Essential Electric	K	918			2/15/17

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING AND RENOVATED EXISTING BLD			(X3) DATE SURVEY COMPLETED	
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K 918	Continued From pa	age 6	К	918			
	Maintenance and The generator or of and associated equations are within 10 sociated in a criterion is not met process shall be processed in a capability for the lift Maintenance and the transfer switches a with NFPA 110. Generator sets are under load 30 minuted load 30 minuted and intervals, and months for 4 continuated cold start transfer of all EES competent persons stored energy power accordance with Noticuit breakers are program for period components is est manufacturer required in a component in the circuits are marked Minimizing the pose mergency power consideration for model of the consideration for model	ther alternate power source uipment is capable of supplying econds. If the 10-second during the monthly test, a rovided to annually confirm this e safety and critical branches. esting of the generator and are performed in accordance inspected weekly, exercised ates 12 times a year in 20-40 exercised once every 36 huous hours. Scheduled test ons include a complete at and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder e inspected annually, and a lically exercising the ablished according to irements. Written records of testing are maintained and EES electrical panels and d and readily identifiable. Is is is is a design the installations. (NFPA 99), NFPA 110, NFPA			Updated monthly Emergency Ge log to include transfer time. Copy updated log placed in log book at file also updated with new form.	/ of	

	OF DEFICIENCIES F CORRECTION	TION IDENTIFICATION NUMBER: A. BUILDING 02 - NEW BUILDING AND RENOVATED EXISTING BLD			E SURVEY IPLETED		
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K 918	Electrical Systems Maintenance and The generator or o and associated equatoric within 10 societarion is not met process shall be processed in transfer switches a with NFPA 110. Generator sets are under load 30 minuted load 30 minuted load conditions simulated cold start transfer of all EES competent persons stored energy power accordance with Noriccuit breakers are program for period components is est manufacturer required maintenance and freedily available. In circuits are marked Minimizing the pose emergency power consideration for model. 4.4, 6.5.4, 6.6.4 111, 700.10 (NFPA FINDINGS INCLU)	et 72 of 72 residents. - Essential Electric System Festing Ther alternate power source uipment is capable of supplying econds. If the 10-second during the monthly test, a rovided to annually confirm this e safety and critical branches. esting of the generator and are performed in accordance e inspected weekly, exercised attes 12 times a year in 20-40 exercised once every 36 huous hours. Scheduled test and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder e inspected annually, and a lically exercising the ablished according to irements. Written records of testing are maintained and EES electrical panels and d and readily identifiable. esibility of damage of the source is a design lew installations. (NFPA 99), NFPA 110, NFPA A 70) DE:	77	918			
	On facility tour bet	ween 10:00 AM and 1:00 PM					

STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING AND RENOVATED EXISTING BLD		(X3) DATE SURVEY COMPLETED		
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K 918	that not all the required documented during Generator Load Te	cumentation reviewed revealed uired information is being the Month Emergency st. The transfer time of how nergency generator to assume	K	918			
	This deficient pract Maintenance Direc	tice was verified by the Facility stor.					
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Current Status: Active PolicyStat ID: 3236464



 Effective:
 05/2006

 Approved:
 02/2017

 Last Revised:
 02/2017

 Expiration:
 02/2018

Owner: Kevin Schroeder: Environmental

Services Director

Policy Area: Emergency Preparedness

Applicability: Avera Marshall Regional Hospital

Fire Response and Evacuation Plan for Morningside Heights Care Center

POLICY:

Emergency response to fire and evacuation requires careful planning and execution to provide for the utmost safety and security of the residents and staff in the event of fire or other disaster.

PURPOSE:

To provide for a systematic means of evacuation egress that compliments the organization's Fire Emergency/ Code Red Response Policy.

PROCEDURE:

a. In the event of fire, the Fire Emergency (Former Code Red) Response Plan will be enacted and followed. Specifically, the LTC will respond as follows:

When a **smoke detector** is activated in a resident room the following should take place:

- i. The detector sends a call to the nurse call system, it is placed to all staff audio stations (stations at the nurse stations in corridor, shower rooms, utility rooms) because it is a emergency call.
- ii. A staff member must go to the room that is in alarm and verify whether or not it is a real fire.
- iii. In the event of a real fire, the staff member should perform R.A.C.E. procedures, rescue the resident by removing them from the room (RESCUE) and then close the door when exiting (CONTAIN) and communicate with staff/facility "FIRE ALARM ALERT". At this time team work is essential. All staff will start helping with clearing residents from affected smoke compartment. Clear all corridors of any equipment (i.e. medicine carts, shower chairs, etc.) into vacated resident rooms/utility rooms or lounges
- iv. A staff member should pull the pull station (ALERT) when "FIRE ALARM ALERT" is being communicated.
- v. Transmission of fire alarm is through a phone line to Marshall Municipal Utilities (MMU) dispatch then transmits to the Marshall Fire Department.
- vi. A staff member should call 911 to confirm fire call has been received and the fire department is in route.

- vii. A staff member must then move the resident to a safe smoke compartment. A smoke compartment is created on each side of the fire (double) doors in the corridors; so the resident must be moved to the other side of a fire (double) door in the corridor away from the fire.
- viii. Extinguish the fire if possible (EXTINGUISH). If this is not possible, keep the door closed and let sprinkler system do its job and wait for fire department.
- ix. Make sure all other residents in that smoke compartment are evacuated (EVACUATE) to a safe smoke compartment as follows:
 - 1. The facility will be evacuated as follows:
 - a. Evacuation placards are placed in several places throughout the facility.
 - b. The placards identify the location the individual is in and the closest defined smoke compartment barrier.
 - c. The resident is transported to a safe smoke compartment nearest to the current location and away from the fire.
 - d. On first floor, there are 3 designated smoke compartments these are identified as the yellow fire evacuation zone, the green fire evacuation zone, and the blue fire evacuation zone.
 - e. On ground floor, there are four designated smoke compartments, the yellow fire evacuation zone, the green fire evacuation zone, the red fire evacuation zone, and the blue fire evacuation zone.
- b. In addition to the above response, the incident command system will be enacted to lead the evacuation plan if appropriate.
 - i. The incident commander or designated leader will create an immediate labor pool of all available staff in the long term care facility AND request assistance from all other departments of Avera Marshall. The labor pool will be set up in an area away from the area requiring evacuation. Examples include Adult Day Care, Long Term Care Dining Room, Human Resources, Cafeteria, etc.
- c. The mechanism for evacuation will be determined immediately typically the horizontal (to another wing or section of same floor)/vertical (up or down) evacuation of residents from the area of fire to another designated and defined smoke compartment is best.
- d. Evacuation should occur in phases as stated below:
 - i. Phase one bring the resident/residents to the closest safe smoke compartment.
 - ii. Phase two brings the resident/residents to the exterior of the building or other designated holding areas.
 - iii. In conjunction with these two phases separate staff should be assigned to each phase to hasten the evacuation process.
- e. Additional staff should be assigned to locate and secure equipment needed by each resident as they are evacuated. This includes oxygen, wheelchairs, gurneys, etc.
- f. Oxygen System:
 - The main oxygen shutoff valve for Avera Marshall Regional Medical is located outdoors at the oxygen supply tank (near HR entrance), and also in the oxygen storage room by the loading dock receiving area.

- 2. It is the responsibility of the Chief Executive Officer to order this valve to be shut off if he/she deems it necessary. In the absence of the Chief Executive Officer, his/her designee or the Director of Environmental Services will assume this responsibility.
- 3. All other oxygen shutoffs will be the responsibility of the unit in which they are located. This is done based on the knowledge of the oxygen utilization, availability of portable oxygen supply and the location of the fire.
- 4. The decision to shut off the oxygen will be made by the Director of Environmental Services or his/her designee in conjunction with the fire department, Incident Commander, and the Director of Respiratory Therapy.

DO NOT SHUT OFF OXYGEN VALVES WITHOUT BEING TOLD TO DO SO!!!

WHEN FIRE ALARM SOUNDS:

A. FOR ALL EMPLOYEES:

1.

Fire in immediate area! (Each action, each person-vital!) R=Rescue: Immediate action may be needed to save a life-and CLOSE THAT DOOR, yet do not delay the alarm A=Alarm: Alert help and pull fire alarm C=Confine: Close doors and windows, shut off fans to prevent smoke spread and cut off air supply to the fire
do not delay the alarm A=Alarm: Alert help and pull fire alarm C=Confine: Close doors and windows, shut off fans to prevent smoke spread and cut off
C=Confine: Close doors and windows, shut off fans to prevent smoke spread and cut off
E=Evacuate: The LTC is protected by automatic fire sprinklers, so fight the fire only if:
The fire has already been reported
 It is small, contained and in its beginning state. Remember P.A.S.S: Pull, Aim,
 Squeeze, and Sweep to use the fire extinguisher
 The exit is clear and you can fight the fire with your back to the exit
 Never go back with another extinguisher
P=Pull Pull the pin between the handles
A=Aim Aim at the base of the fire
S=Squeeze Squeeze the handles together
S=Sweep Sweep side to side to evenly coat entire area of the fire

- 2. Turn on all lights in corridors.
- 3. Clear hallways of any equipment.
- 4. Know extinguisher locations in your area.
- 5. Keep all stairways clear and exits unlocked.
- 6. DO NOT USE ELEVATORS.
 - a. LTC First Floor Charge Nurse: Lock open to First Floor Nursing Home.

- b. Maintenance Personnel: Lock open to Ground Floor Old Hospital.
- 7. Request visitors to remain where they are.
- 8. If an actual fire should occur in your department, the department staff should go to an alternate meeting place.
- 9. Await further instructions.
- 10. ONLY Environmental Services/Maintenance Dept. will "reset" the fire alarm panel. The department staff may ONLY silence an alarm IF AND ONLY IF, they have proven to the best of their ability and knowledge that no fire does exist.

NOTE: Multiple steps can be performed at he same time by assisting staff.

B. FOR ALL DIRECT PATIENT CARE PROVIDERS:

(Long Term Care and Adult Day Care)

- 1. After implementation of the above 1-9 "FOR ALL EMPLOYEES"
- 2. Develop evacuation plan for patient case load to include extra help that may be needed to implement plan. The plan must include:
 - a. an accurate list of patients,
 - b. room numbers,
 - c. and how to transfer.
 - d. plan for patients requiring respiratory support.
- 3. Identify rooms with oxygen and suction or electrical appliances and be prepared to disconnect if ordered by the fire department or Environmental Services.

RELATED P&P(S):

Fire Emergency/Code Red Response Policy, Fire alarm Checklist

This policy was developed as a guide for the delivery of health services and is not intended to define the standard of care. This policy should be used as a guide for the delivery of service, although hospital personnel may deviate from this guide to provide appropriate individualized care and treatment for each patient.

Attachments: No Attachments

Approval Signatures

Approver	Date
Sharon Williams: VP of Finance and Info Technology	02/2017
Kevin Schroeder: Environmental Services Director	02/2017
Dave Skorczewski: Manager	01/2017



Current Status: Active PolicyStat ID: 3299138



 Effective:
 02/2017

 Approved:
 02/2017

 Last Revised:
 02/2017

 Expiration:
 02/2018

Owner: Dave Skorczewski: Manager
Policy Area: Environmental Services

(Maintenance, Hskg, Laundry)

Applicability: Avera Marshall Regional Hospital

Portable Space Heaters

POLICY

Portable Space Heaters

PURPOSE

To control where space heaters are and are not allowed, what features the space heater must have in locations where allowed, and protocol to follow before a space heater is used.

SCOPE

Avera Marshall

PROCEDURE

- 1. Portable Space Heaters are not allowed in patient care areas or patient/resident sleeping rooms.
- 2. Portable Space Heaters shall be allowed in non patient care areas provided:
 - a. They are UL Listed
 - b. They have an automatic shut off if tipped over
 - c. They have high limit control that does not exceed 212 degrees
- 3. All Portable Space Heaters shall be checked by Maintenance before use.
 - a. Maintenance will mark Space Heaters to confirm they were inspected

REFERENCE(S)

RELATED P&P(S)

COLLABORATOR(S)

This policy was developed as a guide for the delivery of health services and is not intended to define the standard of care. This policy should be used as a guide for the delivery of service, although hospital personnel may deviate from this guide to provide appropriate individualized care and treatment for each patient.

Attachments:

No Attachments





Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted February 13, 2017

Ms. Doris Derynck, Administrator Avera Morningside Heights Care Center 300 South Bruce Street Marshall, MN 56258

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5228027

Dear Ms. Derynck:

The above facility was surveyed on January 23, 2017 through January 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Avera Morningside Heights Care Center February 13, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

01/27/2017

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

B. WING _

00343

		00343				01/2	27/2017
	PROVIDER OR SUPPLIER	IS CARE CENTE	300 SOUT	TH BRUCE S			
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2 000	Initial Comments ****ATTEN	TION*****		2 000			
	In accordance with M 144A.10, this correct pursuant to a survey found that the deficie herein are not correct not corrected shall be with a schedule of fit the Minnesota Depar	tion order has beer f. If, upon reinspect ency or deficiencies cted, a fine for each e assessed in accones promulgated by	section issued tion, it is cited iviolation ordance				
	Determination of wh corrected requires or requirements of the number and MN Rul When a rule contain comply with any of the lack of compliance. re-inspection with ar result in the assessment that was violated durcorrected.	ompliance with all rule provided at the e number indicated s several items, faine items will be cor Lack of compliancy item of multi-partnent of a fine even	e tag d below. lure to nsidered e upon t rule will if the item				
	You may request a hat may result from orders provided that the Department with notice of assessmen	non-compliance w a written request is in 15 days of receip	ith these s made to ot of a				
	INITIAL COMMENTS You have agreed to receipt of State licenthe Minnesota Depa Informational Bulletin http://www.health.sfobul.htm The Stadelineated on the att	participate in the el sure orders consis rtment of Health n 14-01, available a tate.mn.us/divs/fpo te licensing orders	tent with at: :/profinfo/in				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/20/17

STATE FORM 6899 If continuation sheet 1 of 48 531Z11

TITLE

(X6) DATE

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00343	B. WING		01/	27/2017	
	ROVIDER OR SUPPLIER ORNINGSIDE HEIGH	ITS CARE CENTE 300 SOU	DDRESS, CITY, S TH BRUCE S ALL, MN 5625				
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	you electronically. Is necessary for State enter the word "correct. You must then State licensure proceedings of the corrected prior to elected prior to electe	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Ith, 2016, surveyors of this visited the above provider and the electronic plan of the have reviewed these orders, e when they will be completed then of Health is documenting. Correction Orders using an umbers have been total state statutes/rules for the ent of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis column als					

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		00343	B. WING		01/2	7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S L, MN 5629			
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2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 255	MN Rule 4658.0070 Assurance Commit	O Quality Assessment and tee	2 255			3/31/17
	assessment and as of the administrator services, the medic designated by the rithree other membe representing disciplinesident care. The assurance committ respect to which quinecessary and development appropriate plans of quality deficiencies, address, at a minim	est maintain a quality esurance committee consisting it, the director of nursing all director or other physician medical director, and at least it is of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with lality assurance activities are elop and implement if action to correct identified. The committee must num, incident and accident control, and medications and				
	by: Based on interview facility failed to ens and assurance (QA evaluated and deve concerns with rega (a telemedicine ser and face to face vis emergent acute cha	and document review, the ure the quality assessment A)committee identified, eloped a plan to address rd to protocols for use of eLTC vice available in the facility) sits being conducted for anges in condition. This ad the potential to affect all 72 ility.		Corrected		

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
0(0.15	CLIMMA DV CTA		LL, MN 5625		ON!	()/5)
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2 255	Continued From pa	ge 3	2 255			
	and document revietimely medical treat residents (R66, R11 transferred from the room department with condition. This resulting in discomfairisk of aspiration properties as well as actual has history of cardiac didelayed treatment for A graph entitled eC Morningside Height 5/2016 through 12/2 six month period of encounters, with a six resident six month period of encounters, with a six resident six month period of encounters, with a six resident six medical treatment for the six month period of encounters, with a six resident six medical treatment for the six month period of encounters, with a six resident six medical treatment for the six month period of encounters, with a six resident six medical treatment for the s	sed on observation, interview ew, the facility failed to ensure ment was provided to 2 of 12 (6) reviewed who were a facility to the emergency with acute changes in their lited in immediate jeopardy for ced actual harm due to or an esophageal obstruction fort, esophageal irritation and neumonia/airway compromise arm for R116, who had a sease and experienced or severe chest pain. ARE Senior Care - Avera is Care Center for the dates of 2016 showed a total for this 37 urgent care video large percentage of telephone are occurring between the and 3:00 p.m.				
	medical director (M center, stated the g for residents to see providers were ava	1/25/17, at 11:55 a.m. the D)-A for Morningside Care oal of the eLTC program was a provider timely. eLTC ilable via telephone, or				
	intravenous lines at facility had a grant a service to support in	order labs, tests, medications, and x-rays. MD-A explained the and were trying to utilize the mmediate access to the led the service was not				
	appropriate if there or the resident had obstruction, breathi MDS explained the	was an acute change in care, an emergency; with airway ng difficulty or cardiac arrest. re were protocols, pathways s for the nurse to follow, and				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 255	non-emergent." Wexample of a patier attack such as cheescalating within the given Maalox for in nausea, one dose or responded that he there, "If the person to the emergency rappropriate to send further stated the dand he "believed" the CMS, but was not confirmed he was obeen administered. In addition, MD-A of the facility three dameetings. MD-A st system had not been eetings and wishen the could be aware providers were stare. During interview on administrator (who primary QA commit emergent situations directly to the ER passessment, howevexperienced emergadministrator stated reviewed upon initiate been training in 8/2 program requiremental to whether the additional propriately for not buring interview on the could be available.	hen presented with an at exhibiting signs of a heart st pain rated at 8 out of 10, e hour to 10/10, who was digestion, and Zofran for of Tylenol for pain, he would get the quickest person a indicated they wanted to go doom (ER), then it would be at them to the ER". MD-A doctor must do a face to face the requirement was from certain. In this situation he disappointed that R116 had not a stronger medication for pain. Onfirmed he was present in ys/week and attended the QAA atted improper use of the eLTC on reviewed at the QAA atted improper use of the eLTC on the thing on his residents. In 1/25/2017, at 3:21 p.m. the was identified as the facility's the contact) stated for the election of the el	2 255			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o. I `	-	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00343	В	3. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	TIC CARE CENTE		BRUCE ST ., MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	quality improvemer survey citations, be antipsychotic media recommendations a Physician services within the last year, monitoring being us be emergent vs. not facility had implemereduce acute care the emergency roopresent during this not feel anything haregard to R66 and obstruction on 6/17 been taken to the edirected by her prinhad not been addrestather MD-A had do administrator further breathing there wor analysis done. The facility policy endicated the progracomprehensive, and transitions, aiming while emphasizing life for residents. The facility policy endicated the progracomprehensive, and transitions aiming while emphasizing life for residents. The facility policy endicated the progracomprehensive and Scope or Servithe LTC (long-terminations).	ant ideas included previous chavioral management issuration reduction and incident reports. That been a topic of discussion for conditions that mister the electron and incident reports with estated for conditions that mister the electron and repeat trips and repeat trips and repeat trips and stated she ad been done wrong with the incident of a food bolic for a	s sues, ussion eLTC ght e nod to to s also e did us not ED) as en eee, eeen	2 255			

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00343	B. WING		01/2	7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	HIS CARE CENTE	TH BRUCE S LL, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	action to correct the Quality Committee Committee of the E Feedback, Data Sy indicated the commonitor care and so variety of sources. staff, patients, family performance indicate events and other so SUGGESTED MET	evelop and implement plans of ese deficiencies. The LTC will report to the Quality Board. A section entitled estems and Monitoring nittee will develop systems to ervices, obtaining data for a Data will be obtained from lies and others as appropriate, stors, survey findings, adverse ources as appropriate.	2 255			
	related to quality as improvement with remergent care epis nursing care and ed. The administrator compliance periodicommittee for furth practice and ongoin	evise polices and procedures surance and performance relation to monitoring of sodes for appropriateness of ducate staff on these changes. Or designee could audit facility cally and report to the QAPI er recommendations for facilitying monitoring. R CORRECTION: Twenty-one				
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the t.	2 565			3/31/17
	by:	ent is not met as evidenced ion, interview, and document		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	review the facility fa for grooming service residents (R54) rev living (ADL's), and applied to prevent for contractures for 1 of for range of motion Findings include: On 1/23/17, at 4:22 seated in recliner in unshaven facial neron the right side of approximated 1/4-1 hair continued to be from 1/23/17 throughout the care plan revision personal care active noted: It is very imputed in the right of the line in the recliner in the recliner in the care plan revision and care active noted: It is very imputed in the right of the line in the recliner in the	ailed to follow the plan of care ses related to shaving for 1 of 3 siewed for activities of daily failed to ensure a splint was surther development of of 1 resident (R45) reviewed. It p.m. R54 was observed a her room. R54 had long ar her chin along the jawline her face. The hairs were /2 inch in length. The facial expresent all days of the survey gh 1/27/17. In the face of daily living (ADL) goal as portant to my mental health is ed/groomed daily. The face of the face of the form of the face	2 565			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00343	B. WING	·····	01/2	7/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 8	2 565				
	confirmed R54 had mainly on the right swas aware of the far approximately 6 mot to be shaved; howe stated R54 did not a desired to have one purchase a shaver. preferred to look nice necklace daily) and Monday after her baroom with the surve whether she preferremoved if a shave R54 responded, "Y and down. After lea approached adminifront desk to inform personal shaver. Wresponsible for acquired to have the past the facility available for resider always thoroughly confection if not thorowere required to pushavers. CM-B alse extra shavers availatime. CM-B verified	on 1/27/17, at 11:02 a.m. NA-A long unshaven facial hair side of face, explaining she icial hair and questioned R54 onths ago whether she desired over, R54 declined. NA-A also a personal shaver and if she is, the family would need to NA-A verified that R54 ce (requested to wear a had a hair appointment every ath. Upon entering R54's eyor present, NA-A asked R54 red to have her facial hair are was purchased for her use. If you have her facial hair and the interest and nodded her head up aving the room, NA-A strative assistant (AA)-A at the AA-A of R54's need for a When questioned who was uiring the shaver, AA-A stated have to purchase unless to use funds from R54's pount for staff to purchase a con 1/27/17, at 11:27 a.m. M)-B verified residents were ser own razor. CM-B stated in had community shavers at use but they were not cleaned. Due to the risk of bughly cleaned, residents rchase their own personal to confirmed there were no able for resident use at this is the facility was responsible to any needs per the plan of care.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00343	B. WING		01/	27/2017
	PROVIDER OR SUPPLIER	HTS CARE CENTE 300 SOU	DRESS, CITY, S TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE D DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	When interviewed of confirmed the beau available for reside a personal shaver at R45's care plan, last R45 wore a hand shours per day and a hand. The care platherapy directions in splints/braces. R45 stated: right hand thours per dayon Review of R45's que (MDS) assessment as comatose with a injury (TBI). It furth impairment on both with functional limit. On 1/24/17, at 9:32 in bed with a carrot splint was on right the assistant (NA)-B state splint to his left hand any other splint development on and on R45 earlier, indimorning cares by the During interview on the splint of the splint on and on R45 earlier, indimorning cares by the splint or splint development of the splint on and on R45 earlier, indimorning cares by the splint or splint development of the splint on and on R45 earlier, indimorning cares by the splint or splint development of the splint or spl	on 1/27/17, at 11:50 a.m. AA-A aty shop did have a shaver int use when they did not have available. St revised 1/16/17, identified plint in right hand/arm 6-8 a carrot splint at all times in left in further directed staff to see in R45's room for 5's current undated splint order forearm splint/brace on for 6-8 6:00 a.m. off at 2:00 p.m. Starterly Minimum Data Set addaed 1/11/17, identified R45 a diagnosis of traumatic brain her identified R45 as having a sides of upper extremities ation in range of motion. Start. R45 was observed lying splint in place to left hand. No hand at this time. Nursing ated R45 only wore a carrot and, and did not wear or utilized vices for right hand. Start. Dicensed practical nursed ved to apply a splint to R45's stated R45 was suppose to NA-B must have forgot to put it cating it was to be applied with the NA.		DEFICIENCY)		
	R45 wearing a carr	ed they were only aware of ot splint to left hand and not devices or splints for right				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
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		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	ORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 10	2 565			
	completed to both a NA-D with carrot sphowever, no splint whand following the On 1/27/17, at 8:07 dressed and groom 9:21 a.m. NA-G verplace on left hand, worn by resident. A indicated R45 did not applied as ordered not been posted in plan of care. During interview on director of nursing expected staff to fo verified R45 was to	a.m. R45 was laying in bed ned, no splint to right hand. At rified R45 had carrot splint in and stated no other splint is At 9:27 a.m. NA-F also not wear a right hand splint. 1/27/17, at 10:22 a.m. LPN-C thave a right hand splint and that splint instructions had the room as directed on the 1/27/17, at 10:23 a.m. the (DON) confirmed she ollow the plan of care and have a right hand splint on				
	The administrator or resident cares for or Findings of the aud	THOD OF CORRECTION: or designee could audit compliance with the care plan. lits could be reported to the rongoing compliance her policy change				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			3/31/17

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	L L, MN 562 5	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition.			Corrected		
	Findings include:					
	orders signed 4/25/ stricture, chronic of (COPD), asthma, d	entified on the physician (16, included: esophageal estructive pulmonary disease ysphonia, dysphagia, eflux disease (GERD) and				
	assessment dated Interview for Menta indicating moderate MDS also indicated	num Data Set (MDS) 8/23/16, identified a Brief I Status (BIMS) score of 9, ely impaired cognition. The I that R66 fed herself a swallowing disorder, a				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		00343	B. WING		01/2	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOUT	DRESS, CITY, S FH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	mechanically altere or choking during medications. Review of a Care A 8/23/16, related to rhad swallowing product or altered cons R66 had experience transfer to the Eme R66's care plan Up "Self-Feeding: I am setup." R66's care pauthored by registe "Diet: NDD3 with grathso included "My dysphagia diet and had an instance of in the dining room. esophagus in the pabefore. It is safer to ground up to not eathave small portions snacks between mewatch for symptoms esophageal stricture mealtimes, more dinotify my Dr. and Spathologist (SLP) sepathologist (SLP) sepathologist (SLP) sepathologist (SLP) decurrently receiving sepathologist (SLP) decurrently receivi	d diet, and exhibited coughing heals or when swallowing rea Assessment (CAA) dated nutritional status, revealed R66 blems and required a special istency. The CAA indicated ed a choking episode requiring regency room (ER). dated: 8/18/15 included, able to feed myself with staff blan last revised on 1/8/17 and red nurse (RN)-F, identified ound meat and thin liquids" liet was changed to a my meat is ground because I choking on a piece of chicken I have had problems with my last and have had it dilated real chunky foods. I prefer to at meals & like to be offered eals Staff and nurses should increasing related to my le such as coughing at estimated to my le such as coughing at estimated on the speech language order." Cord, speech language ervices had been initiated on the speech language ocumented, "the resident is speech therapy to strengthen the a report from staff of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00343	B. WING		01/0	7/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	01/2	7/2017	
		300 SOUT	'H BRUCE S	•			
AVERA I	MORNINGSIDE HEIGH	HTS CARE CENTE MARSHA	LL, MN 5625	58			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 13	2 830				
	room. At that time, was working on voi	ch therapy session in her the SLP acknowledged R66 ce strengthening. R66 was vely participating in the					
	p.m., having had wa with assistance, an	with R66 on 1/26/17 at 12:10 alked out to the dining room d stated it felt good to walk. In d she was having no pain or me.					
		7 p.m., R66 was observed to ire meal and when finishing ghed twice.					
	A preoperative history and physical document, authored by MD (medical doctor)-B, dated 6/17/16 at 3:30 p.m. included the following information in regards to R66 choking on a piece of chicken and needing urgent medical treatment:						
	has a previously kn last EGD, (Esophage procedure during we endoscope is introcadvanced through the stomach, and/or durin April of last year	ESENT ILLNESS: The patient own peptic acid stricture. Her gogastroduodenoscopy, a which a small flexible duced through the mouth and the pharynx, esophagus, todenum), and dilatation was (2015) and she has been well since then. Today at lunch					
	and it apparently go nursing home tried water, tried to coug regurgitate the piec did not work. They them to send the pa For reasons that I s	te of her chicken sandwich of stuck. The staff at the to get her to take sips of h, they even tried to get her to ses of chicken up but that all contacted me and I asked atient to the emergency room. Still do not quite understand the er to the emergency room as I					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	PLE CONSTRUCTION (X3) DATE SURVICES: (X0) DATE SURVICES (X1) DATE SURVICES (X3) DA		
		00343	B. WING		01/2	7/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOU	DDRESS, CITY, S TH BRUCE S ALL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	requested, as they face-to-face visit fir that this is a medica should go to the endid call [MD-C] and ER to come. I was they were still waitin nursing home. I the herewith her son still has some chick able to speak but s swallow and has be emesis bag off and She does not have that "my chest feels HISTORY: She has as dilatationsIMP of chicken following EGD to remove the likely we will probat at a later date in the 1-2 weeks. This is The Esophagogast Report dated 6/17/Dysphagia in respoimpactionThe gas great difficulty throw visualization and acof the duodenum. T	ge 14 stated "she needed to have a st". I explained to the nurse al emergency and that she nergency room directly and I he was waiting for her in the just notified shortly ago that no for me to come to the n brought the patient over, [FM-1] present. The patient sen stuck in her throat. She is the has not been able to sen regurgitating into any on her spit and secretions. any pain except she states a full" PAST SURGICAL had multiple EGDs, as well RESSION: 1. Acute impaction I lunch todayPLAN: Urgent foreign body. More than oly have to stretch or dilate here near future, probably within an emergent EGD." roduodenoscopy Procedure 16, included: "Indications: nse to solids, causing acute stroscope was passed with ligh the mouth under direct divanced to the second portion he scope was withdrawn and refully examinedFindings:				
	the middle third of t centimeters (cm) fr was removed with a Stenosis was found obstruction in the m 34 cm from the ent traversed (laying ac	e quantity of food was found in he the esophagus, 30 om the entry site. The food a basket, with success. I to be causing a moderate hiddle third of the esophagus, ry site. The obstruction was cross). Moderately less of skin secondary to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOUT	DRESS, CITY, S TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	injury, infection) methird of the esophage Journal of Gastroer independent Peer-F Gastroenterol Hpate includes the followin The typical presents a food bolus impactions are acut part, are immediate Most food bolus impintervention, either stomach or by the pingested contents. No obstruction persist a substantial chest dimedical attention. F sensation of squeer frightening as it is dheart attack pain. His additionally assoc excessive salivation esophageal obstruct to eat or drink anythan impaction. It is important to diffichoking. Patients we not have any interrutalk and they can cois truly choking is unthings. Some of the classic impaction are "the the "backyard bark surprisingly, impaction.	ucosa was found in the middle gus" Interology & Hepatology, The Reviewed Journal, of (NY) 2007 Feb; 3(2): 85-86 and definition: Pation of a patient experiencing tion includes a food bolus the events that, for the most ally recognized by the patient. Opactions resolve without by moving forward to the patient regurgitating the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	7/2017
NAME OF PRO\	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVERA MOR	NINGSIDE HEIGH	IIS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
do con der to de food de food der to de food der to de food de f	nditions could be ntures, the use of eat too quickly. To do are beef, chick nte-cooked vege eview of the nursi. List Resdent (sice 26/16 revealed the 16/17/16 as having) but recorded thored by registe corted to RN that lunch time and his mealtime and bits nurse found resident complained domen area. No eathing. Observe itting up of clear as isident to cough a slodge food stuck coess. Contacted ither advice. Spolen documented we commended having the result of the end of	pood sufficiently. Contributing poor dentation, illfitting f alcohol, or a predisposition the most commonly impacted cken, pork, and al				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00343	B. WING		01/	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOU	DDRESS, CITY, S TH BRUCE S' LLL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	see resident and ta (3:20 p.m.)." An acd documented by RN related to 6/17/16 in nursing home around family. New orders on call doctor if term Will monitor for sign Vitals normal range wanted to try a little vegetables for support of an occurrence of p.m.) included: "Rethroat from having atthroat and brought swallowed water we without trouble. To (164, BP (blood pression saturation) 94%, Resident continues eat regular meals the weekend with no ditthroughout weekend Lungs clear all field signs of aspiration." 6/28/16 at 10:07 a.i (LPN)-D document from same day sure dilatation by her sorb breakfast at this tim 174/77. Denies any feel like I have to be MD-B was interview.	ke her to ED at around 1520 Idendum had also been -A at 12:44 p.m. on 6/19/16 Incident, "Resident returned to Ind 1800 (6:00 p.m.) with for diet change and to contact operature increases to 101. Insight of aspiration per orders. In Resident comfortable and mashed potatoes and soft over." RN-C on 6/18/16 at 7:44 a.m., from 6/17/16 at 2200 (10:00 Isident says she has slight sore a piece of food caught in her to ER to have it removed. She call gave medication whole emperature) 98.6, P (pulse) sure) 110/63, O2 sat (oxygen (respirations) 20." In RN-A documented, is to be free of pain and able to be free of pain and able to proughout the rest of the efficulty. Vitals normal range difficulty. Vitals normal range difficulty normal range difficulty normal range difficulty normal range difficult				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		300 SOUT	H BRUCE S	TREET		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	LL, MN 5625			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	age 18	2 830	/		
	boosmo ladgad in k	ner esophagus 6/17/16 during				
		-B said he was the medical				
		day and was working at the				
		8 blocks from the nursing				
		hat RN-A had called him form				
		o report that R66 had choked				
		d not been able to swallow				
		MD-B stated he had given				
		end R66 to the ER. MD-B				
	•	eeded to call the on call doctor				
		cal circulating nurse, and eady when R66 came to the				
		rsing home had been advised				
		iately to the ER. MD-B went on				
		needed an emergency				
		in regards to the chicken stuck				
		MD-B stated when he had				
	finished with the cli	nic patient he was seeing, he				
		one to the hospital's ER to				
		s of R66. MD-B said when he				
		was not in the ER or surgical				
		vestigation, he said he'd been				
		till over at the nursing home.				
		en had a phone call from RN-B MD-B was informed by RN-A				
		first seen for a "face to face"				
		telemedicine to assess her				
		le should be seen in the				
		MD-B stated when he heard				
		y went to the nursing home				
		ER) and found R66 holding an				
		n her room. MD-B stated he				
	had spoken to RN-	B and informed her R66				
		seen in the ER" and that he				
		nedicine!" MD-B said RN-B				
		makes this a medical				
		3 said he had responded to				
		saying, "When you are				
		nd not able to swallow, you are at risk." MD-B then said that				
	pulling your airway	at hok. IVID-D then salu that				i l

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00343	B. WING		01/2	27/2017
AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOUT			DRESS, CITY, S TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	this type of medical patient comfort, pro there was an increa pneumonia. MD-B is nursing home had requiring a "face before a resident casaid that must be a MD-B said that after staff about not havi immediately he had ER himself. He stavisiting R66 at the ten ER. MD-B stated a immediate assessing surgical intervention chicken meat in the MD-B further stated of nursing (DON) be involving R66 not be ER as he had order looked into by the fabeen informed by the trying to prevent un MD-B explained fur the DON was that to on call medical system to call the telement me!" MD-B said the makes this a medical had explained what emergency, and whe mergency based of told the DON, "This MD-B further stated with the DON, he had explained what emergency and whe mergency and whe mergency based of told the DON, "This MD-B further stated with the DON, he had explained what emergency and whe mergency and whe mergency and whe mergency based of the DON, he had explained what emergency and whe mergency based of the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON, he had explained what emergency and when the DON and the D	ge 19 demergency also includes stection for the airway, and that ased risk for aspiration said he was in "Awe" that the not immediately sent R66 to ce with his orders. In regards to face" and or telemedicine an be seen in the ER, MD-B policy of the nursing home are talking to the nursing home are talking to the nursing home in the telefold for	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	27/2017
AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOUT			DRESS, CITY, S TH BRUCE S' LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	resident's care. How been no follow-up remergency medica without an immedia remove the food ob aspiration increased unnecessary discorthe food removed. I did not prevail in this are very uncomforted delay in treatment." impression that the face" or eLTC did not he ER, but rather to policy. Family member (FM 1/25/17 at 4:36 p.m. emergency on 6/17 come to visit his more and that she "was refm-1 said, "I remer handled very good. assistant (NA) was he'd arrived. He say encouraging his more food stuck in her thagain stated, "She stated staff called the Care-Long Term is service) and had his something soft, and maneuver. FM-1 said doctor had said the (several hours away chicken would reso hearing that, he'd reso hearing that the that th	wever, MD-B said there had eceived concerning R66's I concern. MD-B again said te intervention for R66 to estruction, the risk for d, and R66 experienced infort by having to wait to have MD-B stated, "Common sense is situation, these impactions able and there was definitely a MD-B then stated it was his directive to have a "face to ot come from the hospital or that it was the nursing home's M)-1 was interviewed on, in regards to R66's medical /16. FM-1 stated that he had other after lunch on 6/17/16, iniserable" and not feeling well. In the room with R66 when in the room with R66				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00343		B. WING		01/2	7/2017		
NAME OF	PROVIDER OR SUPPLIER	STREE	Γ ADDRESS, CITY,	STATE, ZIP CODE			
AVERA I	MORNINGSIDE HEIGH	HTS CARE CENTE	OUTH BRUCE S HALL, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 21	2 830				
	said that he would emergency room (I be prepared for his surgical interventio confirmed staff had the ER immediately "we were on our wa when [RN-A] got a was off and then sa nursing home." FM back to his mother he would work on it was another 2 hour miserable until MD her to the ER arour MD-B came in and "he was not very had upset then I was." I upsetting to watch was mom and I. Titimes and the nurse one seemed to do discomfort then add the whole thing him handled." FM-1 als ER, MD-B had his the piece of chicke time they'd waited thad been miserable bags with secretion he did not blame R something else in the FM-1 further stated had problems, espendid that her esoph then once before. Fa very narrow pass required. When FM followed up with him followed up with him the state of	immediately notify the ER) and surgery so they would mother who might require in to remove the food. FM-1 dispensed been told to bring R66 over by by MD-B. FM-1 then stated ay over to the emergency roughone call that the transfer aid we had to return to the last and get it worked out, but it it and get it worked out, but it it is of watching my mother be able to a mother suffer stating, "it he NA came into the room to appy, I think he was more FM-1 added that it had been his mother suffer stating, "it he NA came into the room to anything to relieve her ded, "[MD-B] ended up doing the self, and he got the situation so stated once she got to the mother go into surgery to ha in removed, and that the entito be seen in the ER, his more and had filled three [emesing she'd spit up. FM-1 stated in the self was she'd spit up. FM-1 stated in the self was asked if anyone matter this episode, FM-1 in was asked if anyone mafter this episode, FM-1 in head' person had called	ald tool, om nat took m vo o o o o o o o o o o o o o o o o o				

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AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOUTH BRUCE STREET MARSHALL, MN 56258 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			00343	B. WING		01/2	7/2017
AVERA MORNINGSIDE HEIGHTS CARE CENTE MARSHALL, MN 56258 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTAGE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	ΔVFRΔΙ	MORNINGSIDE HEIGH	ITS CARE CENTE 300 SOU	TH BRUCE S	TREET		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	AVENA	WOTHINGOIDE TIEIGI	MARSHA	LL, MN 5625	58		
DEFICIENCY)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
and apologized for the way the situation had been handled. FM-1 said he had been told by the foundation head that the matter would be looked into and had been assured it would not happen again to his mother or any other resident. When FM-1 was asked if he was knowledgeable about the eLTC service, he stated. "I was not aware of the telemedicine Dr. no one has ever talked to me about that." FM-1 expressed relief that MD-B had intervened and stated, "he [MD-B] was concerned about a potential rupture, or that coughing all of that time would cause more damage." Registered nurse (RN)-A was interviewed on 1/25/17 at 8:17 a.m., in regards to the events that happened on 6/17/16 with R66's choking episode. RN-A was asked about the "face to face" eLTC protocol the nursing home utilizes. RN-A said, "On weekends, basically the policy is if the doctor from Avera is here and if they are not available to see the patient [face to face'in person], the nurse can use eLTC system. If the nurse cannot make contact with the doctor [on call], use of the eLTC is always an option for the nurse." RN-A confirmed eLTC had been contacted regarding R66's choking episode on 6/17/16. He verified eLTC doctor had ordered small sips of water, or soft food to try to dislodge the partial obstruction of meat. RN-A stated, when the interventions did not work, he called MD-B, who gave the order to send R66 to the ER. RN-A stated that MD-B was not able to see the resident to do a "face to face" before the transfer, and confirmed it was the facility's policy that if a provider was from the affiliated community medical center (ACMC) versus Avera the MD was supposed to come over to the runsing home to see the resident first and complete a "face to face" the transfer, and confirmed it was the	2 830	and apologized for handled. FM-1 said foundation head that into and had been a again to his mother FM-1 was asked if the eLTC service, he telemedicine Drime about that." FM had intervened and concerned about a coughing all of that damage." Registered nurse (F1/25/17 at 8:17 a.m happened on 6/17/RN-A was asked at protocol the nursing "On weekends, bas from Avera is here see the patient [faccan use eLTC system contact with the door is always an option confirmed eLTC hare R66's choking epistel ETC doctor had or soft food to try to di of meat. RN-A state not work, he called send R66 to the EF not able to see the before the transfer, facility's policy that affiliated community versus Avera the M to the nursing home.	the way the situation had been he had been told by the at the matter would be looked assured it would not happen or any other resident. When he was knowledgeable about the stated. "I was not aware of the no one has ever talked to 1 expressed relief that MD-B stated, "he [MD-B] was potential rupture, or that time would cause more RN)-A was interviewed on the model of the stated, in regards to the events that the would cause more RN)-A was interviewed on the stated, in regards to the events that the would cause more RN)-A was interviewed on the stated, in regards to the events that the would cause more RN)-A was interviewed on the stated, in regards to the events that the would cause more RN)-A was interviewed on the world the stated that model to the world the events that the world the world the world the world the world the world the events that the world the world the events that the world the world the world that model the world that model the world that model that mod		DELIGITION 1		

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		-,
AVFRA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
		MARSHAI	LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 23 attack, the nurse can use nursing judgement to		2 830			
		lirectly over to the emergency				
	room. After reviewing the documentation of R66's					
	choking event on 6/17/16, RN-A stated that R66 was coughing up some things, but her airway					
	obstruction did not appear to be "emergent."					
	RN-A further stated R66 "was not turning blue or I would have thought her airway was blocked."					
	RN-A confirmed that MD-B had come over to the					
	facility, and added that the MDs were all aware of the policy regarding the use of eLTC system.					
	RN-A further stated the ACMC providers signed a					
	contract/policy and	confirmed that if a family				
		their family member to go to nust contact the resident's MD				
		e" first. RN-A referred to a care				
		y care center unit in a binder,				
		mine if eLTC should be used d if the incident on 6/17/16 had				
	been reviewed with	him by administration, RN-A				
		had been reviewed with him by EM)-A. RN-A continued to say,				
		M-A reminded us to review the				
		place, including the care				
		said that before the facility had come				
	in from Sioux Falls,	South Dakota to talk with the				
	nursing staff about	the use of eLTC.				
	Medical Director (M	ID)-A was interviewed on				
		m., in regards to the events				
		17/16 with R66's choking ed that the goal of the eLTC				
	program was for th	e patient to see a provider				
		roviders are available via				
		era, and will order labs, tests, enous access (IV), x-rays, etc.				
	that can be comple	ted at the nursing home. MD-A				
		acility has a grant, and are service to support immediate				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		300 SOUT	H BRUCE S	TREET		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	LL, MN 5625			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	age 24	2 830			
	access to the MD, and to prevent unnecessary					
		ncy room (ER) to contain costs.				
		say that the eLTC service is				
		en there is an acute change,				
		ent had an emergency due to				
		roke, breathing, and/or cardiac				
		ined that there are protocols or are to use and they are located				
	on all the units in the care center for the nurse to follow. MD-A added that "a lot of the situations are non-emergent." MD-A was asked if he					
		raining of care center staff on				
		and he said he had not. MD-A				
		reports are emailed to him as				
		atients. MD-A was asked				
		vare of R66's medical				
		7/16, and he said he had				
		ion. MD-A stated the event				
		ously between administration at in his opinion, the situation				
		ctly. MD-A confirmed that the				
		ble, however stated the				
	•	ve signs or symptoms of an				
		as evidenced by "can't breathe				
		ated if R66 had been sent to				
	the ER nothing cou	ld have been done however,				
		for an endoscopy was				
		explained that when he				
		MD he would come to the				
		e to face with the patient and				
		scopy. He stated the eLTC				
		given an order to send R66 to				
		pital. MD-A stated when he'd				
		ent regarding this patient, he ethat the eLTC MD had not				
		ace to face" to conduct an				
		the video equipment had not				
		D-A could not explain why R66				
		ated 'face to face' by eLTC per				
		he facility's protocol. MD-A				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	7/2017
	PROVIDER OR SUPPLIER MORNINGSIDE HEIGH	ITS CARE CENTE 300 SOU	DRESS, CITY, S TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	stated there possib response if R66 had In addition, in an erfacility to surveyors from MD-A to the n MD-A had written, "camera so technical consult was made of the review of the response to a request of the review of the response to a request response to a response response to a response response response to a response	ly would have been a different d been seen by the eLTC MD. nail document provided by the dated 6/29/16 at 2:55 p.m., ursing home administrator, E LTC was called but not on ally no F2F (face to face) for R66]." The email was part case MD-A had conducted in				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. [` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
		00242	B. WING		01/0	7/2017
		00343	D. W. KG		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, S	STATE, ZIP CODE		
A\/EDA	MODNINGCIDE LIEIGI	300 CARE CENTE	SOUTH BRUCE S	TREET		
AVERAI	MORNINGSIDE HEIGH	MAI	RSHALL, MN 5625	58		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	COMPLETE DATE
2 830	Continued From pa	ige 26	2 830			
	interviewed on 1/25 stated the intent for residents to get as possible while in the non-emergent situated aware of a facility pate face to face visit of the emergency room to facility had used elected are reviewed periodeducated/oriented to charge nurses. In a eLTC had been conthere was "chicken FM-1 was with R66 stable. NM-A also here is not going to	ations. NM-A stated not be policy that would have required the MD prior to cansport. NM-A stated the TC for a few years, that edically, and that nurses are to eLTC processes by othe addition, NM-A recalled that nacted when R66 felt like stuck in throat." NM-A says and her vital signs had be stated, "if a simple interved work, the telemonitor wormed the food bolus put R	eing uired vents e er at aid een ention uldn't			
	3:21 p.m., regardin R66 on 6/17/16. The situation was "emericated by editional management of the informed him that a completed by eLTC it was an option to than by video. The expectation for RN-when given an order the correct protocol MD-B had refused is an algorithm for the situation for the correct protocol management of the cor	was interviewed on 1/25/1 g the medical incident with the administrator stated if the administrator stated if the administrator stated if the administrator stated if the decision about situation is emergent or determined by the nurse resident. When the surve a face to face had not bee by the administrator confirming the administrator	h he rould om. s yor n ned her e visit een if there DM			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	ER when there was MD-B. When prese aspiration, airway in the ADM stated she and had not seen the During a follow up in at 8:22 a.m., RN-A received a call on the with R66 on 6/17/16 call had been from been directed not to had returned R66 to On 1/26/17 at 9:24 had worked on 6/17 called RN-A to stop hospital. On 1/26/17 at 10:00 and stated eLTC was provider from Average stated that if the resulting provider group, the the staff to use eLT on 1/26/17 at 10:20 conducted with CM on 6/17/16. CM-A awith directions to reconducted cause analys medical director did	s an order from to do so by inted with potential issues of nanagement, and discomfort, had not been in the facility he resident. Interview with RN-A on 1/26/17 stated he remembered having he way over to the hospital S. RN-A stated he thought the the DON, and stated he had take R66 to the ER, so he of her room at the facility. Interview with RN-A on 1/26/17 stated he remembered having he way over to the hospital so. RN-A stated he thought the the DON, and stated he had to take R66 to the ER, so he of her room at the facility. In a.m., the DON confirmed she was not available. RN-B sident used when a resident's a was not available. RN-B sident used one of the other the outside provider ACMC resident used one of the other the outside provider ACMC resident with either doctor did a workup or told C, depending on the situation. In a.m., an interview was resident to the facility. There was discussion ident after it had occurred and the situation and I did not feel there was risk of at discussion and I did not feel	2 830			
	On 1/27/17 at 11:23	Ba.m., the DON and				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		-,
AVFRA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
		MARSHAI	LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 28		2 830			
	given the eLTC orie implemented, and so orientation checklis stated she felt the r R66. The administr had been actively owould have taken Fadministrator and of for eLTC process tr RN-A. However, nowas found in RN-A reviewed. Registered nurse (I 1/27/17 at 12:33 p.I RN-A said he had r change in the protosystem the prior ev	d that RN-A would have been entation at the time it was should have had the basic tin his file. The DON again ight thing had been done for ator then stated that if R66 hoking with distress, RN-A R66 to the ER. Also the director of nursing were asked raining was requested for one was provided and none is personal record when a personal record when a personal record when the ceived training regarding a personal record when the ceived training regarding a personal record when the ceived training regarding a personal record when the serious concern about ent.				
	Agreement (undate sign to be designate physician for each of the medical care of will: [bullet six] Corbefore ordering that an Emergency Depronon-life threatening An Avera Marshall consent form, was authorization of eLT not provided. A policy for manage and a policy for the	ent titled Physician Services ed) for the medical providers to ed as the resident's attending resident included: "Supervising [name for resident] means I mplete a face to face visit to a resident be transferred to eartment or to the hospital (for a, non-emergent situations)." Regional Medical Center requested for R66 for TC use, the consent form was ement of a choking resident, Heimlich maneuver was se survey. A second request				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	7/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOUT	DRESS, CITY, S FH BRUCE S' LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was made by e-ma that the facility did r choking resident, or maneuver.	ge 29 il to the DON, who responded not have a policy specific for a r use of the Heimlich ecord was reviewed. A ursing home)/AL(assisted	2 830			
	living) summary dathad a previous med hypertension, atrial placement, and arthfurther identified a pamyloidosis (a dise substance known a heart, which causes deteriorates the purand poor appetite, a code for resuscitation R116's admission N	ted 12/21/16, indicated R116 dical history including: fibrillation, pacemaker nritis. The discharge summary primary problem of cardiac ase that occurs when a s amyloid builds up in the s it to get increasingly stiff and mping function), hyperkalemia and indicated R116 was a full				
	indicating R116 had expressed verbal sylook back. A subse MDS, dated 1/2/17 facility. An Avera Marshall I consent form, dated family had authorize absence of her prindesignee.	d intact cognition, and had ymptoms of pain within the equent discharge tracking indicated R116 had died in the Regional Medical Center d 12/22/16 indicated R116's ed use of eLTC services in the nary physician or his/her				
	12/23/16, indicated due to moderate to started around 3:30 indicated R116 had could be unstable a segment elevated raddition, the note in	ehealth Encounter Note dated R116 had been seen by eLTC severe chest pain which had p.m. on that date. The note "acute chest pain, certainly ingina or NSTEMI (non-st myocardial infarction)." In indicated staff were to obtain a neck severity of congestive				

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Millinesc	nta Department of He	eaim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00343	B. WING		01/3	7/2017
		00343			01/2	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
A\/ED	AODNINGCIDE LIFICI	JTC CARE CENTE 300 SOU	TH BRUCE S	TREET		
AVERA	MORNINGSIDE HEIGH	MARSHA	LL, MN 562	58		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
2 830	Continued From pa	age 30	2 830			
		40 milligrams of Lasix (a				
		sly, to stop R116's oral				
		er diuretic), and to provide				
		liever) now, and that pending a	l			
		ratory value of a complex of				
		contraction of the heart				
		ated after a heart attack) could				
		rin or morphine for pain				
		urther indicated R116's family aving the resident stay at the				
		nad decided to transfer her to				
		m so her case had been				
		local emergency room				
		gnosis was listed as chest				
	pain, unspecified.	griosis was listed as criest				
		gress notes revealed the				
	following entries:	greed noted revealed ind				
		tion was entered by RN-A 5:24	L			
		mplained of epigastric/chest				
		noon around 3:30 p.m. She				
	had rated the pain a	at an 8 on a 10 point scale (10				
	being the most seve	ere pain). R116 had been				
	administered Maalo	ox (an antacid) and Zofran (a				
	medication for naus	sea) by RN-A. After 20				
		rated her pain at a 10 out of				
		hysician was contacted to see				
		ble to be reached. As a result,				
		ne service) had been				
	contacted for a wor					
), a chest x-ray and review of				
		e note indicated pain				
		stered and family wished to				
		ursing home but would				
		er pending lab results and				
		tion. The note indicated eLTC				
		s test results came in, that				
		etly in bed with family at				
		pain was a little better. Will				
	continue to monitor					
	KII6'S EKG results	s, dated 12/23/16 at 4:54 p.m.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` ,	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
71140 1 12/114	OF COTTLECTION	IDENTIFICATION NOW	DEI I.	A. BUILDING:		OOM	LLILD
		00343		B. WING		01/2	27/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	IIS CARE CENTE		H BRUCE S LL, MN 5625			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	WAI IOI IAI	-	PROVIDER'S PLAN OF CORR	ECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 31		2 830			
2 830	indicated a ventricula analysis was obtain pacemaker. R116's medication the facility revealed milliliters of Maalox tramadol at 11:03 a milligrams orally on reflect any intraventany further medicat treat chest pain. A subsequent nursi On 12/23/16 at 7:42 documented by lice Family requested Femergency room at doctor. R116 was thaving only been at days. The notes fur R116 was found to (indicative of heart cardiac risk). The pR116 and her family family indicated the transferred to an outreatment. R116's emergency dated 12/23/16, aut (MD)-G indicated Fepigastric pain at 2 and family and the of a possible MI (mheart attack) so R1 evaluation and mar of pain rated at a 10	administration record R116 had received 30 at 3:40 p.m., a dose of the fact R11 administration received 30 at 3:40 p.m., a dose of the fact R11 and Tylenol tablets 12/23/16. The MAR ous Lasix administration being given to R11 and progress note indicated p.m. a notation was ensed practical nurse (116 be transferred to 16:00 p.m. RN notified the fact of	(MAR) at (MA				
	were not tried include	nal. Modifying factors ded analgesics, antac	ids,				
	aspirin, breathing, o	coughing, eating, exer	cise,				

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STATE FORM 5899 531Z11 If continuation sheet 32 of 48

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IVIIIIIII	na Department of Tie	aitri				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		300 SOUT	TH BRUCE S	TREET		
AVERA N	ORNINGSIDE HEIGH	IIS CARE CENTE	LL, MN 562			
(V4) ID	SHMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 32	2 830			
	lying down movem	ent, nitroglycerin, other,				
	oxygen, palpation a					
		ork revealed that the basic				
		easuring kidney function and				
		and a troponin were not				
		p.m., after R116 had been				
	transferred to the e					
		home progress note entry				
	indicated the follow					
		B a.m. documentation by				
	LPN-F included: At	8:00 p.m. (on 12/23/16),				
		back to her room to get her				
		R116 was being transported				
		oux Falls to receive treatment.				
		vas due to R116 sustaining				
		a bed hold was signed per				
		s too upset to make any				
	decisions at this tim					
		Hospital of South Dakota				
		I dated 12/23/16 at 11:16 p.m.,				
		aint of "?" and indicated R116				
		from the ER in Marshall, with				
		vated troponin level and				
		ces. R116 had received 4 nine to control chest pain along				
		s (anti-clotting medication) and				
		prior to transport to South				
		recommended to help with				
		and to get her potassium level				
	down.	and to get her potassium lever				
		e at the Avera Heart Hospital				
		being given additional Lasix				
		tassium levels and that				
		cipated back to the nursing				
		s considering hospice care.				
		1/24/17 at 5:07 p.m., the				
		was interviewed about when				
		OON stated, "If it is an				
		e seen emergently in the ER."				
		ware of any requirements for a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOU	DDRESS, CITY, S TH BRUCE S' ALL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	resident to be seen emergency room transidents seen in the from long-term care. The list included R1. During interview on verified the facility to weekends and after stated that if the resident and they were unawaseen, then eLTC weekends are unaway to the eliment of pain mat the time of pain mat the time of pain mat the time for medica thought the eLTC distated the eLTC distated the eLTC produced and the explained to her regarding interview on family (F)-2, stated amyloidosis and the explained to her regarding to her regarding to her regarding interview on family (F)-2, stated amyloidosis and the explained to her regarding to	face to face prior to an ansfer and provided a list of the emergency department within the last 12 months.	2 830			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I LAN OI	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVII	LLILD
		00343	B. WING		01/2	7/2017
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVERA MC	ORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
the second of th	signed a consent for hought there was repare of their mother experiencing chest unaware her mother experiencing chest unaware her mother experiencing chest unaware her mother experiencing chest unaway. F-2 merself why her motight away, and that amily was presented additionally, F-2 states to the ED, and he chest discomfort during interview on an experience of the Affichic (ACMC) doct was called first. Eit workup or told the soon the situation. The computers as well. During interview on the situation with computers as well. During interview on the situations, not sympolicated serious chas an emergent situations, not sympolicated serious chas an emergent situation of accevisit with a computer of clinical conditions warranting transportation of clinical conditions of c	F-2 stated the family had or eLTC services however, had no doctor available to take r at the time she started pain. F2 stated she was er could have been sent to the stated she was not sure ther had not been sent over to basically as soon as the ed with this option they did so, ated her mother had wanted to lad experienced very severe	2 830			

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
			LL, MN 5625			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 35	2 830			
2 830	NM-A reviewed the stated new, acute of unrelieved would we according to the parameters of the eLTC program of the eLTC providers were camera, and could intravenous lines at the facility had a gratilize the service to the doctor. MD-A renot appropriate if the care, or the resider airway obstruction, arrest. MDS explain pathways on the unstated that "a lot of nonemergent." Who of a patient exhibiting as chest pain rated within the hour to 1 for indigestion, and of Tylenol for pain, the quickest person they wanted to go to then it would be appled. MD-A further so face to face, and he was from CMS, but situation he confirm	eLTC pathway book and shest pain which was arrant immediate ED transfer thway. 1/25/17, at 11:55 a.m. the D-A) stated that the goal of was to see a provider timely. The available via telephone, or order labs, tests, medications, and x-rays. MD-A explained that ant, and they were trying to be support immediate access to evealed that the service was are was an acute change in at had an emergency, with breathing difficulty or cardiace and that there were protocols, wits for the nurse to follow, and	2 830			
	stronger medication had been hard feeling home and one of the resulting in some le	n for pain. MD-A stated there ngs between the nursing se other medical providers				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00343	B. WING		01/2	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOUT	DRESS, CITY, S TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	administrator stated appropriate for som pain rated a 10 out what would constitute non-emergent situated be used and the rest ED. During additional in p.m. MD-A (the merprimary physician), cardiac condition at the day on 12/21/16 pacemaker inserted effectively and was director stated he hiscuss R116's confound out about her had a day off on 12 on duty. The medic providers were used coverage for his resindicated R116's conwished someone has that she "probably someone has that she "probably someone from the eL morphine or nitrogly. The medical director visit had been very symptoms. A facility policy entiting Services LTC (long and Expiration: 11/2 "F. Complete a face resident to be trans Department or to a for acute changes in the street of the str	ge 36 If she felt eLTC use was beene reporting severe chest of 10 and was unable to state at ean emergent versus tion in which eLTC would not sident brought directly to the sterview on 1/25/17, at 1:41 dical director and also R116's stated R116 had an unusual and had been admitted late in the facility. R116 had a diversity weak. The medical ad not had time to fully dition with family and had not repisode of chest pain as he /23/16 until he returned back all director stated the eLTC did after hours for on-call sidents. The medical director indition was terminal, however ad called him on 12/23/16 and should have" gotten pain FC physician such as yeerin on board right away. For stated he did not feel the effective in managing R116's led Physician/Medical term care), Effective: 11/2011 (page 1 of 4) included: The to face visit before ordering a ferred to an Emergency hospital. This requirement is a medical condition of a ce visit is not required if a	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			K3) DATE SURVEY COMPLETED	
			7.1. 20.121.10.				
		00343	B. WING		01/2	7/2017	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
AVERA N	ORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S L, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	appointment, and/o procedure, or if goind department] for an condition (as specification) and condition (as specification) and condition (arow to next box) medical condition? "Resident taken to for evaluation" (if N consent to utilize elechart?" (If Yes arrow contacted." SUGGESTED MET The facility could rerelated to emergen resident conditions, resident transfers a changes. The facility could be reported to further recommend compliance.	a hospital for a scheduled or a scheduled out patient ng to the ED [emergency emergency, life threatening fied later in this policy)." ical Services LTC algorithm on included "Change in resident's requiring physician intervention "Emergency, life threatening (If Yes arrow to next box) ED [emergency department] o arrow to next box) "Resident LTC present on resident's w to next box) "eLTC THOD OF CORRECTION: eview and revise policies to care, acute changes in a physician services and and educate staff on the lity could audit resident records in resident condition to monitor and medical follow-up. Results to the QAPI committee for lations related to ongoing	2 830	BEHOLENOTY			
	(21) days.	R CORRECTION: Twenty-one					
2 850	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 D Adequate and re; Shaving	2 850			3/31/17	
	proper care. The cadequate and prop	or determining adequate and criteria for determining er care include: with or supervision of shaving					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00343	B. WING	····	01/2	7/2017
_	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 SOUT	DRESS, CITY, S TH BRUCE S LL, MN 562!			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	of all residents as and well-groomed.	ge 38 necessary to keep them clean ent is not met as evidenced	2 850			
	by: Based on observati review the facility fa services to meet the	on, interview, and document illed to provide facial shaving e grooming needs for 1 of 3 iewed for activities of daily		Corrected		
	seated in recliner in unshaven facial nea on the right side of approximated 1/4-1	p.m. R54 was observed her room. R54 had long ar her chin along the jawline her face. The hairs were /2 inch in length. The facial e present all days of the survey				
	assessment dated Interview for Menta indicating severe corequired extensive hygiene. R54's dia (paralysis on one si	num Data Set (MDS) 1/4/17, included a Brief I Status (BIMS) score of 6/15, ognitive impairment, and assistance with personal gnoses included hemiplegia de of the body) following CVA ocident/stroke) affecting the				
	personal care activi noted: It is very imp that I look well dres Interventions includ all grooming needs	ed requiring assist of staff for				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S			
040.15	CLIMMA DV CTA		L, MN 5625		ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 39	2 850			
	nursing assistant (NA)-A stated residents need to have their own shavers if wanting to be shaved. NA-A confirmed R54 did not have her own shaver nor had asked to be shaved.					
	confirmed R54 had mainly on the right was aware of the fa R54 approximately desired to be shave NA-A also stated R shaver and if she d would need to purc that R54 preferred a necklace daily) are every Monday after R54's room with the asked R54 whether facial hair removed her use. R54 responses	on 1/27/17, at 11:02 a.m. NA-A long unshaven facial hair side of face, explaining she acial hair as had questioned 6 months ago whether she ed; however, R54 declined. 54 did not own a personal esired to have one, the family hase a shaver. NA-A verified to look nice (requested to wear and had a hair appointment her bath. Upon entering e surveyor present, NA-A she preferred to have her if a shaver was purchased for onded, "Yes" and nodded her . After leaving the room, NA-A				
	approached adminifront desk to inform personal shaver. V responsible for acq R54's family would approval was given	strative assistant (AA)-A at the AA-A of R54's need for a When questioned who was uiring the shaver, AA-A stated have to purchase it unless to use funds from R54's ount for staff to purchase a				
	confirmed R54's fa providing a shaver personal funds for s stated in the past the cleanable razor whi without a personal whether this was a	on 1/27/17, at 11:24 a.m. AA-A mily would be responsible for and/or approval to utilize staff to purchase one. AA-A ne beauty shop used to have a ch was used for resident's shaver. but was unaware current option. AA-A stated ere admitted with their own				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVERA I	ORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 40	2 850			
	personal shavers but she would follow up with the beauty shop.					
	clinical manager (C required to have the the past the facility available for resider always thoroughly confection if not thorowere now required personal shavers. Were no extra shave at this time. CM-B responsible to meet the plan of care. When interviewed confirmed the beau available for resider	on 1/27/17, at 11:27 a.m. M)-B verified residents were eir own razor. CM-B stated in had community shavers at use but they were not cleaned. Due to the risk of oughly cleaned, residents to purchase their own CM-B also confirmed there ers available for resident use verified the facility was t R54's grooming needs per on 1/27/17, at 11:50 a.m. AA-A ty shop did have a shaver at their grooming needs.				
	1/2016, included: (and obtain resident wishes to be groom following: Facial ha	esident Quality of Life dated Grooming: staff will recognize preference as to how resident led. Grooming includes the air: how resident likes to be n, does resident like to have				
	The administrator of resident grooming finantial plan. The administresults to the QAPI	THOD OF CORRECTION: or designee could audit for compliance with the care rator or designee could report committee for follow up related to ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00343	B. WING		01/2	7/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
AVERA N	IORNINGSIDE HEIGH	IIS CARE CENTE	TH BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 41	2 895			
2 895	MN Rule 4658.0525 Motion	Subp. 2.B Rehab - Range of	2 895			3/31/17
	that is directed towathrough positioning implemented and more comprehensive resident of nursing services development of a more provides that: B. a resident with receives appropriating increase range of modernease in range of the decrease in rang	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which the a limited range of motion the treatment and services to notion and to prevent further of motion.				
	by: Based on observation, interview, and document review the facility failed to ensure a splint was applied to the right hand to prevent further development of contractures (permanent shortening of a muscle or joint preventing normal movement) for 1 of 1 resident (R45) reviewed for range of motion (ROM).			Corrected		
	Findings include:					
	(MDS) assessment as comatose with a injury (TBI). The M total assistance for dressing and perso- identified R45 as ha	arterly Minimum Data Set dated 1/11/17, identified R45 diagnosis of traumatic brain DS identified R45 as requiring bed mobility, transfers, nal hygiene. It further aving impairment on both emities with functional f motion.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00343	B. WING		01/	27/2017
	PROVIDER OR SUPPLIER	ITS CARE CENTE 300 S	ET ADDRESS, CITY, SOUTH BRUCE S SHALL, MN 562	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 895	Review of R45's calidentified R45 wore hand/arm 6-8 hours all times in left hand directed staff to se room for splints/brasplint order stated: splint/brace on for 6 a.m. off at 2:00 p.m. On 1/24/17, at 9:32 in bed with a carrot splint was on right hassistant (NA)-B stasplint to his left han any other splint dev. On 1/24/17, at 2:06 (LPN)-A was observight hand. LPN-A have the splint on b.	re plan last revised 1/16/17 a hand splint in right is per day and a carrot splint. The care plan further e therapy directions in R45 ces. R45's current undate right hand forearm 6-8 hours per dayon 6:00 i. a.m. R45 was observed by splint in place to left hand and at this time. Nursing ated R45 only wore a carrod, and did not wear or utilities.	nt at 5's ed 0 ving No ot ze rse 5's o			
	NA-E and NA-D sta R45 wearing a carr of any other devices On 1/26/17, at 10:1 completed to both to NA-D with a carrot	1/24/17, at 2:07 p.m. both ated they were only aware of splint to left hand; not as or splints for right hand. 2 a.m. ROM exercises we upper extremities by NA-C splint placed to the left har was applied to R45's right ROM.	of ware re and			
	dressed and groom 9:21 a.m. NA-G ver	a.m. R45 was lying in bed led; no splint to right hand. rified R45 had a carrot splin out no other splint was wor	At nt in			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00343	B. WING		01/2	7/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
AVERA I	MORNINGSIDE HEIGH	HIS CARE CENTE	TH BRUCE S LL, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 895	Continued From pa	age 43	2 895				
	R45. At 9:27 a.m. NA-F also indicated R45 did not wear a right hand splint.						
	LPN-C verified R45 splint applied as ord	on 1/27/17, at 10:22 a.m. of did not have a right hand dered and indicated that splint ot posted in R45's room as n of care.					
	director of nursing (expected staff to fo	1 1/27/17, at 10:23 a.m. the (DON) confirmed she ollow the plan of care and owear a right hand splint on as ordered.					
	During interview on 1/27/17, at 11:33 a.m. the certified occupational therapist assistant (COTA) stated splints are ordered for residents to prevent further contractures and when therapy gives recommendations and schedules for splint use they expect nursing to follow it.						
	A facility policy relativas requested but	ted to following plan of care not provided.					
	The administrator of resident cares relating activities. To could review and reference of motion and splint the changes. The of	THOD OF CORRECTION: or designee could audit ted to splints and restorative. The administrator or designee exise policies related to range ts and educate staff related to QAPI committee could review and make recommendations ance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JLTIPLE CONSTRUCTION (X3) DATE COMP		
		00343	B. WING	B. WING 01/2		27/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE S LL, MN 5625			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 44	21995			
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults		21995			3/31/17
	(a) Each facility shongoing written proapplicable licensing of suspected maltrefacility has an internandated reporter requirements of this internally. Howeve responsible for conreporting requirements of this internally. Howeve responsible for conreporting requirements of this internally. Howeve responsible for conreporting requirements of allegating the sased on interview facility failed to impact Abuse Prevention for reporting of allegating State Agency (SA) (R66) who experient without being transimmediately as ord Findings include: Refer to F309 - Base and document reviet imely medical trear residents (R66, R1 transferred from the room department with condition. This resulting in pain, established aspiration pneumonal in pain, established aspiration pneumonal in the resulting in pain, established aspiration pneumonal internal	I reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ons of potential neglect to the for 1 of 8 incidents reviewed anced a decline in health status ferred to the emergency room ered by her primary physician. The facility failed to ensure the facility to the emergency with acute changes in their acute changes in their acute in immediate jeopardy for ced actual harm due to for an esophageal obstruction sophageal irritation and risk of nia/airway compromise as well R116, who had a history of		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BOILDING.				
	00343	B. WING		01/2	7/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
AVERA MORNINGSIDE HEIGHT	IS CARE CENTE	TH BRUCE S LL, MN 5625				
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
The facility's Vulnera Plan, last revised 1/2 Avera Marshall will n patient, resident, clie anyone including stat visitors, or family me the deprivation by an taker, or goods or se attain or maintain physychosocial well-be residents, irrespective condition, cause phy anguish. Abuse incluationabuse, physical abuse including abuse facilituse of technology. The policy defined not Failure of the facility, providers to provide resident that are necharm, pain, mental adistress. All health careporters. A report is believe that abuse or Immediately means a minutes of knowledge to incidents is initiate investigation of the ir incidents of neglect that agency. Taking all nethanges are needed occurrences. Keepin	experienced delayed chest pain. able Adult Abuse Prevention 2017 indicated: not condone abuse of any ent and/or participant, by off, physicians, volunteers, embers. Definition of abuse: n individual, including a care ervices that are necessary to hysical, mental, and eing. Instances of abuse of all or of any mental or physical resical harm, pain or mental ades verbal abuse, sexual se and mental abuse itated or enabled through the eglect as: n, it's employees or service goods and services to a deessary to avoid physical	21995				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED					
		00343	B. WING		01/2	7/2017					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE								
AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOUTH BRUCE STREET MARSHALL, MN 56258											
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE						
21995	report should be file be made immediate incident. Review of to the Vulnerable A identifies that once are aware of a incidentifies that once are aware of a incidentifies that once (investigation) is consubmitted to OHFO A facility email, dated director of nursing not been taken to the immediately as peresophageal food be primary physician (conferred with the asubsequently contact chart review. A reput to the state agency and an internal investinct of authority and interviewed at the time. When interviewed at the time was not reported to incident of abuse nurse director had completed at the time. The DON stated "lobeen reportable, consume the director facility could reprocedures related resident abuse in the changes. The state of the changes of the changes of the changes.	ed with OHFC, the report will ely, upon knowledge of the a decision pathway attached dult Abuse Prevention Plan, the administrative personnel dent a report is made to the lity complaints (OHFC) a resident care assessment empleted, a final report is then within 5 days of the incident. ed 6/21/16 indicated the (DON) was informed R66 had the emergency room physician's orders after an olus obstruction by R66's MD-B). The DON then administrator (A), who acted the medical director for a cort was not immediately made (SA) regarding the incident at staff members was not	21995								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMI	(X3) DATE SURVEY COMPLETED						
		00343	B. WING	***************************************	01/2	27/2017						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AVERA MORNINGSIDE HEIGHTS CARE CENTE MARSHALL, MN 56258												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE						
21995	for timely reporting agency. Results co	to the administrator and state ould be reported to the QAPI	21995									

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