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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5DYB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**

2.STATE VENDOR OR MEDICAID NO.
(L2) **739745300**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 05/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/04/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5238

On April 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 10, 2014 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 6, 2014. We presumed, based on the facility's plan of correction, that the facility had corrected these deficiencies as of April 10, 2014. Based on our PCR, we have determined thatther facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 6, 2014, effective April 10, 2014 and therefore remedies outlined in our letter to dated March 24, 2014, will not be imposed. Refer to the CMS 2567b for both health and life safety code for the results of this visit.

Effective April 10, 2014, the facility is certified for 48 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5238

June 20, 2014

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Dear . Klassen:

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 April 10, 2014 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 7, 2014

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238024

Dear . Klassen:

On March 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 6, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 10, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 6, 2014, effective April 10, 2014 and therefore remedies outlined in our letter to you dated March 24, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure 5238r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245238	A. Building B. Wing	4/29/2014

Name of Facility	Street Address, City, State, Zip Code
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	05/07/2014	28035	04/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/6/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245238	01 - 1969 BUILDING WITH 1975 ADDITION	4/10/2014

Name of Facility	Street Address, City, State, Zip Code
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/01/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	05/07/2014	19251	04/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/5/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 24-5238

2. NAME AND ADDRESS OF FACILITY
(L3) Mahnomen Health Center
(L4) 414 West Jefferson PO Box 396
(L5) Bemidji STATE (L6) MN 56557

3. STATE VENDOR OR MEDICAID NO.
(L2) 1710912787

4. TYPE OF ACTION
1. INITIAL SURVEY
2. RECERTIFICATION
3. TERMINATION
4. CHOW
5. VALIDATION
6. COMPLAINT
7. ON SITE VISIT
8. TERMINATION OF ICF BEDS
9. OTHER
2
(L8)

5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY
(L34) 03/06/2014

TYPE
(L7) 2

7. PROVIDER/SUPPLIER CATEGORY
01 HOSPITAL; 02 SNF/ICF (DUALLY CERTIFIED); 03 SNF/ICF (DISTINCT PART); 04 SNF; 05 HHA; 06 LAB; 07 X-RAY; 08 OPT/SP; 09 ESRD; 10 ICF; 11 IMR; 12 RHC; 13 PTIP; 14 CORF; 15 ASC; 16 HOSPICE

9. FISCAL YEAR ENDING DATE
(L35) MONTH/DAY

8. ACCREDITATION STATUS
(L10) ____ 0 - UNACCREDITED; 1 - JCAH; 2 - AOA; 3 - OTHER

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

10. THE FACILITY IS CERTIFIED AS:
A. IN COMPLIANCE WITH PROGRAM REQUIREMENTS COMPLIANCE BASED ON:
1. ____ ACCEPTABLE POC

AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS:
2 ____ TECHNICAL PERSONNEL
____ 24 HR RN
4 ____ 7-DAY RN (RURAL SNF)
____ LIFE SAFETY CODE
6 ____ SCOPE OF SERVICE LIMITED
7 ____ MEDICAL DIRECTOR
8 ____ PATIENT ROOM
9 ____ BEDS PER ROOM

B. X NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS:
(L12) A/B (IF APPLICABLE CODES 1-9) B

12. TOTAL FACILITY BEDS
(L18) 48

13. TOTAL CERTIFIED BEDS
(L17) 48

14. LTC CERTIFIED BED BREAK DOWN	A. (L37) 18 SNF	B. (L38) 18/19 SNF	C. (L39) 19 SNF	D. (L42) ICF	E. (L43) IMR	F. SNF/ICF (L40) DUALLY CERT.
		48				

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1)
(L15) 1-YES 2-NO

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

See attached page(s).

17. SURVEYOR SIGNATURE
Yvonne Switajewski
HFE NEII
(L19) 04/11/2014 MM/DD/YY

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
(L20) 04/28/2014 MM/DD/YY MPM

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

19. DETERMINATION OF ELIGIBILITY
1-FACILITY IS ELIGIBLE TO PARTICIPATE
2-FACILITY IS NOT ELIGIBLE TO PARTICIPATE
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT

21. 1. STATEMENT OF FINANCIAL SOLVENCY (CMS-2572)
2. OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT (CMS-1513)
3. BOTH OF THE ABOVE

22. ORIGINAL DATE OF PARTICIPATION
(L24) MM/DD/YY

23. LTC AGREEMENT BEGINNING DATE
(L41) MM/DD/YY

24. LTC AGREEMENT ENDING DATE
(L25) MM/DD/YY

25. LTC EXTENSION DATE
(L27) MM/DD/YY

27. ALTERNATIVE SANCTIONS
A. SUSPENSION OF ADMISSIONS
(L44) MM/DD/YY

B. RESCIND SUSPENSION DATE
(L45) MM/DD/YY

26. TERMINATION ACTION
VOLUNTARY
1- MERGER, CLOSURE
2- DISSATISFACTION WITH REIMBURSEMENT
3- RISK OF INVOLUNTARY TERMINATION
4- OTHER REASON FOR WITHDRAWAL
INVOLUNTARY
5- FAILURE TO MEET HEALTH/SAFETY
6- FAILURE TO MEET AGREEMENT
OTHER
7- PROVIDER STATUS CHANGE
(L30)

28. TERMINATION DATE
(L28) MM/DD/YY

29. INTERMEDIARY/CARRIER NO.
(L31) MM/DD/YY

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32) MM/DD/YY

32. DETERMINATION APPROVAL DATE
(L33) MM/DD/YY

DETERMINATION APPROVAL

FORM CMS1539 (7/84) (DESTROY PRIOR EDITIONS)

1. CMS REGIONAL OFFICE
2. SINGLE STATE AGENCY (DHS)
3. STATE SURVEY AGENCY (FILE)
4. STATE SURVEY AGENCY (DO)
5. COURTESY COPY

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5DYB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

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(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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

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(L9)

6. DATE OF SURVEY **04/29/2014** (L34)

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2 AOA 3 Other

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **48** (L18)

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

And/Or Approved Waivers Of The Following Requirements:
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___ 4. 7-Day RN (Rural SNF)
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___ 7. Medical Director
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18 SNF	18/19 SNF	19 SNF	ICF	IID
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(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 05/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/20/2014 (L20)

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

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3. Both of the Above :

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08/04/1981
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23. LTC AGREEMENT BEGINNING DATE
(L41)

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25. LTC EXTENSION DATE:
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A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5238

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Effective April 10, 2014, the facility is certified for 48 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5238

June 20, 2014

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Dear . Klassen:

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 April 10, 2014 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 7, 2014

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238024

Dear . Klassen:

On March 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 6, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure 5238r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245238	A. Building B. Wing	4/29/2014

Name of Facility	Street Address, City, State, Zip Code
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	05/07/2014	28035	04/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/6/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245238	A. Building B. Wing **01 - 1969 BUILDING WITH 1975 ADDITION**	4/10/2014

Name of Facility	Street Address, City, State, Zip Code
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0050	Correction Completed **04/01/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** MM/LB	**Date:** 05/07/2014	**Signature of Surveyor:** 19251	**Date:** 04/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/5/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

On March 6, 2014 a standard survey was completed. Deficiencies were found. The provider is given an opportunity to correct before remedies will be imposed. Refer to the CMS 2567 for both health and life safety code along with the providers plancorrection. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4592

March 24, 2014

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238024

Dear Ms. Klassen:

On March 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 15, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 15, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 6, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5238s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/06/2014

RECEIVED APR 07 2014 Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Approved c Addendum 4/11/14 SB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	4/3/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement care planning interventions related to the coordination of care for 1 of 1 resident (R35) receiving hospice services. In addition, the facility failed to develop a plan of care for 1 of 3 (R15) residents who required non-pharmacological interventions prior to the administration of anti-anxiety medications. Findings include: R35's significant change Minimum Data Set (MDS) dated 1/16/14, indicated R35's diagnoses included Alzheimer's disease, renal insufficiency, congestive heart failure (CHF), anemia and malnutrition. The MDS also indicated R35 was cognitively impaired, required extensive assistance with bed mobility, transfers, eating, toileting and personal hygiene. In addition, the MDS indicated R35 utilized a wheelchair for mobility and was currently receiving hospice services. R35's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 1/27/14, indicated R35 required limited to extensive assist of one staff for ADL's and had a worsening mental status. The Hospice Initial Certification form, signed 1/3/14, indicated R35 had terminal renal insufficiency and had declined dialysis. R35's physician's plan of care (POC) dated 1/2/14, indicated R35 was certified as eligible for Hospice care. The POC entry dated 1/16/14 indicated the Hospice agency was contacted and	F 279	**F-279:** R35's hospice care plan was added to the chart on 3.5.2014. Care plan for R15 was amended on 04.01.2014 to add non-pharmacological interventions to be used prior to anti-anxiety medications. Care Conference summary amended to add the review of psychotropic medication care planning along with new anxiety scale entry for LSW. See attachment #1. IDT notes were amended to add the addition of current hospice care plan on record. See attachment # 2. Staff was trained on the new documentation requirements on 04.01.2014. Nursing will be responsible for auditing the inclusion of the hospice care plan and anti-anxiety care plans. The delegated RN will monitor care plans and report to QA quarterly.	4-10-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 2 an agreement for hospice services was developed. Review of 35's medical record revealed R35 lacked a hospice services POC to indicate the coordination of services within the facility. On 3/5/14, at 11:05 a.m. registered nurse (RN)-C verified she was unable to locate a hospice POC within R35's medical record. On 3/5/14, at 11:10 a.m. the Hospice RN stated R35's hospice POC was to be placed in the medical record and confirmed R35's POC was not in place. The RN stated the agency social worker was responsible to provide the facility with the POC, however, had not. At 11:15 a.m. the director of nursing (DON) verified R35's medical record lacked the hospice POC. At the same time the Hospice RN made a telephone call to the hospice agency and stated a Hospice POC would be faxed to the facility. The facility policy, "Hospice Program", revised 2/2013, indicated when a resident participates in the hospice program, a coordinated POC between the facility, hospice agency and resident/family would be developed and would include directives for managing pain and other uncomfortable symptoms. R15's POC lacked identification and indication for the use of non-pharmacological interventions prior to the administration of as needed (PRN) anti-anxiety medications.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 R15's POC dated 1/8/14, indicated R15 was diagnosed with dementia. However, the POC lacked indication R15 was also diagnosed with anxiety and was administered antianxiety medication PRN and did not identify non-pharmacological interventions to be attempted prior to the use of the medication. R15's current Physicians Orders dated 12/31/13, included an order for Ativan 0.5 mg to be given three times a day PRN for anxiety. Review of R15's Medication Administration Records revealed the following information: - January 2014, R15 received 17 doses of PRN Ativan. - February 2014, R15 received five doses of PRN Ativan -March 2014, 3/1- 3/5/14, R15 had not requested PRN Ativan. R15's medical record record did not include documentation of non-pharmacological interventions attempted prior to the administration of the medication. On 3/5/13, at 2:45 p.m. RN-A confirmed R15 received PRN anti-anxiety medications and R15's POC did not identify any type of non-pharmacological interventions to be attempted prior to administration.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 4 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care to include ambulation interventions for 1 of 1 resident (R39) who required assistance with ambulation. In addition, the facility failed to revised the plan of care to include non pharmacological interventions prior to the administration of as needed (PRN) antianxiety medication for 2 of 3 residents (R39, and R10) who received as needed anti-anxiety medications. Findings include: R39's ambulation plan of care (POC) was not revised to include ambulation interventions. R39's Mobility Assessment dated 1/24/13,	F 280	**F-280:** R39's care plan was revised on 03.27.2014 to include ambulation interventions. R39 and R10's care plans were amended on 04.01.2014 to include non-pharmacological interventions. Monthly, for the last 30 minutes of IDT meetings, we will discuss each resident on nursing rehab, whether they are making goals, and if their care plan needs amending. See attachment #2. A new prn documentation form was created for staff to list appropriate interventions prior to medicating. See attachment #3. Staff was trained on the new documentation requirements on 04.01.2014. Nursing will be responsible for auditing the inclusion of anti-anxiety care plans. Nursing Rehab will be responsible for updating and communicating with IDT team progress, goals, care plan and further rehab needs of all residents on a nursing rehab program. The delegated RN and Nursing Rehab coordinator will monitor care plans and report to QA quarterly.	4-10-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 5	F 280		

indicated R39 was inconsistently able to sit up by himself and was able to ambulate with assistance from staff.

R39's physical therapy notes dated 1/20/14, indicated R39 was able to ambulate 120 feet with a front wheeled walker and stand by assistance. The note also indicated R39 had reached a plateau in abilities therefore formal therapy was discontinued.

R39's printed POC dated 1/8/14, directed staff to assist with ambulation. However, the POC failed to identify and direct the staff as to the number of times a week R39 was to ambulate.

R39's current computerized plan of care (undated) directed staff to assist R39 with ambulation three times a day.

On 3/5/14, at 11:11 a.m. the certified occupational therapy assistant (COTA) stated he provided R39 with an ambulation program which included direction for R39 to ambulate five times a week.

On 3/5/14, at 11:30 a.m. R39 was observed to ambulate greater than 140 feet with a front wheeled walker and assistance from the COTA and nursing assistant (NA)-B.

On 3/5/14, at 1:50 p.m. registered nurse (RN)-A confirmed R39 was to be receiving assistance with ambulation. However, RN-A verified R39's computerized and printed POC did not match and neither directed the staff on how R39 was to be receiving assistance with ambulation according to the ambulation program set up by the COTA. RN-A confirmed R39's POC was in need of revision.

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F 280	Continued From page 6	F 280		

R39's POC was not revised to address non-pharmacological interventions to be attempted prior to the administration of anti-anxiety medications.

R39's POC dated 1/15/14, indicated R39 had behavioral problems which included fidgeting, restlessness, unsafe self transfer attempts and pulling off incontinence briefs. The POC directed staff to monitor and document side effects and effectiveness of medications and provide one to one activities and ensure resident needs were met. However, the POC did not include non-pharmacological interventions which were to be attempted prior to the administration of the PRN anti-anxiety medications.

R39's Physician's Orders dated 2/4/14, included an order for Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered every 6 hours PRN for anxiety, fidgeting, restless, up and down and attempting to self ambulate. The order also included an order for Klonopin (a benzodiazepines which helps with the treatment of panic type disorders) 0.5 mg to be given three times a day as needed for restlessness.
R39's February 2014, Medication Administration Record (MAR) indicated R39 had received four PRN doses of Klonopin 0.5 mg and the January 2014, MAR indicated R39 had received 15 doses of PRN Ativan 0.5 mg.

Review of R39's Interdisciplinary Progress notes (nurses notes) from 1/9/14 - 2/23/14, lacked non-pharmacological interventions attempted prior to the administration of the anti-anxiety medications.

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F 280	Continued From page 7	F 280		

On 3/5/14, at 2:05 p.m. RN-A stated R39 received anti-anxiety medications for the treatment of increased restlessness. She confirmed the R39's medical record record did not identify nor direct staff as to which type of non-pharmacological interventions were to be attempted prior to the administration of the medications. She confirmed R39's POC was in need of revision.

The facility's Compressive Care Plan policy dated 3/2013, directed the staff to revise the plan of care as needed to ensure the residents received appropriate services.

R10's POC did not include non pharmacological interventions to be attempted prior to the administration of PRN antianxiety medications.
R10's Diagnosis Report dated 3/5/14, indicated R10's diagnoses included Alzheimer's disease, anxiety, dementia without behavioral disturbance, depressive disorder and tear film insufficiency.
R10's quarterly Minimum Data Set (MDS) dated 12/26/13, indicated R10 had intact cognition.
R10's Psychotropic Drug Use Care Area Assessment (CAA) dated 4/6/13, indicated R10 became anxious about her eyes and ongoing difficulty related to complaints of pain to them, especially her right eye.
R10's Physician orders dated 11/21/13, indicated lorazepam (antianxiety) 0.5 mg orally twice daily PRN for picking at eyes, anxiety related to nursing home stay, pacing and verbal aggression.
R10's POC dated 2/3/14, identified the following

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F 280	Continued From page 8 non-pharmacological interventions for R10's eye complaints: avoid alcohol and raw vanilla beans or products that contain them due to allergies, baby wash to eyes daily as ordered, offer warm wash cloth when complains of eyes itching, follow up with eye doctor as ordered/prn [as needed] for acute problems, provide eye drops as ordered, scheduled and prn. However, the POC lacked direction/coordination for the use of the antianxiety medication in conjunction with these non-pharmacological interventions. On 3/6/14, at 9:14 a.m. licensed practical nurse (LPN)-B stated R10 did not use antianxiety medication often, but use would be indicated when R10 "obsessed about her eyes and worked herself up until she was frantic and crying." LPN-B confirmed directions related to the use of the antianxiety medication use was not included in the POC.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with repositioning, toileting and range of motion as directed by the individual written plan of care for 1 of 11 residents (R39) in the sample who required assistance with repositioning, toileting and range of motion.	F 282		

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F 282	Continued From page 9 Findings include: R39's plan of care (POC) dated 1/24/14, directed staff to assist R39 with repositioning every two hours. The POC also directed staff to assist R39 with toileting every two hours for bowel continence. On 3/5/14, on 7:40 a.m. R39 was observed to be assisted into his wheelchair. R39 was observed to remain in the chair until 11:20 a.m. at which time nursing assistant (NA)-B and licensed practical nurse (LPN)-B were observed to assist R39 to the toilet (a total of 3 hours and 40 minutes later). R39 was observed to be incontinent of bowel. R39's Restorative Nursing Plan dated 1/20/14, directed staff to assist R39 with hand exercises for twenty repetitions, flex band exercise for five repetitions and to use the arm bike for two minutes. The exercise program was to be completed three times per week. On 3/5/14, at 7:20 a.m. R39 was observed to receive assistance with dressing by NA-A. R39 was observed to be able to fully extend his shoulders, elbows, wrists and hands and require the assistance of the NA to complete the dressing task. R39 was not observed to participate in a repetitive range program during cares. Review of the Rehab documentation for January, February and March 2014, indicated R39 had not received range of motion services as directed by the POC. On 3/5/14, at 1:50 p.m. registered nurse (RN)-A	F 282	**F-282:** It is the policy of Mahnomen Health Center that residents are toileted and repositioned according to their individualized care plan needs. In order to meet their needs, a new toileting/repositioning form has been created. See attachment #4. This form will be monitored daily by the nurses on duty to make sure care plans are being followed. ROM is currently being completed by nursing rehab. All residents on a ROM program will be discussed at our monthly nursing rehab meeting. See attachment #2. RN to monitor compliance with new T/R program, Nursing Rehab to monitor compliance with ROM program. Report findings to QA quarterly.	4-10-14

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F 282	Continued From page 10 stated R39 was dependent upon staff for all activities of daily living and was to receive assistance according to his POC. The Care Plan policy dated 3/2013, directed the staff to provide assistance according to the established plan of care.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain the resident's ability to ambulate for 1 of 1 resident (R39) reviewed in the sample who was on an ambulation program. Findings include: R39's initial Minimum Data Set (MDS) dated 1/1/14, indicated R39's diagnoses included Alzheimer's disease, diabetes mellitus and atrial fibrillation. The MDS indicated R39 had severe cognitive impairment and required extensive assistance for bed mobility, transfers and ambulation. R39's Mobility Assessment dated 1/24/13, indicated R39 was inconsistently able to sit up by himself and was able to ambulate with assistance from staff.	F 311	**F-311:** R39's care plan was revised on 03.27.2014 to include ambulation interventions. FMP orders for nursing rehab were added to the weekly IDT meeting agenda. See attachment #2. Staff was trained on the new documentation requirements on 04.01.2014. PT will be responsible for updating and communicating with IDT team the residents ambulation rehab needs when being added to an FMP. The Rehab Nursing Coordinator will monitor that FMP orders are being followed and care planned and will report to QA quarterly.	4-10-14

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F 311	Continued From page 11 R39's physical therapy (PT) note dated 1/20/14, revealed R39 was able to ambulation 120 feet with a front wheeled walker and stand by assistance. The note also indicated R39 had reached a plateau in ability, therefore, formal therapy was discontinued. R39's current printed plan of care dated 1/8/14, directed staff to assist R39 with ambulation. However, the POC did not identify the number of times a week R39 was to ambulate. R39's current, undated, computerized POC directed staff to assist R39 with ambulation three times a day. R39's Rehab documentation revealed the following information: -March 2014, R39 had not ambulated -February 2014, R39 ambulated a total of 15 times. -January 2014, R39 had ambulated 9 times. On 3/5/14, at 11:11 a.m. the certified occupational therapy assistant (COTA) stated he provided R39 with an ambulation program which included ambulation assistance five times a week. He stated when the physical therapist (PT) discontinued therapy, a formal functional maintenance program had not formally been established by the therapist, but since he had been working with the therapist for a long time, he knew the therapist would require a program be developed and in place for R39 so he developed the program in order for R39 to maintain his ambulation status. The COTA confirmed R39's ambulation program had not been implemented	F 311		

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F 311	Continued From page 12 as often as directed. On 3/5/14, at 11:30 a.m. R39 was observed to ambulate greater than 140 feet with a front wheeled walker and assistance from the COTA and nursing assistant (NA)-B. On 3/5/14, at 1:50 p.m. registered nurse (RN)-A confirmed R39 was to be receiving assistance with ambulation. She confirmed the therapist had not written a formal functional maintenance program upon the completion of therapy, however, stated the program established by the COTA should have been implemented. RN-A stated R39 was to receive ambulation services in order to ensure he maintained his current level of mobility. On 3/5/14, at 2:45 p.m. the PT confirmed R39 was to receive assistance with ambulation. He stated when R39 was discontinued from therapy, a formal program should have been developed which would have directed the staff on how often R39 was to receive assistance. The PT stated the program established by the COTA was an appropriate ambulation program for R39 however, verified he should have written the formal program upon completion of therapy. The PT stated the COTA was to provide the services and ensure R39 participated in the program. On 3/5/14, at 4:15 p.m. the director of nurses (DON) stated the interdisciplinary team reviewed the restorative programs at each care conference. The DON stated R39 was to receive assistance with ambulation three times a week. She provided the interdisciplinary review sheet dated 1/31/14, which indicated for R39 "trouble with not complete all areas of exercise." The	F 311		

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F 311	Continued From page 13 DON confirmed the interdisciplinary team had identified a problem with the restorative program, yet did not develop a system to ensure R39 participated in the program as directed. A restorative program policy was requested but not provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with bowel care for 1 of 1 resident (R39) in the sample who was dependent on staff for toileting. Findings include: R39's initial Minimum Data Set (MDS) dated 1/1/14, identified R39 had diagnoses which included Alzheimer's disease and diabetes mellitus. The MDS also indicated R39 had severe cognitive impairment, required extensive assistance for bed mobility, transfers and ambulation was incontinent of bowel. The Urinary Incontinence Care Area Assessment (CAA) dated 1/6/14, indicated R39 required the use of an indwelling Foley catheter and was incontinent of bowel.	F 312	**F-312:** It is the policy of Mahnomen Health Center that residents are toileted according to their individualized care plan needs. In order to meet their needs, a new toileting form has been created. See attachment #4. This form will be monitored daily by the nurses on duty to make sure care plans are being followed. Toileting schedules and compliance will be added to our QA program and reported on quarterly.	4-10-14

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F 312	Continued From page 14 R39's plan of care (POC) dated 1/24/14, directed staff to check for incontinence every 2 hours and assist R39 onto the toilet every day at 10:00 a.m. to promote bowel movements. On 3/5/14, at 7:40 a.m. nursing assistant (NA)-A and NA-D were observed to assist R39 to transfer from bed to the wheelchair. At 8:00 a.m. R39 was wheeled from his room to the dining room. At 8:30 a.m. R39 was observed to be wheeled to the lobby area and remain there until 9:10 a.m. at which time licensed practical nurse (LPN)-C was observed to wheel R39 to the laboratory for a blood draw. At 9:25 a.m. R39 returned to the lobby and continued to sit in the wheelchair until 11:20 a.m. for a total of 3 hours and 40 minutes without toileting assistance. On 3/5/14, at 10:36 a.m. LPN-C verified she had wheeled R39 to the laboratory for a blood draw at 9:10 a.m. LPN-C confirmed while R39 was in the lab he remained in the wheelchair and did not receive assistance to the toilet. On 3/5/14, at 11:14 a.m. NA-A confirmed she had not checked R39 for incontinence nor assisted him to the toilet since assisting him out of bed at 7:40 a.m. On 3/5/14, at 11:20 a.m. NA-B and LPN-B were observed to assist R39 to transfer from the wheelchair to the toilet. R39 was observed to be incontinent of bowel. LPN-B stated R39 was to receive assistance with bowel incontinence every two hours. On 3/5/14, at 1:50 p.m. registered nurse (RN)-A verified R39 was incontinent of bowels and was to receive assistance with incontinence cares every	F 312		

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F 312	Continued From page 15 two hours and was also to be assisted onto the toilet every day at 10:00 a.m. as directed by the POC. The facility's Care Plan policy dated 3/2013, directed the staff to provide assistance according to the established plan of care.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received repositioning assistance necessary to prevent the development of pressure ulcers for 1 of 1 resident (R39) in the sample identified at risk for pressure ulcers. Findings include: R39's initial Minimum Data Set (MDS) dated 1/1/14, identified R39 had diagnoses which included Alzheimer's disease and diabetes mellitus. The MDS also indicated R39 had severe cognitive impairment, required extensive	F 314	**F-314:** It is the policy of Mahnomen Health Center that residents are repositioned according to their individualized care plan needs. In order to meet their needs, a new toileting form has been created. See attachment #4. This form will be monitored daily by the nurses on duty to make sure care plans are being followed. Repositioning schedules and compliance will be added to our QA program and reported on quarterly.	4-10-14

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F 314	Continued From page 16 assistance for bed mobility, transfers and ambulation and was at risk for the development of pressure sores. The Pressure Ulcer Care Area Assessment (CAA) dated 1/6/14, indicated R39 was at risk for the development of pressure ulcers due to cognitive impairment, bowel incontinence, dependence upon staff for mobility and history of skin irritation. R39's Braden assessment (pressure ulcer risk assessment) dated 1/17/14, indicated R39 was at risk for the development of pressure ulcers. R39's undated Checklist of Skin Risk Factors and Interventions also identified R39 at risk for the development of pressure ulcers. R39's plan of care (POC) dated 1/24/14, directed staff to assist R39 with repositioning every two hours. On 3/5/14, at 7:40 a.m. nursing assistant (NA)-A and NA-D were observed to assist R39 to transfer from bed to the wheelchair. At 8:00 a.m. R39 was wheeled from his room to the dining room. At 8:30 a.m. R39 was observed to be wheeled to the lobby area and remain there until 9:10 a.m. at which time licensed practical nurse (LPN)-C was observed to wheel R39 to the laboratory for blood a blood draw. At 9:25 a.m. R39 returned to the lobby and remained there, seated in the wheelchair until 11:20 a.m. a total of 3 hours and 40 minutes. On 3/5/14, at 10:36 a.m. LPN-C confirmed she had wheeled R39 to the laboratory for blood draws at 9:10 a.m. and verified while R39 was there, he had remained in the wheelchair.	F 314		

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F 314	Continued From page 17 On 3/5/14, at 11:14 a.m. NA-A confirmed she had not assisted R39 with repositioning since assisting him out of bed at 7:40 a.m. On 3/5/14, at 11:20 a.m. NA-B and LPN-B were observed to assist R39 to stand from the wheelchair. R39's skin was observed pink and free of open areas. The wheelchair was observed to be equipped with a pressure redistribution cushion. LPN-B stated R39 was to receive assistance with repositioning every two hours. On 3/5/14, at 1:50 p.m. registered nurse (RN)-A stated R39 was at risk for the development of pressure ulcers and was to be assisted with repositioning every 2 hours as directed by the POC. The facility policy Prevention of Pressure Ulcer, dated 3/2013, directed the staff to reposition a resident in a chair every hour and assist check and change incontinent residents every two hours.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		

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F 318	Continued From page 18 Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain ROM ability for 1 of 2 residents (R39) in the sample who required a ROM program. Findings include: R39's initial Minimum Data Set (MDS) dated 1/1/14, identified R39 had diagnoses which included Alzheimer's disease and diabetes mellitus. The MDS also indicated R39 had severe cognitive impairment, required extensive assistance for bed mobility, transfers and ambulation. On 3/5/14, at 7:20 a.m. R39 was observed to received assistance with dressing by nursing assistant (NA)-A. R39 was observed to be able to fully extend his shoulders, elbows, wrists and hands and required the assistance of the NA to dress. R39 was not observed to have limitations of ROM. R39's Occupational Therapy (OT) progress note dated 12/26/13, indicated R39 had shoulder weakness and required a strengthening program to maintain self-dressing, grooming and transferring. The OT discharge summary dated 1/16/14, directed staff to continue a functional maintenance program for activities of daily living and for ROM and strengthening. R39's Restorative Nursing Plan dated 1/20/14, directed staff to assist R39 with hand exercises for twenty repetitions, flex band exercise for five repetitions and to use the arm bike for two minutes. The plan indicated R39's exercise	F 318	**F-318:** R39's care plan was amended on 03.27.2014 to include ROM services by our nursing rehab program. FMP orders for nursing rehab were added to the weekly IDT meeting agenda. See attachment #2. Staff was trained on the new documentation requirements on 04.01.2014. OT will be responsible for updating and communicating with IDT team the residents ROM rehab needs when being added to an FMP. The Rehab Nursing Coordinator will monitor that FMP are being followed and care planned and will report to QA quarterly.	4-10-14

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	245238	A. BUILDING _____ B. WING _____	03/06/2014

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F 318	Continued From page 19 program was to be completed three times per week. R39's plan of care (POC) dated 1/15/14, did not address a ROM program. R39's Rehab documentation indicated the following information: -March 2014, 1-5 R39 had participated in the program 2 out of 5 opportunities. -February 2014, R39 had participated in the program 5 out of 12 opportunities. -January 2014, R39 had participated in the program 2 out of 12 opportunities. On 3/5/14, at 11:11 a.m. the certified occupational therapy assistant (COTA) responsible for implementing R39's exercise program stated he provided R39 with the exercise program a couple times a week. Upon review of the restorative documentation, the COTA confirmed R39 had not completed the established program as often as directed. On 3/5/14, at 1:50 p.m. registered nurse (RN)-A confirmed R39 was to be receiving a restorative program for ROM three times a week to ensure he maintained his current level of mobility. On 3/5/14, at 2:45 p.m. the physical therapist stated R39 was to receive an active ROM program three times a week. On 3/5/14, at 4:15 p.m. the director of nurses (DON) stated the interdisciplinary team reviewed the restorative programs at each care conference. She confirmed R39 was to be	F 318		

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F 318	Continued From page 20 receiving ROM services three times a week. The DON provided the interdisciplinary review sheet dated 1/31/14, which identified R39 had "trouble with not complete all areas of exercise." The DON confirmed the interdisciplinary team had identified a problem with the restorative program, yet they did not develop a system to ensure R39 participated in the program as directed. A restorative program policy was requested but not provided.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F-329:** R10, R39 and R15's care plans were amended on 04.01.2014 to include non-pharmacological approaches to use prior to Ativan use. Care Conference summary amended to add the review of psychotropic medication care planning and potential for GDR. See attachment #1. LSW will complete and anxiety scale quarterly on all residents prescribed an anti-anxiety medication. See attachment #. She will report her findings to nursing if GDR is warranted. Staff was trained on the new documentation requirements on 04.01.2014. LSW to QA Anxiety scale completion with GDR's and report to QA quarterly.	4-10-14

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F 329	Continued From page 21	F 329		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continued use of antianxiety medications for 3 of 3 residents (R10, R39, R15) in the sample who were receiving an as needed (PRN) antianxiety medication.

Findings include:

R10's Diagnosis Report dated 3/5/14, indicated R10's diagnoses included Alzheimer's disease, anxiety, dementia without behavioral disturbance, depressive disorder and tear film insufficiency.

R10's quarterly Minimum Data Set (MDS) dated 12/26/13, indicated R10 had intact cognition. The MDS also indicated R10 reported little to no interest in doing things, feeling tired or having little energy 2-6 days during the assessment period and reported no hallucination, delusions or behavioral symptoms during the assessment period.

R10's Psychotropic Drug Use Care Area Assessment (CAA) dated 4/6/13, indicated R10 stated no feelings of depression with interview. She does get anxious about her eyes and ongoing difficulty related to complaints of pain to them, especially her right eye. She states happy here and could not think of anything to improve her quality of life here, other than fix her eyes.

R10's Physician orders dated 11/21/13, indicated lorazepam (antianxiety) 0.5 milligrams (mg) orally

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F 329	Continued From page 22 twice daily as needed for picking at eyes, anxiety related to nursing home stay, pacing and verbal aggression. R10's Medication Administration Records (MAR) dated 1/1/14, through 3/5/14, indicated the PRN lorazepam had been administered four times in January, five times in February, and three times in March for rubbing, picking and agitation about eyes. Additionally, the MAR indicated R10 was administered lorazepam once in January per family request, prior to an appointment, and once in March for pacing. R10's plan of care (POC) dated 2/3/14, identified non-pharmacological interventions for R10's eye complaints, however lacked direction/coordination for the use of the antianxiety medication in conjunction with the non-pharmacological interventions. Review of R10's Interdisciplinary Progress Notes (IPN) 12/28/13, through 3/3/14, revealed inconsistency in documentation of non-pharmacological interventions prior to the administration of antianxiety medication. On 3/6/14, at 9:14 a.m. licensed practical nurse (LPN)-B stated she would first offer R10 a hot or cold compress for R10's complaints of eye discomfort. She stated that R10 also had scheduled eye drops and PRN eye drops that could be used. LPN-B stated R10 was not administered antianxiety medication often, however, stated use would be indicated when R10 "obsessed about her eyes and worked herself up until she was frantic and crying." LPN-B confirmed that non-pharmacological interventions used were not consistently	F 329		

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F 329	Continued From page 23 implemented or documented in R10's clinical record prior to the administration of the antianxiety medication. R39 did not receive non-pharmacological interventions prior to the administration of anti-anxiety medications. Findings include: R39's initial MDS dated 1/1/14, identified R39 had diagnoses which included Alzheimer's disease and diabetes mellitus. The MDS also indicated R39 had severe cognitive impairment, required extensive assistance for bed mobility, transfers, ambulation and displayed behaviors such as self abusive behaviors and smearing feces. The MDS indicated R39 received anti-anxiety medications daily. R39's psychotropic drug use Care Area Assessment (CAA) dated 1/6/14, indicated R39 had Alzheimer's dementia and restlessness/anxiety associated with the dementia. The assessment directed staff to reorient R39 as possible and administer medications. R39's POC dated 1/15/14, identified R39 as having behavior problems such as fidgeting, restlessness, attempting unsafe self transfers and pulling off incontinence briefs. The POC directed staff to monitor and document side effects and the effectiveness of medications and to provide one to one activities and ensure R39's needs were met. R39's Physician's Orders dated 2/4/14, included an order for Ativan (an anti-anxiety medication)	F 329		

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F 329	Continued From page 24 0.5 mg to be administered every 6 hours PRN for anxiety - fidgeting, restless, up and down and attempting to self ambulate. The order also included Klonopin (a benzodiazepines used for the treatment of panic type disorders) 0.5 mg to be given three times a day as needed for restlessness. On 3/5/14, throughout the day from 7:00 a.m. to 3:30 p.m. R39 was observed. R39 was observed to follow directions given to him by the staff, he was cooperative while receiving cares and was able to sit quietly in common areas. R39 was not observed to display any type of disruptive behavior. R39's February 2014, MAR indicated R39 received four PRN doses of Klonopin 0.5 mg on 2/8/14, 2/14/14, 2/17/14, and 2/22/14. The documented reason for administering the medication included anxious, restlessness, setting off alarm numerous times, standing without help and attempting to get out of bed by himself. Out of the four medications administered, the 2/14/14, was the only dose which had a follow up documentation which indicated "some relief." R39's January 2014, MAR indicated R39 received 11 doses of PRN Ativan 0.5 mg. R39 received the medication on 1/9/14 (two doses), 1/10/13, 1/11/14, 1/12/14 (two doses), 1/13/15, 1/15/15, 1/17/14, 1/28/14 and 1/29/14. The documented reason for the medication administration was noted as "restless." The MAR identified the medication effectiveness as "sleeping" following two administrations. The remaining administration follow up documentation was blank.	F 329		

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F 329	Continued From page 25 Review of R39's Interdisciplinary Progress notes (nurses notes) from 1/9/14 - 2/23/14, lacked indicated of the non-pharmacological interventions attempted prior to the administration of the anti-anxiety medication. On 3/5/14, at 9:40 a.m. licensed practical nurse (LPN)-B stated R39 had not displayed behaviors during the day shift. She stated R39 displayed behaviors in the evening when he was trying to get up independently but confirmed she had not observed any type of behaviors on the day shift. On 3/5/14, at 9:50 a.m. nursing assistant (NA)-F stated R39 did not display behaviors during the day shift and she could not recall R39 having behavior problems. On 3/5/14, at 10:20 a.m. NA-B stated R39's behaviors were related to him attempting to walk on his own. NA-B stated on the evening shift R39 would attempt to stand on his own. She stated R39 was not easily redirected during those times. On 3/5/14, at 10:40 a.m. LPN-C stated R39 displayed behaviors such as being fidgeting and attempting to stand. She stated R39 was not directable during these times and the behaviors were not easily redirected. She stated R39 mostly displayed behaviors on the evening shift. In addition, LPN-C stated she could not describe non-pharmacological interventions which could have been attempted prior to the administrations of medications. On 3/5/14, at 2:05 p.m. registered nurse (RN)-A stated R39 received anti-anxiety medications for	F 329		

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F 329	Continued From page 26 the treatment of increased restlessness. She confirmed R39's medical record did not instruct nor direct the staff as to which type of non-pharmacological interventions were to be attempted prior to the administration of the medications. She confirmed R39 displayed behaviors and the staff were to attempt non-pharmacological interventions prior to the administration of anti-anxiety medications. R15 did not receive non-pharmacological interventions prior to the administration of anti-anxiety medications. R15's annual MDS dated 12/31/13, identified R15 as having diagnoses including dementia, depression, anxiety and Parkinson's disease. The MDS indicated R15 had moderate memory impairment and required extensive assistance with all activities of daily living. The MDS also indicated R15 had expressed feelings of being down or depressed once during the assessment period. The assessment did not indicate R15 had episode of anxiety during the assessment period. R15's Mood CAA dated 1/6/14, identified R15 as having episodes of negative statements and feeling weepy. The CAA indicated R15 benefited from taking PRN Ativan when she requested. R15's POC dated 1/8/14, identified R15 had dementia, but it did not address R15 as requiring medication for anxiety and it did not include non-pharmacological interventions to be attempted prior to the use of medications.	F 329		

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F 329	Continued From page 27 R15's current Physician's Orders dated 12/31/13, included an order for Ativan 0.5 mg to be given three times a day PRN for anxiety. Review of R15's MARs revealed the following: - January 2014, R15 had received 17 doses of PRN Ativan per her request for "nerves." The medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. - February 2014, R15 had received five doses of PRN Ativan per her request. The medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. -March 2014, 3/1- 3/5/14, R15 had not requested PRN Ativan. Throughout observations on 3/5/14, from 7:00 a.m. to 3:30 p.m. R15 was observed to be polite, alert, followed directions from the staff and carried on conversations with other residents and visitors without difficulty. R15 was not observed to display any type of behavioral concerns during the observation. R15's medical record did not include documentation of non-pharmacological interventions attempted prior to the administration of the medication. On 3/5/14, at 2:40 p.m. LPN-D stated R15 would become out of breath and will request the medication. She stated R15 calls the medication her "shaky pill." LPN-D stated she administered R15 the medication per her request and stated R15 would not have any further complaints. LPN-D stated she did not attempt any type of	F 329		

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F 329	Continued From page 28 non-pharmacological interventions prior to the administration of the medication. On 3/5/14, at 2:55 p.m. NA-D stated R15 would sit and worry about personal changes and things/activities around her. NA-D stated R15 would become very anxious in which NA-D would inform the medication nurse who administered the medication which seemed to help. On 3/5/14, at 3:00 p.m. LPN-C stated R15 did not have outward behaviors but stated R15 would request medications for her nerves. She confirmed R15 would become anxious and may not outwardly show the anxious feelings in behaviors, but will request the medication. LPN-C stated once R15 felt the need for the medication, it was too late for non-pharmacological interventions. LPN-C confirmed she does not attempt non pharmacological interventions prior to the administration of R15's prn Ativan. On 3/5/14, at 3:05 p.m. NA-D stated R15 would become anxious and report false information. She stated when R15 became anxious, she would report to the medication nurse and R15 would be given a pill for anxiety. On 3/5/13, at 2:45 p.m. RN-A confirmed R15 received PRN anti-anxiety medications and the facility did not identify any type of non-pharmacological interventions to be attempted prior to administration. The facility's Medication Orders policy dated 3/2013, directed the staff to ensure any as needed psychotropic medication was to include the identified behavior the mediation was to	F 329		

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F 329	Continued From page 29 reduce. However; the policy did not direct the staff to attempt non-pharmacological interventions prior to the administration of the medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the licensed pharmacist reported medication irregularities related to the use of as needed (PRN) anti-anxiety medication without non pharmacological interventions in place to the attending physician and the director of nursing to be acted upon for 2 of 3 residents (R39, R15) in the sample who required a report. Findings include: R39 received PRN anti-anxiety medication and the consultant pharmacist did not identify nor report to the facility R39's lack of non-pharmacological interventions to be attempted prior to the administration of the medication.	F 428	**F-428**: On 03.29.2014, the consultant pharmacist review form was changed to add a notification to alert MD/DON that a psychotropic prn medication was given without prior non-pharmacological interventions before medicating. See attachment # 6. A new prn documentation form was created for staff to list appropriate interventions prior to medicating. See attachment #3. Staff was trained on the new documentation requirements on 04.01.2014. DON to QA compliance with pharmacy review documentation and report to QA quarterly.	4-10-14

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F 428	Continued From page 30 R39's initial Minimum Data Set (MDS) dated 1/1/14, identified R39 had diagnoses which included Alzheimer's disease and diabetes mellitus. The MDS also indicated R39 had severe cognitive impairment, required extensive assistance for bed mobility, transfers, ambulation and displayed behaviors such as self abusive behaviors and smearing feces. The MDS indicated R39 received anti-anxiety medications daily. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 1/6/14, indicated R39 had Alzheimer's dementia with restlessness/anxiety associated with the dementia. The assessment directed staff to reorient R39 as possible and administer medications. R39's plan of care (POC) dated 1/15/14, identified R39 as having behavior problems such as fidgeting, restlessness, attempting unsafe self transfers and pulling off incontinence briefs. The POC directed staff to monitor and document side effects and the effectiveness of medications and to provide one to one activities and ensure R39's needs were met. R39's Physician's Orders dated 2/4/14, included an order for Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered every 6 hours PRN for anxiety - fidgeting, restless, up and down and attempting to self ambulate. The order also included Klonopin (a benzodiazepines used for the treatment of panic type disorders) 0.5 mg to be given three times a day as needed for restlessness. On 3/5/14, throughout the day from 7:00 a.m. to	F 428		

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F 428	Continued From page 31	F 428		

3:30 p.m. R39 was observed. R39 was observed to follow directions given to him by the staff, he was cooperative while receiving cares and was able to sit quietly in common areas. R39 was not observed to display any type of disruptive behavior.

R39's February 2014, Medication Administration Record (MAR) indicated R39 received four PRN doses of Klonopin 0.5 mg on 2/8/14, 2/14/14, 2/17/14, and 2/22/14. The documented reason for administering the medication included anxious, restlessness, setting off alarm numerous times, standing without help and attempting to get out of bed by himself. Out of the four medications administered, the 2/14/14, was the only dose which had a follow up documentation which indicated "some relief."

R39's January 2014, MAR indicated R39 received 11 doses of PRN Ativan 0.5 mg. R39 received the medication on 1/9/14 (two doses), 1/10/13, 1/11/14, 1/12/14 (two doses), 1/13/15, 1/15/15, 1/17/14, 1/28/14 and 1/29/14. The documented reason for the medication administration was noted as "restless." The MAR identified the medication effectiveness as "sleeping" following two administrations. The remaining administration follow up documentation was blank.

Review of R39's Interdisciplinary Progress notes (nurses notes) from 1/9/14 - 2/23/14, lacked indicated of the non-pharmacological interventions attempted prior to the administration of the anti-anxiety medication.

Review of R39's Pharmacist Drug Regimen Review forms dated 1/30/14, and 2/26/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 32 revealed a lack of documentation related to the lack of identification and implementation of non-pharmacological interventions to be used by staff prior to the administration of anti-anxiety medications. On 3/5/14, at 2:05 p.m. registered nurse (RN)-A stated R39 received anti-anxiety medications for the treatment of increased restlessness. She confirmed R39's medical record did not direct staff as to which type of non-pharmacological interventions were to be attempted prior to the administration of the medication. She confirmed R39 displayed behaviors and the staff were to attempt non-pharmacological interventions prior to the administration of anti-anxiety medications. She confirmed the pharmacist had not identified any concerns related to non-pharmacological interventions prior to the administration of the medication. R15 received PRN anti-anxiety medication and the consultant pharmacist did not identify nor report to the facility R15's lack of non-pharmacological interventions to be attempted prior to the administration of the medication. R15's annual MDS dated 12/31/13, identified R15 as having diagnoses including dementia, depression, anxiety and Parkinson's disease. The MDS indicated R15 had moderate memory impairment and required extensive assistance with all activities of daily living. The MDS also indicated R15 had expressed feelings of being	F 428		

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F 428	Continued From page 33 down or depressed once during the assessment period. The assessment did not indicate R15 had an episode of anxiety during the assessment period. R15's Mood CAA dated 1/6/14, identified R15 as having episodes of negative statements and feeling weepy. The CAA indicated R15 benefited from taking PRN Ativan when she requested. R15's POC dated 1/8/14, identified R15 had dementia, but it did not address R15 as requiring medication for anxiety and it did not include non-pharmacological interventions to be attempted prior to the use of medications. R15's current Physician's Orders dated 12/31/13, included an order for Ativan 0.5 mg to be given three times a day PRN for anxiety. Review of R15's MARs revealed the following: - January 2014, R15 had received 17 doses of PRN Ativan per her request for "nerves." The medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. - February 2014, R15 had received five doses of PRN Ativan per her request. The medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. -March 2014, 3/1- 3/5/14, R15 had not requested PRN Ativan. Throughout observations on 3/5/14, from 7:00 a.m. to 3:30 p.m. R15 was observed to be polite, alert, followed directions from the staff and carried on conversations with other residents and	F 428		

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F 428	Continued From page 34 visitors without difficulty. R15 was not observed to display any type of behavioral concerns during the observation. R15's medical record did not include documentation of non-pharmacological interventions attempted prior to the administration of the medication. R15's monthly Pharmacist's Medication Regimen Review forms completed from 7/26/12 - 2/26/14, revealed a lack of documentation related to the lack of identification and implementation of non-pharmacological interventions to be used by staff prior to the administration of anti-anxiety medication. On 3/5/13, at 2:45 p.m. RN-A stated R15 received PRN anti-anxiety medications and confirmed the facility did not identify any type of non-pharmacological interventions to be attempted prior to administration. On 3/5/14, at 10:15 p.m. the consultant pharmacist was interviewed via telephone. The pharmacist verified non-pharmacological interventions were to be attempted prior to the administration of as needed medication. The consultant confirmed she had not identified this as a concern to the facility but stated it would be an expected practice. The Pharmacy Review policy dated 3/2013, directed the consultant pharmacist to communicate any drug irregularities to the facility.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 35 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F-441 It** is the policy of Mahnomen Health Center to adhere to IC practices by issuing a new glucometer to all newly admitted residents requiring accu checks. On 03.06.2014 all community glucometers were discarded and new glucometers were issued to those who had not received them. Each med cart is now stocked with each individual glucometer and bleach wipes for cleaning. On 3.11.2014, all nursing staff was educated on proper cleaning and disinfection. RN to QA accu check completion and appropriate disinfection and cleaning and report to QA quarterly.	4-1-14

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F 441	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were followed while providing blood glucose monitoring with a community glucometer for 4 of 4 residents (R26, R4, R37, R24) observed to utilize the community glucometer. Findings include: On 3/3/14, at 6:51 p.m. licensed practical nurse (LPN)-A was observed to conduct a blood glucose check on R26 who was seated in the facility common area. After completing the glucometer check, LPN-A returned to the medication cart with the glucometer and was observed to wipe the glucometer off with an alcohol prep wipe. LPN-A confirmed most residents had their own glucometers in their room, however stated when the resident was in the common area it was more efficient to utilize the community glucometer which was stored in the medication cart. LPN-A verified the facility practice was to wipe down the glucometer with an alcohol wipe after each resident use. LPN-A provided a sample of the alcohol prep wipe, which indicated it contained 70% isopropyl alcohol. On 3/3/14, at 7:00 p.m. LPN-A was observed to use the same community glucometer and conduct a blood glucose check on R4 who was seated in the main common area. Upon completion of the glucometer check, LPN-A was observed to return to the medication cart and wipe the glucometer off with an alcohol prep wipe.	F 441		

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F 441	Continued From page 37 On 3/3/14, at 7:15 p.m. LPN-A utilized the same community glucometer and conducted a blood glucose check on R37 who was in their own room. LPN-A confirmed R37 did not have her/his own glucometer. Upon completion of the glucometer check, LPN-A was observed to return to the medication cart and wipe the glucometer off with an alcohol prep wipe. On 3/3/14, at 7:22 p.m. LPN-A utilized the same community glucometer and conducted a blood glucose check on R24 while seated in the main common area. upon completion of the glucometer check, LPN-A was observed to return to the medication cart and wipe the glucometer off with an alcohol prep wipe. On 3/4/14, at 1:47 p.m. the director of nursing (DON) confirmed the facility did utilize a community glucometer and her expectation was glucometers were to disinfected with either an alcohol or bleach wipe after each resident use. DON stated the bleach wipes were hard on the glucometer machines and sometimes left a film on the glucometer. The facility's Blood Sampling-Capillary (Finger Sticks) policy dated 3/2013, directed staff to wipe any visible blood from the spring-loaded device with an alcohol pledget and to follow manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. On 3/5/14, the DON provided the glucometer manufacturer's guidelines, which specifically directed users to not utilize alcohol to clean the glucometers.	F 441		

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Attachment #1

MHC
MANOMEN HEALTH CENTER

Assessment Type: Admit___ Quarterly___ Sig Change___ Medicare___ Annual___

Resident:_____ **Date:**_____

Diagnosis:_____

Pain/Interventions:_____

_____

Current Medications: **Refer to MAR**

Psychotropic Med Review: Are all psychotropic medications care planned with non-pharmacological interventions? Have prn medications been utilized?_____

_____

_____

Depression Scale:_____
Anxiety Scale:_____
Is GDR indicated at this time?_____

Fall History/Interventions:_____

_____

Infection Control Issues:_____

_____

Skin Integrity:_____

_____

Dignity:_____

_____

Bath Summary:_____

Dietary Preferences:_____

Sleep/Wake Preferences:_____

Vitals/Wts:_____

Safety/Self Preservation: **Staff to provide safe, well lit and clutter free environment. Staff to provide physical and emotional support in an emergency. Call light in place at all times. Bed in lowest position deemed safe for resident.**

Attachment # 1, cont.

Late Loss ADL Summary: (Toileting, Bed Mobility, Transferring, Eating)_____

_____

_____

_____

_____

Stability:_____

Discharge Potential:_____

Care Conference Summary:
Nursing:_____

_____

_____

_____

Dietary:_____

_____

_____

_____

Activities:_____

_____

_____

Social Services:_____

_____

_____

NursingRehab: to include progress toward goals, treatment programs, care plan changes needed._____

_____

_____

_____

Resident/Family want_____**or decline**_____**bi-annual physical.**

Family Concerns/Need for Follow Up:
1.

2.

3.

Conference Attendees:

_____ _____

_____ _____

_____ _____

Care Plan Coordinator:_____ **Date:**_____

Attachment # 2

THURSDAY MORNING IDT/ AQREVA TELEPHONE MEETING **Date:**_____

Therapy: PT/OT/ST

Medicare A Residents:	**Medicare B Residents:**	**Medicaid Residents:**
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____

For those residents being discharged from PT/OT/ST to a Nursing Rehab program, has an FMP been completed and given to Nursing/Nursing Rehab for follow up/care planning purposes?_____

_____

Hospice Residents- Care Plans in Chart/Current

1._____ _____ Y or N

2._____ Y or N

3._____ Y or N

Discharges: _____ Date_____

_____ Date_____

Deaths: _____ Date_____

_____ Date_____

Admissions: _____ Date_____

From: _____

PAS Done? YES / NO Insurance:_____

Billing Admission Paperwork Done? YES / NO

Falls:_____

ER Visits: _____

Hospital Admissions: _____

Hospital Discharges: _____

Transfers:_____

New Wounds: _____

New Treatments for New Wounds: _____

New Antibiotics: _____

New Psychotropics: _____

Residents due for GDR:_____

New Treatments: _____

Narcotic Book Review completed by DON or RN designee_____

Attachment #2, cont.

Nursing Rehab Monthly Meeting Minutes: Are residents meeting goals? Do changes need to be made to CP? Does FMP need to be changed? New rehab plan needed?_____

Ambulation Program:_____

ROM Program: _____

Attendance Signatures:_____ _____ _____

_____ _____ _____

_____ _____ _____

Attachment #3

DATE:	TIME:	INDICATION: (ie. pain site/pain scale, behavior – BE SPECIFIC)	NON-PHARMALGOCIAL APPROACH OR INTEVENTION PRIOR TO MED:	DRUG/DOSE:	ROUTE OR SITE	OUTCOME: (ie. pain scale, change in behavior)	SIGNATURE

PRN SHEET

ALLERGIES: _____

_____

MR# _____

MONTH: _____

RESIDENT NAME: _____

Attachment # 4

TOILETING/REPOSITIONING SCHEDULE

	CHECK & REPOSITION Q2HOURS, CHANGE PRN	TOILET & REPOSITION
12A	Ken C., Florentine B., Agnes R., Rolland F. Arlene N., Ron S.	Mary D., Edna V, Leslie H., Darrell W.
1A		Francis D., Margaret K., Warren W.
2A	Ken C., Florentine B., Agnes R., Rolland F. Arlene N., Ron S.	Mary D., Edna V., Darrell W.
3A		Margaret K., Warren W., Leslie H.
4A	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Mary D., Edna V., Darrell W.
5A		Francis D., Margaret K., Warren W.
6A	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Mary D., Leslie H.
7A		Francis D. , Margaret K., Edna V., Warren W., Darrell W., Paul M., Linda H.
8A	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D., Marion P.
9A		Warren W., Leslie H., Darrell W., Paul M.
10A	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Margaret K., Mary D., Ron S. (for BM), Roland F. (for BM), Marion P.
11A		Francis D. , Leslie H., Paul M., Linda H.
12P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D., Margaret K., Mary D., Warren W. , Darrell W., Marion P.
1P		Paul M.
2P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D. , Mary D., Warren W. , Leslie H., Marion P.
3P		Margaret K., Paul M.
4P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Darrell W., Marion P., Linda H.
5P		Francis D. , Margaret K., Mary D., Warren W., Leslie H., Paul M.
6P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D., Darrell W., Marion P.
7P		Margaret K., Mary D. , Edna V., Paul M.
8P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D., Leslie H., Marion P.
9P		Margaret K., Warren W., Paul M.
10P	Ken C., Florentine B., Agnes R., Roland F. Arlene N., Ron S.	Francis D., Mary D., Warren, Leslie H., Darrell W.
11P		Margaret K.

*Peri-care/skin barrier with incontinent episodes.
*Toileting can consist of standard toilet, commode, bedpan, or urinal.
*Can set resident on toilet with check change schedule to promote elimination in toilet.
*Report to RN for any re-evaluation needed regarding schedule.
*Reposition any residents who have not repositioned self

Attachment #5

MAHNOMEN HEALTH CENTER
ZUNG SELF-RATING ANXIETY SCALE

Name _____ Date _____
Examiner _____ Score _____

SYMPTOMS	None of the time	Some of the time	A good part	Most or all
1. I feel more nervous and anxious than usual.	0 pts	2 pts	3 pts	4 pts
2. I feel afraid for no reason at all.	0 pts	2 pts	3 pts	4 pts
3. I get upset easily or feel panicky.	0 pts	2 pts	3 pts	4 pts
4. I feel like I'm falling apart and going to pieces.	0 pts	2 pts	3 pts	4 pts
5. I feel that everything is all right and nothing bad will happen.	4 pts	3 pts	2 pts	0 pts
6. My arms and legs shake and tremble.	0 pts	2 pts	3 pts	4 pts
7. I am bothered by headaches or neck and back pain.	0 pts	2 pts	3 pts	4 pts
8. I feel weak and get tired easily.	0 pts	2 pts	3 pts	4 pts
9. I feel calm and can sit still easily.	4 pts	3 pts	2 pts	0 pts
10. I can feel my heart beating fast.	0 pts	2 pts	3 pts	4 pts
11. I am bothered by dizzy spells.	0 pts	2 pts	3 pts	4 pts
12. I have fainting spells or feel like it.	0 pts	2 pts	3 pts	4 pts
13. I can breathe in and out easily.	4 pts	3 pts	2 pts	0 pts
14. I get feelings of numbness and tingling in my fingers and toes.	0 pts	2 pts	3 pts	4 pts
15. I am bothered by stomachaches or indigestion.	0 pts	2 pts	3 pts	4 pts
16. I have to empty my bladder often.	0 pts	2 pts	3 pts	4 pts
17. My hands are usually dry and warm.	4 pts	3 pts	2 pts	0 pts
18. My face gets hot and blushes.	0 pts	2 pts	3 pts	4 pts
19. I fall asleep easily and get a good night's rest.	4 pts	3 pts	2 pts	0 pts
20. I have nightmares.	0 pts	2 pts	3 pts	4 pts
Total in each column				

SCORING:		Column 1 _____
< 45	No Anxiety	Column 2 _____
45-59	Minimal Anxiety	Column 3 _____
60-74	Marked to Severe Anxiety	Column 4 _____
75+	Extreme Anxiety	
		TOTAL SCORE

Current psychotropic medications _____
_____
_____
_____

Provider Signature _____ Date _____

Attachment #6

Consultant Pharmacist Medication Review

Resident Name_____Date_____

Comments: (Psychotropic PRN medications require non-pharmacological interventions prior to medicating. Note any med pass issues found.)

Pharmacist Signature_____

Physician/RN review and response:

Review forwarded to Specialist for review: Y____ N____ Date_____
Specialist Recommendations_____

PCP/RN signature verifying med review completion:
_____Date_____

Mahnomen Health Center
Maintenance Policy

Fire Drills

Policy: MHC's Facility Director will be responsible for managing the Fire Drills. The Drills will be conducted following NFPA 19.7.1.2 guidelines.

Purpose: It is the mission of MHC to provide a safe environment for residents, patients, visitors and staff. Fire Alarm systems will be functioning for this purpose with periodic testing required to familiarize MHC staff with signals and emergency action under varied conditions.

Procedure:

1. Drills will be conducted quarterly on each shift
2. The times of the drills will need to be conducted at variable time intervals three hours and greater. IE: one day shift scheduled at 9 a.m. will need to have the next one scheduled after 12 pm.
3. When Drills are conducted between 9 pm and 6 am, coded announcement shall be permitted instead of audible alarms, for resident comfort.
4. Bed ridden patients shall not be required to be removed during drill to safe areas or exterior of the building.
5. A list of participants will be required to sign in on the designated Fire Drill Report Form.
6. Participates will be updated on their performance. Corrections will be made.
7. All MHC staff will be responsible for annual mandatory education of MHC Fire Plan, RACE, and fire safety and evacuation.
8. Facility Director will complete the Fire Drill Report form and keep it on file in the FD's office.

Attention: Lyla Burkman

RE: Mahnomen Health Center Survey 3/03/2014:

Addendum:

F-279: Nursing will be responsible for monitoring the inclusion of the hospice care plans and anti-anxiety care plans weekly at IDT meetings and report to QA quarterly.

F-280: The delegated RN and Nursing Rehab coordinator will monitor care plans weekly x 1 month and monthly thereafter.

F-282: R-39's care plan was amended on 04.01.2014 to include his individualized toileting and repositioning needs. RN to monitor compliance with T/R form weekly and report to QA quarterly.

F-311: Orders from PT for an FMP will be monitored weekly at IDT. Report to QA quarterly.

F- 312: R-39's care plan was updated on 04.01.2014 to add his individualized toileting needs. RN to monitor compliance with T/R form weekly and report to QA quarterly.

F-314: R-39's care plan was updated on 04.01.2014 to add his individualized repositioning needs. RN to monitor compliance with T/R form weekly and report to QA quarterly.

F-318: Orders from OT for an FMP will be monitored weekly at IDT. Report to QA quarterly.

F- 329: LSW to QA Anxiety scale completion with potential GDR's weekly and report to QA quarterly.

F- 428: R39 and R15's care plans were amended on 04.01.2014 to include non-pharmacological approaches to use prior to Ativan use. DON to QA compliance with pharmacy review documentation monthly and report to QA quarterly.

F-441: RN to QA accu check completion, appropriate disinfection and cleaning weekly and report to QA quarterly.

Respectfully submitted,

Rachel M. Tuenge RN, DON

Rachel M. Tuenge, RN DON

04.11.2014

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	245238	A. BUILDING 01 - 1969 BUILDING WITH 1975 ADDITION B. WING _____	03/05/2014

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MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	K 000	POC ok TB 4-8-14 RECEIVED APR - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 3-6-14 DC: 4-15-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	4/3/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/05/2014**

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K 000	Continued From page 1 Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Automatic fire detectors are in all hazardous areas in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 48 beds and had a census of 32 at the time of the survey. Since the construction types of both buildings comply with the NFPA 101 "The Life Safety Code" and the facility is fully sprinkler protected, the facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records and interview, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 32. Findings include: On facility tour between 9:30 AM and 12:30 PM on 3/05/2014 a review of the available fire drill reports revealed that the facility's Evening-shift fire drills between 6:00 PM, 4:25 PM, 6:30 PM, 4:14 PM, Night-shift between 1:30 AM, 4:00 AM, 2:00 AM, 1:00 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050	**K050:** Fire drills will be done quarterly with times varying per facility policy. See attachment # 7. Will be monitored by Facility Director and compliance reported to QA quarterly.	4/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Attachment # 7

MHC 13.2

Mahnomen Health Center
Maintenance Policy

Fire Drills

Policy: MHC's Facility Director will be responsible for managing the Fire Drills. The Drills will be conducted following NFPA 19.7.1.2 guidelines.

Purpose: It is the mission of MHC to provide a safe environment for residents, patients, visitors and staff. Fire Alarm systems will be functioning for this purpose with periodic testing required to familiarize MHC staff with signals and emergency action under varied conditions.

Procedure:

1. Drills will be conducted quarterly on each shift
2. The times of the drills will need to be conducted at variable time intervals three hours and greater. IE: one day shift scheduled at 9 a.m. will need to have the next one scheduled after 12 pm.
3. When Drills are conducted between 9 pm and 6 am, coded announcement shall be permitted instead of audible alarms, for resident comfort.
4. Bed ridden patients shall not be required to be removed during drill to safe areas or exterior of the building.
5. A list of participants will be required to sign in on the designated Fire Drill Report Form.
6. Participates will be updated on their performance. Corrections will be made.
7. All MHC staff will be responsible for annual mandatory education of MHC Fire Plan, RACE, and fire safety and evacuation.
8. Facility Director will complete the Fire Drill Report form and keep it on file in the FD's office.