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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5H9J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **06/08/2015** (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 **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 06/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/21/2015
(L33)

Posted 06/09/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245401

June 8, 2015

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

Dear Mr. Pelovsky:

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 May 11, 2015 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 8, 2015

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401024

Dear Mr. Pelovsky:

On May 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 23, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On June 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 18, 2015 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 April 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 11, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 23, 2015, effective May 11, 2015 and therefore remedies outlined in our letter to you dated May 5, 2015, 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.

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

Sincerely,

Mark Meath

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245401	A. Building B. Wing	6/8/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/11/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/11/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/11/2015**
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	Date:	Signature of Surveyor:	Date:
	GL/mm	06/08/2015	15507	06/08/2015
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
4/23/2015			

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
245401	01 - MAIN BUILDING 01	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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 K0048	Correction Completed 05/11/2015	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 05/11/2015	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 PS/mm	Date: 06/08/2015	Signature of Surveyor: 35482	Date: 05/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5H9J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**

2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/23/2015** (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 **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jane Teipel, HFE NEII — 05/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/21/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 5, 2015

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401024

Dear Mr. Pelovsky:

On April 23, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 June 2, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 23, 2015 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

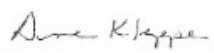
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		5/11/15

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

Electronically Signed | 05/11/2015

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

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	245401	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate notice of the right to request a demand bill when Medicare benefits ended for 1 of 3 residents (R43) reviewed for liability notice. Findings include: R43 was admitted to the facility on 1/27/15. R43 was discharged from Medicare non-coverage on 2/10/15, signed the notice of Medicare non-coverage form on 2/10/15, and was discharged from the facility on 2/11/15. On 4/22/15, at 10:15 a.m. the Centers of Medicare and Medicaid Services (CMS) form 10123 was reviewed for R43. The form lacked documentation showing R43 had been provided a	F 156	Central Health Care ensures that the resident will receive oral and in writing in a language that the resident understands of Medicare A denial upon admission, readmission, continued of stay with 48 hour notice of skilled services ending. The Director of Nurse and therapy Supervisor have been both reeducated and reviewed the policy and procedure on 03-24-15 and understand that the resident must be given a 48 hour notice when skilled services are ending. The DON and therapy supervisor will work closely and communicate with each other as resident services and pay sources changes. Therapy, the DON , ADON and billing personal will continue to have weekly Medicare A meeting to discuss progress	

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F 156	Continued From page 3 48-hour notice as required before Medicare services ended. On 4/22/15, at 10:50 a.m. the director of nursing confirmed she should have given R43 the CMS form 10123 48-hours prior to when services ended. A policy and procedure for demand bill/liability notices was requested, but was not provided.	F 156	of residents skilled need for services and Medicare A days remaining.	
F 279 SS=E	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). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 279	F279 Central Health Care ensures that	5/11/15

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F 279	Continued From page 4 review, the facility failed to care plans were developed for 3 of 3 residents (R37, R30, R11) observed with bruising and/or abrasions. In addition, the facility failed to ensure a care plan was developed for all hospice services for 1 of 1 resident (R32) reviewed for hospice. Findings include: R37 was observed on 4/21/15, at 7:41 a.m. with isolated small bruises on the backs of both hands. R37 had been taking the anticoagulant medication Coumadin, (known to contribute to bruising) which was discontinued the day prior on 4/20/15. R37's care plan dated 3/25/15, and Interim Plan of Care dated 4/14/15, lacked direction for staff to implement measures to minimize bruising risks, or to identify, monitor and assess bruises should they occur. A Weekly Skin Assessment dated 4/15/15 indicated both of the resident's arms "have some discoloration" and on 2/25/15, "bruising fading on arms" was documented. No descriptions such as exact locations, sizes, colors, etc. of the individual bruises were documented. On 4/23/15, at 7:55 a.m. the director of nursing (DON) was interviewed about R37's bruises and reported, "With the Coumadin therapy we kind of expect that. Her care plan says be extra careful because they bruise easily." She added that for new bruises staff, "would fill out an incident report for me and I would follow up with that." The DON acknowledged the plan did not reflect interventions related to bruising potential, and stated, "If there's somebody that has a lot of	F 279	the individual care plans have been reviewed and revised as needed to address resident bruising and approaches to prevent further bruising as able for R37 on 04-23-15 and R30 on 4-22-15. For R11 care plan was reviewed and revised on 4-22-15. On 4-24-2015 reviewed and revised policy and procedures as needed for bruising, skin tear, care planning and skin assessment. Policy and Procedures where given, reviewed and reeducated licensed staff on 04-28-2015. Reeducated staff on incident reports and documentation on 04-28-2015 On 04-28-2015 educated NAR to observe skin daily for changes, redness, bruising, skin tear or any changes in the skin and report to the charge nurses as needed. On 04-21-15 and on 4-22-2015 discussed with the hospice program in place for R32 regarding getting a schedule and notes form hospice, the hospice program for R32 was unwilling to work with facility on collaboration of care with resident. Central Health Care team has choose to longer have that particular hospice at facility on 04-23-2015. 04-24-2015 Reviewed and revised policy and procedure as needed for hospice program. Educated licensed staff of needing schedule of services on 04-24-2015	

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bruising it should be care planned; there isn't one here."

R30 was observed on 4/21/15, at 5:25 p.m. to have a very large oblong purple bruise on the right side of her face that started from just below her right check bone to the chin. R30 was interviewed at the time of the observation, and thought she had fallen a month ago outside on a patch of ice.

R30 care plan dated 1/23/15, indicated the resident was cognitively impaired and had impaired decision making ability. She also had a history of falls, required assistance of two staff for repositioning due to a hip fracture. The plan, however, lacked individualized measures for minimizing the risk of further bruising or monitoring and documentation of bruises. R30's Weekly Skin Assessment sheets from 3/17/15 to 4/14/15 were signed by a RN, and lacked any notations of brushing to R30's face.

On 4/22/15, at 12:37 p.m. the DON verified a temporary care plan had not been initiated to addressed the problem.

R11 was interviewed on 4/20/15, at 5:51 p.m. An abrasion approximately one inch in length was visible just behind the resident's glasses on the right side of her nose. The abrasion was scabbed over. R11 was unaware of the origin of the abrasion. The following day R11 reported at 10:54 a.m. that the abrasion did not hurt, and may have resulted from dry skin. The abrasion appeared unchanged.

The care plan for R11 dated 8/10/14 lacked identification or monitoring of the skin abrasion.

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F 279	Continued From page 6 The treatment administration sheet (TAR) verified R11 received a weekly skin check on 4/18/15 during the evening shift. No alteration in skin integrity was identified. The nursing notes 4/1/15 to 4/22 lacked identification or monitoring of the skin abrasion. In addition, the facility's Weekly Skin Assessment Sheet dated 4/29/15, indicated R11's skin was intact. On 4/22/15, at 8:40 a.m. a registered nurse (RN)-B explained nursing was to initiate a temporary care plan regarding the problem, but neither had been completed for R11's abrasion on her face. During an interview on 4/23/15, at 9:06 a.m. the DON stated she expected staff to have initiated a temporary care plan. The facility's 4/14 For Purple/Discolored [bruising] Area Policy policy instructed staff to fill out an incident report, update the physician and family and put a temporary care plan into place. The facility's 6/14, Skin Tear Policy and Procedure directed staff to ensure a temporary care plan was initiated. R32's record revealed that although the resident was receiving hospice benefits, all hospice services were not coordinated. After the surveyor was unable to find a hospice coordinated plan in R32's medical record on 4/21/15, at 11:19 a.m. RN-A located the Advantage Hospice care plan in the overflow charting file. The DON then stated she expected R32's hospice care plan would have be located in the resident's chart. She thought perhaps due to	F 279		

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F 279	Continued From page 7 new staff, the care plan may have been "thinned" from the resident's medical record by mistake. The DON stated she would have expected a calendar or another form of communication from the hospice agency to have been readily available in order to coordinate care between the agency and the facility. On 4/21/15 at 10:01 a.m. the hospice RN was interviewed via telephone and explained "to the best of my knowledge" that the other disciplines including massage therapy, music therapy, social services, and the chaplain called ahead or put the information in their notes. On 4/22/15, at 12:17 p.m. the DON stated the facility was aware that NAs visited twice each week and a nurse came every Thursday. She further stated the social worker, chaplain, music and massage therapists, however, "just show up." The 1/9/15 Hospice Program Policy dated indicated all hospice services were provided under contractual agreement, that outlined responsibilities of the facility and the hospice agency. In addition, a coordinated plan of care between the facility, the hospice agency and the family "will be developed and hospice providers who contract with the facility are held responsible for meeting the same professional standards and timelines of service as any contracted agency or individual associated with the facility."	F 279		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		5/11/15

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F 309	Continued From page 8 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure non-pressure related skin conditions were identified and monitored for 3 of 3 residents (R37, R30, R11) observed with bruising and/or abrasions. In addition, the facility failed to coordinate hospice services for 1 of 1 resident (R32) reviewed for hospice. Findings include: R37 was observed on 4/21/15, at 7:41 a.m. with isolated small bruises on the backs of both hands. R37 had been taking the anticoagulant medication Coumadin, (known to contribute to bruising) which was discontinued the day prior on 4/20/15. A Weekly Skin Assessment dated 4/15/15 indicated both of the resident's arms "have some discoloration" and on 2/25/15, "bruising fading on arms" was documented. No descriptions such as exact locations, sizes, colors, etc. of the individual bruises were documented. R37's care plan dated 3/25/15, included a handwritten notation indicating: "FYI [for your information]: Coumadin stop date 4/20/15." An Interim Plan of Care dated 4/14/15, lacked direction for staff to implement measures to minimize bruising risks, or to identify, monitor and	F 309	F309 Central Health Care ensures that the individual care plans have been reviewed and revised as needed to address resident bruising and approaches to prevent further bruising as able for R37 on 04-23-15 and R30 on 4-22-15. For R11 care plan was reviewed and revised on 4-22-15. On 4-24-2015 reviewed and revised policy and procedures as needed for bruising, skin tear, care planning and skin assessment. Policy and Procedures where given, reviewed and reeducated licensed staff on 04-28-2015. Reeducated staff on incident reports and documentation on 04-28-2015 On 04-28-2015 educated NAR to observe skin daily for changes, redness, bruising, skin tear or any changes in the skin and report to the charge nurses as needed.	

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assess bruises should they occur.

A nursing assistant (NA)-A familiar with R37 stated on 4/22/15, at 10:11 a.m. "I saw the bruising, but I don't know how it happened. It's been there a while."

On 4/23/15, at 7:55 a.m. the director of nursing (DON) was interviewed about R37's bruises and reported, "With the Coumadin therapy we kind of expect that. Her care plan says be extra careful because they bruise easily." She added that for new bruises staff, "would fill out an incident report for me and I would follow up with that."

The DON then verified the documentation lacked specific information, and said it "isn't really telling where specific bruises are, but the general body area where they are is circled." The DON acknowledged it would have been difficult to know when new bruising had occurred. Although a care plan related to Coumadin had been develop, the DON acknowledged the plan did not reflect interventions related to bruising potential, and stated, "If there's somebody that has a lot of bruising it should be care planned; there isn't one here."

R30 was observed on 4/21/15, at 5:25 p.m. to have a very large oblong purple bruise on the right side of her face that started from just below her right check bone to the chin. R30 was interviewed at the time of the observation, and thought she had fallen a month ago outside on a patch of ice.

A nursing note on 3/28/15, at 2:00 a.m. indicated R30 was found sitting on the floor in the bathroom. Staff noted the resident sustained an

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abrasion and swelling to her right outer eye. The incident/accident report dated 3/30/15, indicated the interdisciplinary team determined the root cause was the R30 self-transferring and ambulating to the bathroom alone.

R30 care plan dated 1/23/15, indicated the resident was cognitively impaired and had impaired decision making ability. She also had a history of falls, required assistance of two staff for repositioning due to a hip fracture. The plan, however, lacked individualized measures for minimizing the risk of further bruising or monitoring and documentation of bruises. R30's Weekly Skin Assessment sheets from 3/17/15 to 4/14/15 were signed by a RN, and lacked any notations of brushing to R30's face.

On 4/22/15, at 12:37 p.m. the DON explained R30 had sustained a fall on 3/28/15, and sustained the bruise from that fall. The DON explained the nursing staff should have been documenting any bruises a resident sustained on the Weekly Skin Assessment sheet. The DON stated, "The whole idea of a skin assessment is to look from top to bottom," and confirmed that R30's weekly skin assessment sheet lacked documentation showing the resident had any bruising. The DON verified a temporary care plan had also not been initiated to addressed the problem.

R11 was interviewed on 4/20/15, at 5:51 p.m. An abrasion approximately one inch in length was visible just behind the resident's glasses on the right side of her nose. The abrasion was scabbed over. R11 was unaware of the origin of the abrasion. The following day R11 reported at 10:54 a.m. that the abrasion did not hurt, and

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may have resulted from dry skin. The abrasion appeared unchanged.

The Minimum Data Set (MDS) dated 2/3/15, revealed R11 was moderately cognitively impaired, and required extensive assistance from staff to complete hygiene tasks, including washing her face. The activities of daily living (ADL) flow sheet dated 4/16/15 through 4/22/15 revealed R11 required extensive assistance on the day and evening shifts for personal hygiene needs. The care plan for R11 dated 8/10/14 directed staff to provide extensive assistance to complete ADL tasks related to a diagnosis including dementia and osteoarthritis. Staff were to set up supplies for a.m. and p.m. cares and daily grooming, and to provide cues and encouragement for the resident. The plan lacked identification or monitoring of the skin abrasion.

The treatment administration sheet (TAR) verified R11 received a weekly skin check on 4/18/15 during the evening shift. No alteration in skin integrity was identified. The nursing notes 4/1/15 to 4/22 lacked identification or monitoring of the skin abrasion.

The facility's Weekly Skin Assessment Sheet dated 4/29/15, was signed by a licensed practical nurse and indicated R11's skin was intact.

An interview with the director of nursing (DON) on 4/21/15 at 1:30 p.m. verified there had been no incident reports filed related to skin issues for R11.

On 4/22/15, at 8:40 a.m. a registered nurse (RN)-B explained that if a NA or a nurse noted a skin abrasion on a resident during cares, she

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would have expected it to be documented on the TAR, and then monitored daily until it healed. In addition, nursing was to initiate a temporary care plan regarding the problem. RN-B neither had been completed for R11's abrasion on her face.

NA- B reported on 4/22/15, at 8:50 a.m. she had assisted R11 with p.m. cares both that day and the day prior, however, she had not noticed the abrasion.

During an interview on 4/23/15, at 9:06 a.m. the DON stated she expected staff to include skin abrasions on the weekly skin assessment sheet, initiate a temporary care plan, investigate, continue daily monitoring until healed, and to update family and physician. She further explained, "That is why we do weekly body audits--so we can capture these things."

The facility's 3/14, Skin Assessment Policy directed nursing staff to complete a comprehensive head to toe assessment with each scheduled assessment, supervise NAs to ensure that each resident's skin was observed daily and with bathing, document the status of skin in the resident's chart or treatment sheet, weekly skin assessment was to be completed by the nurses for all residents on bath day and the results recorded on the weekly skin assessment form.

The facility's 4/14 For Purple/Discolored [bruising] Area Policy policy instructed staff to fill out an incident report, update the physician and family and put a temporary care plan into place.

The facility's 6/14, Skin Tear Policy and Procedure directed staff to the follow policy and

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procedure for skin tears, fill out an incident report, investigate, update the physician and family of the incident and if any changes were noted, and ensure a temporary care plan was initiated.

R32's record revealed that although the resident was receiving hospice benefits, all hospice services were not coordinated.

On 4/21/15, at 10:52 a.m. R32 was observed passively attending a card activity in the common area with other residents, where she reported she was having a good day.

After the surveyor was unable to find a hospice coordinated plan in R32's medical record on 4/21/15, at 11:19 a.m. RN-A located the Advantage Hospice care plan in the overflow charting file. The DON then stated she expected R32's hospice care plan would have be located in the resident's chart. She thought perhaps due to new staff, the care plan may have been "thinned" from the resident's medical record by mistake. The DON then called the hospice agency and was told the calendar and communication book for the coordination of care could be found in R32's room. At 11:37 a.m. the DON said she was unable to located the calendar and communication book in R32's room. The DON stated she would have expected a calendar or another form of communication from the hospice agency to have been readily available in order to coordinate care between the agency and the facility.

Later that day at 1:48 p.m. the DON provided an Advantage Hospice calendar for 3/15 and 4/15, and stated it was the format the agency would incorporate going forward. She further stated she

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was not given a calendar or any other form of communication to alert the facility of upcoming hospice visits. The DON explained the NA from the hospice agency phoned in each week regarding upcoming NA visits and that information was kept on a calendar and in a three-ringed binder kept at the nursing station.

On 4/21/15 at 10:01 a.m. the hospice RN was interviewed via telephone and said she visited R32 every Thursday 80 to 85% of the time. If unable to make the Thursday visit, she called to inform the staff she would not be coming or had the NA tell the facility staff during the NA visits, scheduled each Tuesday and Thursday. She further stated she will "fit it in" on Friday or the following week if she was coming to the facility for a care conference for any of the agencies current hospice patients. The hospice nurse then explained, "to the best of my knowledge" that the other disciplines including massage therapy, music therapy, social services, and the chaplain called ahead or put the information in their notes.

On 4/22/15, at 12:17 p.m. the DON stated the facility was aware that NAs visited twice each week and a nurse came every Thursday. She further stated the social worker, chaplain, music and massage therapists, however, "just show up." At 12:49 p.m. the DON verified the massage therapist and music therapist notes lacked specified days and times of visits. Notes relevant to social work and chaplain visits were unable to be located in the resident's record.

The 1/9/15 Hospice Program Policy dated indicated all hospice services were provided under contractual agreement, that outlined responsibilities of the facility and the hospice

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F 309	Continued From page 15 agency. In addition, a coordinated plan of care between the facility, the hospice agency and the family "will be developed and hospice providers who contract with the facility are held responsible for meeting the same professional standards and timelines of service as any contracted agency or individual associated with the facility."	F 309		
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. This REQUIREMENT is not met as evidenced by:	F 329		5/11/15

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F 329	Continued From page 16 Based on interview and document review, the facility failed to ensure non-pharmacological approaches were implemented and target behaviors monitored for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1 was prescribed Zyprexa 7.5 milligrams (mg) daily on 7/1/14, however, target behavior monitoring was lacking in the resident's medical record to support the continued need for the medication. Diagnoses listed on R1's 2/15 Physician Order sheet included major depression, psychosis, and anxiety. The medication administration record (MAR) revealed R1 received the Zyprexa daily at bedtime. On 4/21/15, at 10:29 a.m. R1 was observed ambulating in the hallway with staff's assistance. he gait was unsteady, but moderately paced. At 11:01 a.m. R1 was in an stretching activity in the common area. She actively participated in the activity. She was alert and her demeanor was pleasant. R1's annual Minimum Data Set (MDS) revealed the resident was cognitively intact and with no signs or symptoms of delirium. No behavioral issues were noted as present on the annual assessment, nor on the three previous quarterly assessments dated 10/29/14, 7/29/14, and 4/29/14. The care plan dated 2/18/15, identified R1 was at risk for drug-related side effects due to use of antipsychotic medication and directed staff to observe for effectiveness of medications and changes in mood and behavior, pharmacist to	F 329	F329 Central Health Care assures that resident on psychotropic medication are being monitored by licensed staff and pharmacist for any unnecessary medications. Policy and procedures for psychotropic drug protocol, Monitor for Appropriate use, Unnecessary Drugs and Screen for behavioral changes have been reviewed and revised as needed. On 4-28-2015 Licensed staff educated and given a copy of psychotropic drug protocol, Monitor for Appropriate use, Unnecessary Drugs and Screen for behavioral changes. Educated on the importance of continuing monthly behavior monitoring even though resident may be stable. Educated non-licensed staff to report any changes in behavior that is noticed and report to charge nurse.	

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F 329	Continued From page 17 review meds and MD to review behavior monitoring sheets to determine dosage changes. The 2014 Psychotropic Drug Protocol Review/Monitor for Efficiency, directed staff to track and document the specific behavior problem as to the number of episodes on an on-going basis. "This can be accomplished by charting every shift on the psychotropic flow record review behavior sheets monthly and as needed for changes in behavior." During an interview on 4/21/15, at 2:51 p.m. the director of nursing (DON) verified target behaviors and non-pharmacological interventions were not documented for R1 related to the use of antipsychotic medication. She explained she had been acting as the social service designee for the past two months. This included responsibility for ensuring target behavior monitoring was completed but the DON stated, "I missed it." She added that non-pharmacological interventions were also typically noted on the behavior tracking sheets, which was also not completed for R1.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		5/11/15

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F 356	Continued From page 18 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post nursing hours as required. This had the potential to affect all 22 residents residing in the facility as well as visitors. Findings include: On 4/20/15, at 1:19 p.m. during the initial facility tour the nursing hours were observed posted in view of the public on a wall by the nurse desk at the facility entrance. The date of the hours posting was correct, but the typed "Actual Hours Worked" did not match the handwritten "Staffing Total." Actual hours worked included the times of a usual day, evening and night shift such as "6-2:30 pm,"	F 356	F356 Central Health Care assures that the the posted daily nurse staffing is posted with actual hours worked. On 04-28-2015 Reviewed and revised Policy and Procedure for posting hours as needed. On 04-23-2015 educated staffing scheduler/medical records of exact way to post hours.	

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F 356	Continued From page 19 however, the staffing totals did not consistently match the actual hours worked. For example, under Actual Hours Worked was "RN/LPN 6-2:30 pm...Restorative," but the corresponding Staffing Total read "6." The previous week's posted hours were then reviewed from 4/16/15 to 4/22/15, and similar inaccuracies were noted. During an interview on 4/23/15, at 10:49 a.m. the director of nursing explained, "The total hours are correct...the actual hours are the shift hours, not the actual hours worked by the employee." The facility's 8/06, Posting Direct Care Daily Staffing Numbers policy directed staff as follows: "Shift staffing information shall be recorded...The shift for which the information is posted...The actual time worked during that shift for each category and type of nursing staff...Total number of licensed and non-licensed nursing staff working for the posted shift."	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 371	F371 Central Health Care has reviewed	5/11/15

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F 371	Continued From page 20 facility failed to ensure proper cooling of foods prepared prior to service to minimize the potential for foodborne illness. This had the potential to affect all 22 residents residing at the facility. Findings include: The director of dietary services was interviewed on 4/20/15, at 1:45 p.m. regarding the facility's system for cooling prepared foods. The cook stated food was placed in a two inch pan, placed in the refrigerator, and was stirred. She was unable to confirm if temperatures were taken to ensure food was then cooled in a safe manner. She asked Cook-A who stated, "We take leftovers and put them in a plastic container for 10 minutes, and then put it in the refrigerator if we are going to use it right away, or the freezer if we're not. We do not take the temperature to make sure it's cooling down." The dietary manager was then interviewed and stated she expected the staff to be taking temperatures of the food to ensure proper cooling and explained the staff had been "given in-services on that." The dietary manager stated the food should have been cooled to 41 degrees Fahrenheit (F). Food at 140 degrees was in the "danger zone" if it remained there for more than so much time. She reported there had been no resident foodborne illnesses. Cook-B was interviewed on 4/22/15, at 12:30 p.m. regarding cooling methods. Cook B explained she put the food into a two inch pan, and then checked the temperature later. "If it's not down" the food was to be thrown out. She stated they wanted the food to be below 40 degrees before it was put into the container. In	F 371	and revised the policy and procedure for Rapid Cooling food items and as needed. 05-05-2015 Dietary staff educated on the policy and procedure for rapid cooling of food and food temperatures to from 135 degrees to 75 degrees within 2 hours and then a temperature below 41 degrees within the next 4 hours. Total cooling time between 135 degrees and below 41 degrees, is not to exceed 6 hours. Will continue to educate upon hire, annually and as needed. Have educated on the use of rapi-kool paddles. Educated on the new cooling log system. Educated staff also on food Bourne illness and the danger zones (41 degrees to 135 degrees). Dietary manager will monitor weekly on temperatures of cooling food and as needed	

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F 371	Continued From page 21 two hours it needed to drop 20-30 degrees. When re-checked again, it should drop another 20-30 more degrees. It was to be cooled in six hours from start to finish to below 40 degrees. Cook-B stated, "I have to be honest. We just started taking the temps, we have known about it but didn't document the temps." The facility's policy for Cooling Hot Food, dated 1/15 did not comprehensively direct staff in cooling food practices. The policy directed staff as follows: "When cooling hot food down, put leftover food in (a) 2 inch shallow pan and measure temperature until it is at the cool down range of below 38 degrees. Then properly store in containers with a tight lid and label and date."	F 371		
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 pharmacy consultant failed to review target behaviors each month to ensure the lowest possible dose for antipsychotic use for 1 of 5 residents (R1) reviewed for unnecessary	F 428	F428 Central Health Care assures that resident on psychotropic medication are being monitored by licensed staff and pharmacist for any unnecessary medications. Policy and procedures for	5/11/15

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F 428	Continued From page 22 medications. Findings include: R1 was prescribed Zyprexa 7.5 milligrams (mg) daily on 7/1/14, however, target behavior monitoring was lacking in the resident's medical record to support the continued need for the medication, and the consulting pharmacist had not noted the lack of behavioral monitoring. Diagnoses listed on R1's 2/15 Physician Order sheet included major depression, psychosis, and anxiety. The medication administration record (MAR) revealed R1 received the Zyprexa daily at bedtime. The care plan dated 2/18/15, identified R1 was at risk for drug-related side effects due to use of antipsychotic medication and directed staff to observe for effectiveness of medications and changes in mood and behavior, pharmacist to review meds and MD to review behavior monitoring sheets to determine dosage changes. The 2014 Psychotropic Drug Protocol Review/Monitor for Efficiency, directed staff to track and document the specific behavior problem as to the number of episodes on an on-going basis. "This can be accomplished by charting every shift on the psychotropic flow record review behavior sheets monthly and as needed for changes in behavior." During an interview on 4/21/15, at 2:51 p.m. the director of nursing (DON) verified target behaviors and non-pharmacological interventions were not documented for R1 related to the use of antipsychotic medication. She explained she had been acting as the social service designee for the	F 428	psychotropic drug protocol, Monitor for Appropriate use, Unnecessary Drugs and Screen for behavioral changes have been reviewed and revised as needed. On 4-28-2015 Licensed staff educated and given a copy of psychotropic drug protocol, Monitor for Appropriate use, Unnecessary Drugs and Screen for behavioral changes. Educated on the importance of continuing monthly behavior monitoring even though resident may be stable. Educated non-licensed staff to report any changes in behavior that is noticed and report to charge nurse.	

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F 428	Continued From page 23 past two months. This included responsibility for ensuring target behavior monitoring was completed but the DON stated, "I missed it." She added that non-pharmacological interventions were also typically noted on the behavior tracking sheets, which was also not completed for R1. The consulting pharmacist (CP)-A was interviewed on 4/23/15, at 6:27 a.m. CP-A reported R1 was prescribed the lowest dose possible of Zyprexa (7.5 mg), and the resident's family did not wish any additional dose reductions in the medication at this time. Because of this, the pharmacist did not think it was necessary for the staff to monitor the resident's target behaviors each shift. CP-A stated the staff "knows these residents well" so if something was happening with a resident, they would be aware and report it. Although CP-A completed monthly pharmacy reviews and looked at R1's record since the last review, he did not think it was necessary to he needed to review behavior monitoring.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		5/11/15

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F 431	Continued From page 24 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotics were destroyed in a manner to prevent possible diversion or unintended use and in accordance with facility policy for 1 of 1 residents (R32) whose administration of narcotic patches was observed, and failed to ensure expired insulin medications were not stored for use in 1 of 2 medication carts, affecting 3 of 3 residents (R16, R23, R46) prescribed insulin. Findings include: R32's Fentanyl narcotic pain medication patch was observed administered on 4/21/15, at 10:34 a.m. by a registered nurse (RN)-A. RN-A	F 431	F431 Central Health Care has reviewed and revised policy and procedures for administration and disposal of narcotic patch. Educated the nurse immediately on 04-23-2015 of the policy and procedure for proper disposal of transdermal controlled patches and giving medication on time. 04-28-2015 educated all licensed staff on disposal of medication of controlled schedule II. Reviewed and educated on labeling, checking for expired meds and properly dating medication when opened. Recommended minimum medication storage perimeter information was reviewed and placed in medication MAR	

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F 431	Continued From page 25 removed the old patch, placed it on a tissue, and rolled the patch up with disposable gloves and placed the patch in the garbage can in the medication room. At 10:38 a.m. RN-A verified the manner in which the medication patch was disposed and said, "We put it face-down on a Kleenex and place it in the med [medication] room garbage can." RN-A then went to the medication cart, signed off that the medication had been administered. She then explained that the trained medication aide (TMA) would place her signature next to the nurse's at her first opportunity. She then placed a plastic spoon in between pages to mark the narcotic sign off page where the TMA was to co-sign that the medication had been destroyed. At 1:16 p.m. RN-A explained, "Our policy is to do the Fentanyl patch change with two staff, and then place the old patch in the med room garbage." R32's removal and re-application of a Fentanyl patch was observed on 4/23/15, at 9:20 a.m. The old patch was removed and was placed on a paper towel in the resident's room and was placed in the garbage can in the medication room. Following the observation at 9:27 a.m. RN-A verified, "I put it in the garbage on that paper towel." The DON was interviewed regarding the facility's system regarding potential drug diversion or unintended medication use on 4/23/14, at 10:49 a.m. The DON explained that after the patch was removed, it was to be placed on a tissue or paper towel. "I like them to flush it, but some of them just throw it away in the med room garbage. The door is locked." She added that disposing of the patch in the sharps container (receptacle to prevent needle re-use) would be "okay too."	F 431	for Nurses to review as needed. DON/ADON will do monthly audit of med cart for properly labeled medication and disposal of medications and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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F 431	Continued From page 26 The facility's 1/15 policy Administration and Disposal of Used Fentanyl/Duragesic Patch directed staff as follows: "Disposal place on tissue paper, napkin or fold patch together, flush down toilet or ok to put in a leak proof sharps container." The Consulting Pharmacist was interviewed on 5/1/15 at 1:01 p.m. about disposal of the used Fentanyl patch, and stated, "I would prefer to see them flushing an old patch rather than discarding in a garbage can because of the risk of retrieval and drug diversion. Flushing or mixing with coffee grounds is acceptable." The manufacturer's instructions for Fentanyl Transdermal System (FTS) noted, "Store [FTS]away from children and in a safe place to prevent stealing or abuse...Fold the used [FTS] in half so that the sticky side sticks to itself...A used [FTS] CAN be VERY dangerous for or even lead to death in babies, children pets, and adults who had not been prescribed [FTS]. The facility's medication storage system was observed on 4/20/15, at 5:57 p.m. Expired insulin labeled for R16 was stored at room temperature inside the medication cart. R16's Humalog insulin vial had a hand written opened date of 3/11/15, and a hand written expiration date of 4/8/15. R23's Lantus insulin pen and R46's Novolog flexpen were stored at room temperature lacked opened dates on the insulin pens. R16's care plan dated 3/25/15, identified R16 had the potential for unstable blood sugar levels due to diagnosis of diabetes mellitus. Interventions included administering insulin as ordered and	F 431		

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F 431	Continued From page 27 observe for signs and symptoms of hypoglycemia and hyperglycemia (too much or too little sugar). R16's medication administration record (MAR) indicated the resident was to receive Novolog insulin injections subcutaneous per sliding scale twice daily when blood glucose levels were greater than 200. R23's care plan dated 4/1/15, identified the resident had the potential for unstable blood sugar levels due to diagnosis of diabetes mellitus. Interventions included administer insulin as ordered and observe for signs and symptoms of hypoglycemia and hyperglycemia. R23's MAR indicated the resident was to receive Lantus insulin injections subcutaneous of 10 units at bedtime. R46's care plan dated 4/15/15, identified the resident had the potential for unstable blood sugar levels. Interventions included administer insulin as ordered and observe for signs and symptoms of hypoglycemia and hyperglycemia. R46's MAR indicated the resident was to receive Humalog insulin injections subcutaneous per sliding scale four times a day when blood glucose levels are greater than 150. During an interview on 4/20/15, at 6:04 p.m. a registered nurse (RN)-A and the director of nursing (DON) both confirmed the insulins had been stored for use at room temperature on the medication cart. Both RN-A and DON confirmed the insulin had expired for R16 and confirmed that R23's and R46's insulin pens lacked documentation of opened dates when the pens were put into use. The DON stated her expectations was that the expired insulins should have been removed from the medication cart for	F 431		

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F 431	Continued From page 28 destruction. Also, once medications were put into use, an opened date should have been documented. The facility's 9/14, Storage of Drugs policy indicated "drugs shall not be kept on hand after the expiration date on the label." The facility provided a 2012, Injectable Medications Storage Recommendation per the Monica pharmacy, which indicated all vials should have been dated when open and discarded 28 days after opening. The manufacturer's package inserts for Novolog and Humalog flexpen and Lantus insulins should have been destroyed after 28 days once opened, even if insulin remained in the vial or pens.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		5/11/15

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F 441	Continued From page 29 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand washing was performed for 1 of 1 residents (R37) whose dressing change was observed. Findings include: R37's pressure ulcer dressing change was observed on 4/22/15, at 10:59 a.m. being performed by a registered nurse (RN)-A. RN-A removed her used gloves after the "dirty" part of the dressing change (removing the old dressing, cleansing the wound). However she did not wash her hands before putting on clean gloves for the dressing application (the "clean" part of the dressing change procedure). After the observation, RN-A stated, "I probably should have washed between taking the dirty	F 441	F 441 Central Health Care provides an annual in-service on the infection control and as needed. Infection control policy has been reviewed and revised as needed. The staff involved was reeducated on 04-22-2015 on proper infection control and procedure with clean and sterile dressing changes. Licensed staff was also educated on proper procedure for dressing changes on 04-28-2015 Don/ADON will continue to monitor licensed staff on proper procedure for dressing changes randomly and as needed.	

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F 441	Continued From page 30 gloves off and putting on the clean pair." The director of nursing explained on 4/22/15, at 2:11 p.m. she would have expected hand washing or the use of hand sanitizer not only before and after the dressing change, but between the removal of the dirty dressing and the application of the new, clean dressing. The facility's 5/15/14, Preventing the Spread of Infection policy indicated..."residents can be exposed to potentially pathogenic organisms in several ways, including...Improper hand hygiene." A second undated policy Central Health Care Infection Control Policies and Procedures included, "...Specific components key to infection management are adequate infection control...Employees must wear gloves when they may reasonably expect contact with blood or a bodily fluid. This pertains to...damaged skin..." The same policy specifically directed, "Employees must wash their hands with soap and water after...removing their gloves...Medical personnel may have to wash their hands between tasks performed for the same patient."	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 22, 2015. At the time of this survey, Central Health Care was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2015

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 40 beds and had a census of 22 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility's fire safety plan did not provide for all nine (9) of the required elements at NFPA 101 (00) Chapter 19, Section 19.7.2.2. This deficient practice could adversely affect 22 of 22 residents, staff and visitors. FINDINGS INCLUDE: On 04/22/2015 at 11:40 AM, during a review of the facility's emergency plan, it was confirmed that not all of the required elements existed in the Facilities Fire Safety Plan, in accordance with NFPA 101 (00) Chapter 19, Section 19.7.2.2 (7). This finding was confirmed with the chief building	K 048	K048 Update and made changes to adequately support the Life Safety Code. Evacuation plan posted and placed in policy book.	5/11/15

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K 048	Continued From page 3 engineer (TB).	K 048		
K 050 SS=E	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 observation and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 22 residents. Findings include: On 04/22/2015 at 11:40 AM, during a review of the facilities fire drill documentation for the the period of April 2015 to April 2014 the following fire drills were missed: 1. August 2014 2. November 2014 3. December 2014 4. January 2015 5. February 2015 6. March 2015	K 050	K050 Central Health Care upon discovery of no fire drill performed immediately on 04-02-2015 educated maintenance on the importance of having fire drills monthly and checking fire extinguishers monthly. Conducted fire drill at 9 pm, was a simulated alarm. 04-07-2015 Fire Plan reviewed and revised as needed. 04-08-2015 Fire drill conducted at 10 am, 5 pm and 1 am. Staff educated on what needs improvements. Reviewed the fire plan with staff. 04-09-2015 All employees given a copy of the Policy and procedure of the fire plan to review and sign. 04-10-2015 Conduct fire drill at 4 am, 1 pm and at 7 pm to educate additional staff on the fire plan and what needs improvement.	5/11/15

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K 050	Continued From page 4 These deficient practices were confirmed by the Facility Maintenance Director (TB) at the time of discovery.	K 050	04-28-2015 Conducted a Mandatory all staff Emergency preparedness in-service and review fire plan and use of fire extinguisher. Central Health Care will continue to conduct fire drills monthly on each shift and will continue with annual emergency preparedness and fire plan.	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 5, 2015

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5401024

Dear Mr. Pelovsky:

The above facility was surveyed on April 20, 2015 through April 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

(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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On _DATES_surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00800	A. BUILDING: _____ B. WING _____	04/23/2015

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to care plans were developed for 3 of 3 residents (R37, R30, R11) observed with bruising and/or abrasions. In addition, the facility failed to ensure a care plan was developed for all hospice services for 1 of 1 resident (R32) reviewed for hospice. Findings include: R37 was observed on 4/21/15, at 7:41 a.m. with isolated small bruises on the backs of both hands. R37 had been taking the anticoagulant medication Coumadin, (known to contribute to bruising) which was discontinued the day prior on 4/20/15. R37's care plan dated 3/25/15, and Interim Plan	2 560	corrected	5/11/15

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2 560	Continued From page 3 of Care dated 4/14/15, lacked direction for staff to implement measures to minimize bruising risks, or to identify, monitor and assess bruises should they occur. A Weekly Skin Assessment dated 4/15/15 indicated both of the resident's arms "have some discoloration" and on 2/25/15, "bruising fading on arms" was documented. No descriptions such as exact locations, sizes, colors, etc. of the individual bruises were documented. On 4/23/15, at 7:55 a.m. the director of nursing (DON) was interviewed about R37's bruises and reported, "With the Coumadin therapy we kind of expect that. Her care plan says be extra careful because they bruise easily." She added that for new bruises staff, "would fill out an incident report for me and I would follow up with that." The DON acknowledged the plan did not reflect interventions related to bruising potential, and stated, "If there's somebody that has a lot of bruising it should be care planned; there isn't one here." R30 was observed on 4/21/15, at 5:25 p.m. to have a very large oblong purple bruise on the right side of her face that started from just below her right check bone to the chin. R30 was interviewed at the time of the observation, and thought she had fallen a month ago outside on a patch of ice. R30 care plan dated 1/23/15, indicated the resident was cognitively impaired and had impaired decision making ability. She also had a history of falls, required assistance of two staff for repositioning due to a hip fracture. The plan, however, lacked individualized measures for	2 560		

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2 560	Continued From page 4 minimizing the risk of further bruising or monitoring and documentation of bruises. R30's Weekly Skin Assessment sheets from 3/17/15 to 4/14/15 were signed by a RN, and lacked any notations of brushing to R30's face. On 4/22/15, at 12:37 p.m. the DON verified a temporary care plan had not been initiated to addressed the problem. R11 was interviewed on 4/20/15, at 5:51 p.m. An abrasion approximately one inch in length was visible just behind the resident's glasses on the right side of her nose. The abrasion was scabbed over. R11 was unaware of the origin of the abrasion. The following day R11 reported at 10:54 a.m. that the abrasion did not hurt, and may have resulted from dry skin. The abrasion appeared unchanged. The care plan for R11 dated 8/10/14 lacked identification or monitoring of the skin abrasion. The treatment administration sheet (TAR) verified R11 received a weekly skin check on 4/18/15 during the evening shift. No alteration in skin integrity was identified. The nursing notes 4/1/15 to 4/22 lacked identification or monitoring of the skin abrasion. In addition, the facility's Weekly Skin Assessment Sheet dated 4/29/15, indicated R11's skin was intact. On 4/22/15, at 8:40 a.m. a registered nurse (RN)-B explained nursing was to initiate a temporary care plan regarding the problem, but neither had been completed for R11's abrasion on her face. During an interview on 4/23/15, at 9:06 a.m. the	2 560		

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2 560	Continued From page 5 DON stated she expected staff to have initiated a temporary care plan. The facility's 4/14 For Purple/Discolored [bruising] Area Policy policy instructed staff to fill out an incident report, update the physician and family and put a temporary care plan into place. The facility's 6/14, Skin Tear Policy and Procedure directed staff to ensure a temporary care plan was initiated. R32's record revealed that although the resident was receiving hospice benefits, all hospice services were not coordinated. After the surveyor was unable to find a hospice coordinated plan in R32's medical record on 4/21/15, at 11:19 a.m. RN-A located the Advantage Hospice care plan in the overflow charting file. The DON then stated she expected R32's hospice care plan would have be located in the resident's chart. She thought perhaps due to new staff, the care plan may have been "thinned" from the resident's medical record by mistake. The DON stated she would have expected a calendar or another form of communication from the hospice agency to have been readily available in order to coordinate care between the agency and the facility. On 4/21/15 at 10:01 a.m. the hospice RN was interviewed via telephone and explained "to the best of my knowledge" that the other disciplines including massage therapy, music therapy, social services, and the chaplain called ahead or put the information in their notes. On 4/22/15, at 12:17 p.m. the DON stated the facility was aware that NAs visited twice each week and a nurse came every Thursday. She	2 560		

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2 560	Continued From page 6 further stated the social worker, chaplain, music and massage therapists, however, "just show up." The 1/9/15 Hospice Program Policy dated indicated all hospice services were provided under contractual agreement, that outlined responsibilities of the facility and the hospice agency. In addition, a coordinated plan of care between the facility, the hospice agency and the family "will be developed and hospice providers who contract with the facility are held responsible for meeting the same professional standards and timelines of service as any contracted agency or individual associated with the facility." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure residents who are at risk of or who experience skin alterations have measures to minimize risk and treat and monitor those issues on their care plans. Appropriate staff could be trained and audits for compliance conducted and brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	2 830		5/11/15

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2 830	Continued From page 7 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure non-pressure related skin conditions were identified and monitored for 3 of 3 residents (R37, R30, R11) observed with bruising and/or abrasions. In addition, the facility failed to coordinate hospice services for 1 of 1 resident (R32) reviewed for hospice. Findings include: R37 was observed on 4/21/15, at 7:41 a.m. with isolated small bruises on the backs of both hands. R37 had been taking the anticoagulant medication Coumadin, (known to contribute to bruising) which was discontinued the day prior on 4/20/15. A Weekly Skin Assessment dated 4/15/15 indicated both of the resident's arms "have some discoloration" and on 2/25/15, "bruising fading on arms" was documented. No descriptions such as exact locations, sizes, colors, etc. of the individual bruises were documented. R37's care plan dated 3/25/15, included a handwritten notation indicating: "FYI [for your information]: Coumadin stop date 4/20/15." An Interim Plan of Care dated 4/14/15, lacked direction for staff to implement measures to minimize bruising risks, or to identify, monitor and assess bruises should they occur.	2 830	corrected	

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2 830	Continued From page 8 A nursing assistant (NA)-A familiar with R37 stated on 4/22/15, at 10:11 a.m. "I saw the bruising, but I don't know how it happened. It's been there a while." On 4/23/15, at 7:55 a.m. the director of nursing (DON) was interviewed about R37's bruises and reported, "With the Coumadin therapy we kind of expect that. Her care plan says be extra careful because they bruise easily." She added that for new bruises staff, "would fill out an incident report for me and I would follow up with that." The DON then verified the documentation lacked specific information, and said it "isn't really telling where specific bruises are, but the general body area where they are is circled." The DON acknowledged it would have been difficult to know when new bruising had occurred. Although a care plan related to Coumadin had been develop, the DON acknowledged the plan did not reflect interventions related to bruising potential, and stated, "If there's somebody that has a lot of bruising it should be care planned; there isn't one here." R30 was observed on 4/21/15, at 5:25 p.m. to have a very large oblong purple bruise on the right side of her face that started from just below her right check bone to the chin. R30 was interviewed at the time of the observation, and thought she had fallen a month ago outside on a patch of ice. A nursing note on 3/28/15, at 2:00 a.m. indicated R30 was found sitting on the floor in the bathroom. Staff noted the resident sustained an abrasion and swelling to her right outer eye. The	2 830		

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2 830	Continued From page 9 incident/accident report dated 3/30/15, indicated the interdisciplinary team determined the root cause was the R30 self-transferring and ambulating to the bathroom alone. R30 care plan dated 1/23/15, indicated the resident was cognitively impaired and had impaired decision making ability. She also had a history of falls, required assistance of two staff for repositioning due to a hip fracture. The plan, however, lacked individualized measures for minimizing the risk of further bruising or monitoring and documentation of bruises. R30's Weekly Skin Assessment sheets from 3/17/15 to 4/14/15 were signed by a RN, and lacked any notations of brushing to R30's face. On 4/22/15, at 12:37 p.m. the DON explained R30 had sustained a fall on 3/28/15, and sustained the bruise from that fall. The DON explained the nursing staff should have been documenting any bruises a resident sustained on the Weekly Skin Assessment sheet. The DON stated, "The whole idea of a skin assessment is to look from top to bottom," and confirmed that R30's weekly skin assessment sheet lacked documentation showing the resident had any bruising. The DON verified a temporary care plan had also not been initiated to addressed the problem. R11 was interviewed on 4/20/15, at 5:51 p.m. An abrasion approximately one inch in length was visible just behind the resident's glasses on the right side of her nose. The abrasion was scabbed over. R11 was unaware of the origin of the abrasion. The following day R11 reported at 10:54 a.m. that the abrasion did not hurt, and may have resulted from dry skin. The abrasion	2 830		

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2 830	Continued From page 10 appeared unchanged. The Minimum Data Set (MDS) dated 2/3/15, revealed R11 was moderately cognitively impaired, and required extensive assistance from staff to complete hygiene tasks, including washing her face. The activities of daily living (ADL) flow sheet dated 4/16/15 through 4/22/15 revealed R11 required extensive assistance on the day and evening shifts for personal hygiene needs. The care plan for R11 dated 8/10/14 directed staff to provide extensive assistance to complete ADL tasks related to a diagnosis including dementia and osteoarthritis. Staff were to set up supplies for a.m. and p.m. cares and daily grooming, and to provide cues and encouragement for the resident. The plan lacked identification or monitoring of the skin abrasion. The treatment administration sheet (TAR) verified R11 received a weekly skin check on 4/18/15 during the evening shift. No alteration in skin integrity was identified. The nursing notes 4/1/15 to 4/22 lacked identification or monitoring of the skin abrasion. The facility's Weekly Skin Assessment Sheet dated 4/29/15, was signed by a licensed practical nurse and indicated R11's skin was intact. An interview with the director of nursing (DON) on 4/21/15 at 1:30 p.m. verified there had been no incident reports filed related to skin issues for R11. On 4/22/15, at 8:40 a.m. a registered nurse (RN)-B explained that if a NA or a nurse noted a skin abrasion on a resident during cares, she would have expected it to be documented on the TAR, and then monitored daily until it healed. In	2 830		

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2 830	Continued From page 11 addition, nursing was to initiate a temporary care plan regarding the problem. RN-B neither had been completed for R11's abrasion on her face. NA- B reported on 4/22/15, at 8:50 a.m. she had assisted R11 with p.m. cares both that day and the day prior, however, she had not noticed the abrasion. During an interview on 4/23/15, at 9:06 a.m. the DON stated she expected staff to include skin abrasions on the weekly skin assessment sheet, initiate a temporary care plan, investigate, continue daily monitoring until healed, and to update family and physician. She further explained, "That is why we do weekly body audits--so we can capture these things." The facility's 3/14, Skin Assessment Policy directed nursing staff to complete a comprehensive head to toe assessment with each scheduled assessment, supervise NAs to ensure that each resident's skin was observed daily and with bathing, document the status of skin in the resident's chart or treatment sheet, weekly skin assessment was to be completed by the nurses for all residents on bath day and the results recorded on the weekly skin assessment form. The facility's 4/14 For Purple/Discolored [bruising] Area Policy policy instructed staff to fill out an incident report, update the physician and family and put a temporary care plan into place. The facility's 6/14, Skin Tear Policy and Procedure directed staff to the follow policy and procedure for skin tears, fill out an incident report, investigate, update the physician and family of the incident and if any changes were noted, and	2 830		

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2 830	Continued From page 12 ensure a temporary care plan was initiated. R32's record revealed that although the resident was receiving hospice benefits, all hospice services were not coordinated. On 4/21/15, at 10:52 a.m. R32 was observed passively attending a card activity in the common area with other residents, where she reported she was having a good day. After the surveyor was unable to find a hospice coordinated plan in R32's medical record on 4/21/15, at 11:19 a.m. RN-A located the Advantage Hospice care plan in the overflow charting file. The DON then stated she expected R32's hospice care plan would have be located in the resident's chart. She thought perhaps due to new staff, the care plan may have been "thinned" from the resident's medical record by mistake. The DON then called the hospice agency and was told the calendar and communication book for the coordination of care could be found in R32's room. At 11:37 a.m. the DON said she was unable to located the calendar and communication book in R32's room. The DON stated she would have expected a calendar or another form of communication from the hospice agency to have been readily available in order to coordinate care between the agency and the facility. Later that day at 1:48 p.m. the DON provided an Advantage Hospice calendar for 3/15 and 4/15, and stated it was the format the agency would incorporate going forward. She further stated she was not given a calendar or any other form of communication to alert the facility of upcoming hospice visits. The DON explained the NA from the hospice agency phoned in each week	2 830		

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2 830	Continued From page 13 regarding upcoming NA visits and that information was kept on a calendar and in a three-ringed binder kept at the nursing station. On 4/21/15 at 10:01 a.m. the hospice RN was interviewed via telephone and said she visited R32 every Thursday 80 to 85% of the time. If unable to make the Thursday visit, she called to inform the staff she would not be coming or had the NA tell the facility staff during the NA visits, scheduled each Tuesday and Thursday. She further stated she will "fit it in" on Friday or the following week if she was coming to the facility for a care conference for any of the agencies current hospice patients. The hospice nurse then explained, "to the best of my knowledge" that the other disciplines including massage therapy, music therapy, social services, and the chaplain called ahead or put the information in their notes. On 4/22/15, at 12:17 p.m. the DON stated the facility was aware that NAs visited twice each week and a nurse came every Thursday. She further stated the social worker, chaplain, music and massage therapists, however, "just show up." At 12:49 p.m. the DON verified the massage therapist and music therapist notes lacked specified days and times of visits. Notes relevant to social work and chaplain visits were unable to be located in the resident's record. The 1/9/15 Hospice Program Policy dated indicated all hospice services were provided under contractual agreement, that outlined responsibilities of the facility and the hospice agency. In addition, a coordinated plan of care between the facility, the hospice agency and the family "will be developed and hospice providers who contract with the facility are held responsible for meeting the same professional standards and	2 830		

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2 830	Continued From page 14 timelines of service as any contracted agency or individual associated with the facility." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure residents who are at risk of or who experience skin alterations have measures in place to minimize risk and treat and monitor those issues. Appropriate staff could be re-trained in the completion of comprehensive and accurate body audits, with the results reflected in each residents' medical record. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure proper cooling of foods prepared prior to service to minimize the potential for foodborne illness. This had the potential to affect all 22 residents residing at the facility. Findings include:	21025	corrected	5/11/15

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21025	Continued From page 15 The director of dietary services was interviewed on 4/20/15, at 1:45 p.m. regarding the facility's system for cooling prepared foods. The cook stated food was placed in a two inch pan, placed in the refrigerator, and was stirred. She was unable to confirm if temperatures were taken to ensure food was then cooled in a safe manner. She asked Cook-A who stated, "We take leftovers and put them in a plastic container for 10 minutes, and then put it in the refrigerator if we are going to use it right away, or the freezer if we're not. We do not take the temperature to make sure it's cooling down." The dietary manager was then interviewed and stated she expected the staff to be taking temperatures of the food to ensure proper cooling and explained the staff had been "given in-services on that." The dietary manager stated the food should have been cooled to 41 degrees Fahrenheit (F). Food at 140 degrees was in the "danger zone" if it remained there for more than so much time. She reported there had been no resident foodborne illnesses. Cook-B was interviewed on 4/22/15, at 12:30 p.m. regarding cooling methods. Cook B explained she put the food into a two inch pan, and then checked the temperature later. "If it's not down" the food was to be thrown out. She stated they wanted the food to be below 40 degrees before it was put into the container. In two hours it needed to drop 20-30 degrees. When re-checked again, it should drop another 20-30 more degrees. It was to be cooled in six hours from start to finish to below 40 degrees. Cook-B stated, "I have to be honest. We just started taking the temps, we have known about it but didn't document the temps."	21025		

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21025	Continued From page 16 The facility's policy for Cooling Hot Food, dated 1/15 did not comprehensively direct staff in cooling food practices. The policy directed staff as follows: "When cooling hot food down, put leftover food in (a) 2 inch shallow pan and measure temperature until it is at the cool down range of below 38 degrees. Then properly store in containers with a tight lid and label and date." SUGGESTED METHOD OF CORRECTION: The dietitian and food service director could review policies and procedures to ensure consistency with standards of practice for minimizing foodborne illness. Appropriate dietary staff could be trained. Audits could be conducted to ensure foods are cooled to safe temperatures as required. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and	21390		5/11/15

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21390	Continued From page 17 procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand washing was performed for 1 of 1 residents (R37) whose dressing change was observed. Findings include: R37's pressure ulcer dressing change was observed on 4/22/15, at 10:59 a.m. being performed by a registered nurse (RN)-A. RN-A removed her used gloves after the "dirty" part of the dressing change (removing the old dressing, cleansing the wound). However she did not wash her hands before putting on clean gloves for the dressing application (the "clean" part of the dressing change procedure). After the observation, RN-A stated, "I probably should have washed between taking the dirty gloves off and putting on the clean pair." The director of nursing explained on 4/22/15, at 2:11 p.m. she would have expected hand washing	21390	corrected	

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21390	Continued From page 18 or the use of hand sanitizer not only before and after the dressing change, but between the removal of the dirty dressing and the application of the new, clean dressing. The facility's 5/15/14, Preventing the Spread of Infection policy indicated..."residents can be exposed to potentially pathogenic organisms in several ways, including...Improper hand hygiene." A second undated policy Central Health Care Infection Control Policies and Procedures included, "...Specific components key to infection management are adequate infection control...Employees must wear gloves when they may reasonably expect contact with blood or a bodily fluid. This pertains to...damaged skin..." The same policy specifically directed, "Employees must wash their hands with soap and water after...removing their gloves...Medical personnel may have to wash their hands between tasks performed for the same patient." SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could ensure all appropriate staff are trained in infection control polices and procedures to minimize the risk for cross contamination. Return demonstration and audits could be conducted to ensure compliance. The results of the audits could be brought to the QA committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		5/11/15

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21426	Continued From page 19 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure baseline tuberculosis (TB) screening included two-step skin Tuberculin Skin Test (TST) for 1 of 5 employees (housekeeping aide--HA-1) reviewed for TB screening. Findings include: The Employee Mantoux Questionnaire/Consent form for HA-1 indicated the initial step one TST was given on 1/19/15, however the results were not recorded. A step two TST was given on 2/11/15 and the results were documented on 2/13/15. On 4/22/15, at 7:15 a.m., the director of nursing (DON) verified the step one TST for HA-1 was not	21426	corrected	

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21426	Continued From page 20 documented. She stated the nurse should have documented the results. The DON could not verify the step one TST had been completed. The facility's 11/12 Policy and Procedure for TB Screening indicated "All employees will receive a baseline TB screen upon hire and yearly, using a two-step TST. The Mantoux test is to be read after 48 to 72 hours of administration." SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could devise a system to ensure all employees are screened as required. Audits could be conducted to ensure appropriate TB practices are followed. The results of the audits could be brought to the QA committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next	21530		5/11/15

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21530	Continued From page 21 physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the pharmacy consultant failed to review target behaviors each month to ensure the lowest possible dose for antipsychotic use for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1 was prescribed Zyprexa 7.5 milligrams (mg) daily on 7/1/14, however, target behavior monitoring was lacking in the resident's medical record to support the continued need for the medication, and the consulting pharmacist had	21530	correction	

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21530	Continued From page 22	21530		

not noted the lack of behavioral monitoring. Diagnoses listed on R1's 2/15 Physician Order sheet included major depression, psychosis, and anxiety. The medication administration record (MAR) revealed R1 received the Zyprexa daily at bedtime.

The care plan dated 2/18/15, identified R1 was at risk for drug-related side effects due to use of antipsychotic medication and directed staff to observe for effectiveness of medications and changes in mood and behavior, pharmacist to review meds and MD to review behavior monitoring sheets to determine dosage changes.

The 2014 Psychotropic Drug Protocol Review/Monitor for Efficiency, directed staff to track and document the specific behavior problem as to the number of episodes on an on-going basis. "This can be accomplished by charting every shift on the psychotropic flow record review behavior sheets monthly and as needed for changes in behavior."

During an interview on 4/21/15, at 2:51 p.m. the director of nursing (DON) verified target behaviors and non-pharmacological interventions were not documented for R1 related to the use of antipsychotic medication. She explained she had been acting as the social service designee for the past two months. This included responsibility for ensuring target behavior monitoring was completed but the DON stated, "I missed it." She added that non-pharmacological interventions were also typically noted on the behavior tracking sheets, which was also not completed for R1.

The consulting pharmacist (CP)-A was interviewed on 4/23/15, at 6:27 a.m. CP-A reported R1 was prescribed the lowest dose

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21530	Continued From page 23 possible of Zyprexa (7.5 mg), and the resident's family did not wish any additional dose reductions in the medication at this time. Because of this, the pharmacist did not think it was necessary for the staff to monitor the resident's target behaviors each shift. CP-A stated the staff "knows these residents well" so if something was happening with a resident, they would be aware and report it. Although CP-A completed monthly pharmacy reviews and looked at R1's record since the last review, he did not think it was necessary to he needed to review behavior monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing with the pharmacist could ensure appropriate monitoring is being tracked for residents prescribed antipsychotic medication. Audits could be conducted for compliance. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the	21540		5/11/15

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21540	Continued From page 24 medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological approaches were implemented and target behaviors monitored for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1 was prescribed Zyprexa 7.5 milligrams (mg) daily on 7/1/14, however, target behavior monitoring was lacking in the resident's medical record to support the continued need for the medication. Diagnoses listed on R1's 2/15 Physician Order sheet included major depression, psychosis, and anxiety. The medication administration record (MAR) revealed R1 received the Zyprexa daily at bedtime. On 4/21/15, at 10:29 a.m. R1 was observed ambulating in the hallway with staff's assistance. he gait was unsteady, but moderately paced. At 11:01 a.m. R1 was in an stretching activity in the common area. She actively participated in the activity. She was alert and her demeanor was pleasant.	21540	corrected	

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21540	Continued From page 25 R1's annual Minimum Data Set (MDS) revealed the resident was cognitively intact and with no signs or symptoms of delirium. No behavioral issues were noted as present on the annual assessment, nor on the three previous quarterly assessments dated 10/29/14, 7/29/14, and 4/29/14. The care plan dated 2/18/15, identified R1 was at risk for drug-related side effects due to use of antipsychotic medication and directed staff to observe for effectiveness of medications and changes in mood and behavior, pharmacist to review meds and MD to review behavior monitoring sheets to determine dosage changes. The 2014 Psychotropic Drug Protocol Review/Monitor for Efficiency, directed staff to track and document the specific behavior problem as to the number of episodes on an on-going basis. "This can be accomplished by charting every shift on the psychotropic flow record review behavior sheets monthly and as needed for changes in behavior." During an interview on 4/21/15, at 2:51 p.m. the director of nursing (DON) verified target behaviors and non-pharmacological interventions were not documented for R1 related to the use of antipsychotic medication. She explained she had been acting as the social service designee for the past two months. This included responsibility for ensuring target behavior monitoring was completed but the DON stated, "I missed it." She added that non-pharmacological interventions were also typically noted on the behavior tracking sheets, which was also not completed for R1. SUGGESTED METHOD OF CORRECTION: The director of nursing and social service	21540		

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21540	Continued From page 26 designee could ensure behavioral tracking is documented for residents who are prescribed antipsychotic medicaitons. Audits could be conducted for compliance. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record.	21630		5/11/15

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21630	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotics were destroyed in a manner to prevent possible diversion or unintended use and in accordance with facility policy for 1 of 1 residents (R32) whose administration of narcotic patches was observed, and failed to ensure expired insulin medications were not stored for use in 1 of 2 medication carts, affecting 3 of 3 residents (R16, R23, R46) prescribed insulin. Findings include: R32's Fentanyl narcotic pain medication patch was observed administered on 4/21/15, at 10:34 a.m. by a registered nurse (RN)-A. RN-A removed the old patch, placed it on a tissue, and rolled the patch up with disposable gloves and placed the patch in the garbage can in the medication room. At 10:38 a.m. RN-A verified the manner in which the medication patch was disposed and said, "We put it face-down on a Kleenex and place it in the med [medication] room garbage can." RN-A then went to the medication cart, signed off that the medication had been administered. She then explained that the trained medication aide (TMA) would place her signature next to the nurse's at her first opportunity. She then placed a plastic spoon in between pages to mark the narcotic sign off page where the TMA was to co-sign that the medication had been destroyed. At 1:16 p.m. RN-A explained, "Our policy is to do the Fentanyl patch change with two staff, and then place the old patch in the med room garbage." R32's removal and re-application of a Fentanyl	21630	corrected	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 28	21630		

patch was observed on 4/23/15, at 9:20 a.m. The old patch was removed and was placed on a paper towel in the resident's room and was placed in the garbage can in the medication room. Following the observation at 9:27 a.m. RN-A verified, "I put it in the garbage on that paper towel."

The DON was interviewed regarding the facility's system regarding potential drug diversion or unintended medication use on 4/23/14, at 10:49 a.m. The DON explained that after the patch was removed, it was to be placed on a tissue or paper towel. "I like them to flush it, but some of them just throw it away in the med room garbage. The door is locked." She added that disposing of the patch in the sharps container (receptacle to prevent needle re-use) would be "okay too."

The facility's 1/15 policy Administration and Disposal of Used Fentanyl/Duragesic Patch directed staff as follows: "Disposal place on tissue paper, napkin or fold patch together, flush down toilet or ok to put in a leak proof sharps container."

The Consulting Pharmacist was interviewed on 5/1/15 at 1:01 p.m. about disposal of the used Fentanyl patch, and stated, "I would prefer to see them flushing an old patch rather than discarding in a garbage can because of the risk of retrieval and drug diversion. Flushing or mixing with coffee grounds is acceptable."

The manufacturer's instructions for Fentanyl Transdermal System (FTS) noted, "Store [FTS]away from children and in a safe place to prevent stealing or abuse...Fold the used [FTS] in half so that the sticky side sticks to itself...A used [FTS] CAN be VERY dangerous for or even lead

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	00800	A. BUILDING: _____ B. WING _____	04/23/2015

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21630	Continued From page 29 to death in babies, children pets, and adults who had not been prescribed [FTS]. The facility's medication storage system was observed on 4/20/15, at 5:57 p.m. Expired insulin labeled for R16 was stored at room temperature inside the medication cart. R16's Humalog insulin vial had a hand written opened date of 3/11/15, and a hand written expiration date of 4/8/15. R23's Lantus insulin pen and R46's Novolog flexpen were stored at room temperature lacked opened dates on the insulin pens. R16's care plan dated 3/25/15, identified R16 had the potential for unstable blood sugar levels due to diagnosis of diabetes mellitus. Interventions included administering insulin as ordered and observe for signs and symptoms of hypoglycemia and hyperglycemia (too much or too little sugar). R16's medication administration record (MAR) indicated the resident was to receive Novolog insulin injections subcutaneous per sliding scale twice daily when blood glucose levels were greater than 200. R23's care plan dated 4/1/15, identified the resident had the potential for unstable blood sugar levels due to diagnosis of diabetes mellitus. Interventions included administer insulin as ordered and observe for signs and symptoms of hypoglycemia and hyperglycemia. R23's MAR indicated the resident was to receive Lantus insulin injections subcutaneous of 10 units at bedtime. R46's care plan dated 4/15/15, identified the resident had the potential for unstable blood sugar levels. Interventions included administer insulin as ordered and observe for signs and symptoms of hypoglycemia and hyperglycemia.	21630		

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21630	Continued From page 30 R46's MAR indicated the resident was to receive Humalog insulin injections subcutaneous per sliding scale four times a day when blood glucose levels are greater than 150. During an interview on 4/20/15, at 6:04 p.m. a registered nurse (RN)-A and the director of nursing (DON) both confirmed the insulins had been stored for use at room temperature on the medication cart. Both RN-A and DON confirmed the insulin had expired for R16 and confirmed that R23's and R46's insulin pens lacked documentation of opened dates when the pens were put into use. The DON stated her expectations was that the expired insulins should have been removed from the medication cart for destruction. Also, once medications were put into use, an opened date should have been documented. The facility's 9/14, Storage of Drugs policy indicated "drugs shall not be kept on hand after the expiration date on the label." The facility provided a 2012, Injectable Medications Storage Recommendation per the Monica pharmacy, which indicated all vials should have been dated when open and discarded 28 days after opening. The manufacturer's package inserts for Novolog and Humalog flexpen and Lantus insulins should have been destroyed after 28 days once opened, even if insulin remained in the vial or pens. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies are in place and staff have been trained. Audits could be conducted for compliance. The results of the audits could be brought to the quality committee for review.	21630		

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21630	Continued From page 31 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21630		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced	21800		5/11/15

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21800	Continued From page 32 by: Based on interview and document review, the facility failed to provide the appropriate notice of the right to request a demand bill when Medicare benefits ended for 1 of 3 residents (R43) reviewed for liability notice. Findings include: R43 was admitted to the facility on 1/27/15. R43 was discharged from Medicare non-coverage on 2/10/15, signed the notice of Medicare non-coverage form on 2/10/15, and was discharged from the facility on 2/11/15. On 4/22/15, at 10:15 a.m. the Centers of Medicare and Medicaid Services (CMS) form 10123 was reviewed for R43. The form lacked documentation showing R43 had been provided a 48-hour notice as required before Medicare services ended. On 4/22/15, at 10:50 a.m. the director of nursing confirmed she should have given R43 the CMS form 10123 48-hours prior to when services ended. A policy and procedure for demand bill/liability notices was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The MDS nurse and DON could ensure a system is in place to inform Medicare recipeint of their right to request a demand bill as required. Audits could be conducted and the results brought to the quality committee for their review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800	corrected	

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21880	Continued From page 33	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		5/11/15

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21880	Continued From page 34 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to make attempts to organize a family council group over the past two years. This had the potential to affect all 22 residents in the facility. Findings include: The facility's Family Council Survey revealed that the last survey had been mailed to family members on 8/29/12. The social service designee (SSD) was interviewed on 4/21/15, at 11:08 a.m. and explained she had accepted the position less than a month ago. The SSD stated she was in the process of typing up a survey to be mailed out to family members to determine interest in forming a family council. She confirmed the last time information had been sent to families encouraging them to form a council had been mailed by the previous SSD on 8/29/12 The administrator was interviewed on 4/21/15, at 11:36 a.m. He stated the SSD facilitated the meetings and mailed out a survey to family members to determine if there was an interest from any family member in forming a council. The administrator verified the last time a request was mailed out to family members was on 8/29/12. He explained the previous SSD had	21880	corrected	

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21880	Continued From page 35 informed surveys had been mailed out annually, however, documentation to that effect was not provided. The administrator stated that he should have taken it upon himself to ensure the letters had been send and said, "It's my fault for not checking to see if the letter really went out or not." A policy and procedure on family council was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator and social service designee could ensure measures are taken to encourage family members to form a council. A letter could be mailed to all family members, and it could be brought up when family members are present at resident care conferences. The annual requirement could be noted on a calendar should family members choose not to form a council at this time. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		