DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATIO PART I - TO BE COMPLETED BY THE S								
1. MEDICARE/MEDICAID PROVIDER N		3. NAME AND ADI			L SURVEY	AGENCY	4. TYPE OF ACTION	Facility ID: 00629	
(L1) 245325	0.	(L3) FOLEY NUR		ĭ			4. TYPE OF ACTION	2. Recertification	
2.STATE VENDOR OR MEDICAID NO.		(L4) 253 PINE ST	REET				3. Termination	4. CHOW	
(L2) 781843200		(L5) FOLEY, MN				(L6) 56329	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	8. Full Survey After C	omplaint	
6. DATE OF SURVEY 06/23.		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	G DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		09/30	DAIL. (L55)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE	09/30		
11LTC PERIOD OF CERTIFICATION		10. THE FACILITY	IS CERTIFIED AS:				·		
From (a):		X A. In Complian					Following Requirements:		
To (b) :		Program Rec Compliance	*			Technical Personnel	6. Scope of Serv		
		-				24 Hour RN	7. Medical Dire		
12.Total Facility Beds	89 (L18)	1. A	cceptable POC			7-Day RN (Rural SNF)	—	Size	
13.Total Certified Beds	89 (L17)	B. Not in Com	pliance with Program		5.	Life Safety Code	9. Beds/Room		
		Requirements a	and/or Applied Waive	ers:	* Code:	A *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILI	ITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) ((1) or 1861 (j) (1):	(L15)		
89 (L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY API	PROVAL	Date:	
Kathy Lucas, Uni	t Supervisor	(06/23/2017	(L19)	Kate JohnsTon, Program Specialist 08/01/2017				
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE (OR SINGLE STAT	E AGENCY		
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH CI	VIL	21.		al Solvency (HCFA-2572)		
X 1. Facility is Eligible to Part	ticipate	RIGH	ITS ACT:			 Ownership/Control I: Both of the Above : 	nterest Disclosure Stmt (HCF	A-1513)	
2. Facility is not Eligible									
	(L21)								
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERM	IINATION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		<u>VOLUNTA</u>	<u>RY</u> <u>00</u>	INVOLUN	TARY	
07/01/1986					01-Merger,			feet Health/Safety	
(L24)	(L41)		(L25)			action W/ Reimbursemer	nt 06-Fail to M	feet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS				nvoluntary Termination	OTHER		
	A. Suspension of	of Admissions:			04-Other Re	ason for Withdrawal		r Status Change	
(L27)	B. Rescind Sus	noncion Doto:	(L44)				00-Active		
	B. Reschid Sus	pension Date.	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	RKS			
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	E	Posted (08/08/2017 Co.			
	(L32)	06/30/2017		(L33)	DETERM	INATION APPRO	VAL		



CMS Certification Number (CCN): 245325

July 5, 2017

Mr. Andrew Huhta, Administrator Foley Nursing Center 253 Pine Street Foley, MN 56329

Dear Mr. Huhta:

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 June 16, 2017 the above facility is recommended for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us



Electronically delivered July 5, 2017

Mr. Andrew Huhta, Administrator Foley Nursing Center 253 Pine Street Foley, MN 56329

RE: Project Number S5325026

Dear Mr. Huhta:

On May 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 27, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 23, 2017 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 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective June 16, 2017 and therefore remedies outlined in our letter to you dated May 10, 2017, 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.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us



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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us



Electronically delivered

July 6, 2017

Mr. Andrew Huhta, Administrator Foley Nursing Center 253 Pine Street Foley, MN 56329

Re: Reinspection Results - Project Number S53252026

Dear Mr. Huhta:

On June 23, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 27, 2017, with orders received by you on May 17, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATION PART I - TO BE COMPLETED BY THE S								
1. MEDICARE/MEDICAID PROVIDER N (L1) 245325 2.STATE VENDOR OR MEDICAID NO. (L2) 781843200 5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 04/27	10. NERSHIP // 2017 (L34)	 NAME AND ADI (L3) FOLEY NUR (L4) 253 PINE ST (L5) FOLEY, MN PROVIDER/SUF 01 Hospital 02 SNF/NF/Dual 	DRESS OF FACILIT SING CENTER REET	Y 09 ESRD 10 NF	(L6) 56329 <u>02</u> (L7) 13 PTIP 22 CL 14 CORF	JA	 TYPE OF ACTION Initial Termination Validation On-Site Visit Full Survey After C FISCAL YEAR ENDING	: <u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		09/30	<i>5 DALE.</i> (1997)	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 89 (L37) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	B. Not in Com Requirements a ICF (L42)	nce With quirements Based On: .cceptable POC pliance with Program and/or Applied Waive IID (L43)	rs:	And/Or Approved Waive 2. Technical Pers 3. 24 Hour RN 4. 7-Day RN (Ru 5. Life Safety Co * Code: A1* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1)	sonnel ural SNF) ode	ollowing Requirements: 6. Scope of Ser 7. Medical Dire 8. Patient Room 9. Beds/Room (L12) (L15)	ctor	
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGE	ENCY APPR	ROVAL	Date:	
Annette Truebenbac	h, HFE NE	<u>II</u> (05/24/2017	(L19)	Kate JohnsTon, Program Specialist 06/27/2017 (L20				
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE	E STATE	AGENCY		
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible 			IPLIANCE WITH CI ITS ACT:	VIL		/Control Int	Solvency (HCFA-2572) erest Disclosure Stmt (HCF	A-1513)	
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEMEN	NT	26. TERMINATION ACT	FION:		(L30)	
OF PARTICIPATION 07/01/1986	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reim	<u>00</u>		<u>TARY</u> Ieet Health/Safety Ieet Agreement	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of	of Admissions:	(L25) (L44)		03-Risk of Involuntary Term 04-Other Reason for Withdr	nination	<u>OTHER</u>	r Status Change	
	B. Rescind Sus	pension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	E	Posted 06/30/20	17 Co.			
	(L32)			(L33)	DETERMINATION A	APPROV	AL		



Electronically delivered May 10, 2017

Mr. Andrew Huhta, Administrator Foley Nursing Center 253 Pine Street Foley, MN 56329

RE: Project Number S5325026 and F5325026

Dear Mr. Huhta:

On April 27, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor St. Cloud B Survey Team Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 kathy.lucas.state.mn.us Telephone: (320)223-7343 Fax: (320)223-7348

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 6, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 6, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of 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 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Yale Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

		AND HUMAN SERVICES		F	ORM APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT		3 NO. 0938-0391 3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		245325	B. WING _		04/27/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FOLEY N	IURSING CENTER			253 PINE STREET FOLEY, MN 56329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	00	
	signature is not req				
F 282 SS=D	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	32	6/6/17
		ive Care Plans led or arranged by the facility, omprehensive care plan,			
	care. This REQUIREMEN by:	ch resident's written plan of			
	review, the facility fare repositioning for 1 c failed to provide or a failed to provide or	<i>v</i> , observation and document ailed to provide timely of 3 residents (R112), and al care for 1 of 3 residents (R9)		Care plans for R112 & R9 have been reviewed and updated as needed to reflect current status.	
	reviewed for followi Findings include:	ng the care plan.		All residents who are dependent on si for ADL assist and repositioning have their care plans reviewed and/or upda as needed.	had
	indicated R112 request with transfers and b	linimum Data Set (MDS) uired extensive assist of two bed mobility, was at risk for e ulcers and had severe nt.		The policy and protocols on reposition and oral cares was reviewed and is current.	ning
	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

05/19/2017

PRINTED: 05/31/2017

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

Electronically Signed

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
					(2
		245325	B. WING _		04/2	27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	
FOLEY	URSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 282	Continued From pa	age 1	F 28	32		
	R112's care plan re R112 had a deficit i dementia, confusio mobility, weakness toileting and reposi needed. During continuous starting at 6:45 a.m wheelchair in the ca and 400 units, clos a.m. R112 was pus beauty shop, where wheelchair. At 8:20 to the dining room breakfast, nursing R112 into the tub re asked another NA f Licensed practical room with R112 alc toileting/repositionin During interview on stated R112 was la approximately 6:30 the morning and th again until after 10 stated the reason t today was that the memory care unit. would have toileted breakfast and woul every 2 hours, but s	evised on 12/30/16, indicated in self care related to on, impaired balance, impaired and required assistance with tioning every 2 hours and as observation on 4/26/17, n. R112 was sitting in her ommon area between the 300 e to the nurses station. At 7:45 shed in her wheelchair to the e she remained in her 0 a.m. nursing staff pushed her for breakfast. Following staff returned R112 back to the sitting in her wheelchair. At g assistant (NA)-F brought bom in the 400 hall. NA-F to assist her in toileting R112. nurse (LPN)-D entered the tub ong with the 2 NAs and		Care Managers w plans to assure ap are in place for ora repositioning assis Managers will con ADL s and repose through PCC docu Care Managers w audits of 10% of th with oral & reposit compliance with d plan interventions Thereafter, these weekly for 2 week varied days for 30 compliance is ach will be conducted the time of the ress observational peri All staff providing residents shall be to complete care p directed on 5/22/2 A repositioning an tracking/audit tool monitoring. DON o	umentation. Additionally, ill conduct observational hose residents identified ioning needs to assure ocumentation & care daily for 7 days. audits will continue 2X s & then 1X/week on days or until 100% ieved. Individual audits on an ongoing basis at sidents MDS od. personal care to educated on the need blan interventions as 2017 and 5/23/2017. d oral cares will be used for or designee shall a. Results of monitoring ubmitted monthly to the review and	

Facility ID: 00629

If continuation sheet Page 2 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		245325	B. WING			(04/2	; 27/2017
NAME OF I	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY N	IURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	hours due to her ris During interview on stated R112 was to then normal. LPN-E care plan, R112 sho hours, however, tha accordance with the R112 could be at ris she is not reposition During interview on director of nursing (that R112 did not ge stated R112 was at and skin breakdown depended on them her expectation that another NA or herse able to complete ca communicating with not get to someone Facility policy Comp date of 11/16/16, in policy, "Is to develo comprehensive carr for each resident ar rights, to ensure we and services to atta possible physical, n being, consistent w comprehensive ass R9's annual MDS d moderate cognitive extensive assistant	k for skin breakdown. 4/26/17, at 11:29 a.m. LPN-D ileted and repositioned later 0 further stated that per the buld be repositioned every 2 at morning it was not done in a care plan. LPN-D stated sk for skin breakdown when ned at least every 2 hours. 4/26/17, at 12:57 p.m. the DON) stated it was "not good" at repositioned. The DON risk due to possible moisture n. The DON stated R112 for repositioning and it was t the NA's either walkie elf to assist when they are not ares and hoped they were n each other when they can brehensive Care Plan revision dicated the purpose of the p and implement a e plan that is person centered ad consistent with resident a provide the necessary care in or maintain the highest nental and psychosocial well ith the resident's	F	282			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	IURSING CENTER				53 PINE STREET OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R9's current care pl ADL (activities of da to muscle weakness needed extensive a personal hygiene, b independently once identified R9 had up oral cares were sup morning and evenir rinse dentures and independently after R9's Bedside Karde identified she wore provided morning a complete oral care During interview on stated she did not r oral cares and did r interview, R9 was of dentures in her more During observation morning cares were NA-E were observe to the wheelchair us to help sit to stand) once in the wheelch to use the restroom room into a larger b was brought back in room, and NA-D ma her lipstick and afte proceeded to ask F wanted to complete room and returned one for R9 and one	an dated 2/14/17, identified an aily living) self-care deficit due s and pain, indicating she assistance from one staff with but could complete oral cares e set up. The care plan oper dentures and directed opose to be done in the ng, identified, "[R9] is able to rinse mouth with mouthwash setup." ex report, dated 4/27/17, again upper dentures, oral care was nd evenings, and could independently after setup. 4/24/17, at 6:40 p.m. R9 eceive any assistance with not have any dentures. During ubserved without teeth or	F 2	282			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245325	B. WING			C 27/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	URSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	to brush her teeth b responded she war During continuous of 8:37 a.m. R9 was ju dining room. A coup a.m. an unidentified the dining room back were provided. At 9 her room, listening a.m. R9 was observe have dentures in her continued to be in h provided after breat During interview on stated staff would g finish up brushing her and brushing her te own oral care arour breakfast, however bathroom during the toothbrush had not in the original wrapp basin sitting on top sink. NA-D reported new toothbrush tha had not gone back check with R9 to se been completed. Na dentures in white pl left of the sink, report have been in there, NA-D went over to dentures. During interview on stated R9 wore den	before or after breakfast. R9 hted to brush after breakfast. bbservation on 4/26/17, at ust finishing breakfast in the ble of minutes later at 8:39 d staff member took R9 from ck to her room. No oral cares :12 a.m. R9 continued to sit in to music on a radio. At 9:40 ved in her room and did not er mouth. And at 9:59 a.m. R9 her room. No oral cares were	F 282			

If continuation sheet Page 5 of 24

		AND HUMAN SERVICES			FORM	: 05/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245325	B. WING	·····		C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY N	URSING CENTER			53 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	R9 up for her oral c some, and staff wor needed help. NA-E been competed sho morning, stating he for oral cares. NA-E completed oral care During interview on registered nurse (R set up assistance a RN-A stated she wo nursing assistants t completed oral care with brushing if she R9's oral cares wer morning and evenir During interview on DON stated resider should have as mud to complete oral care oral cares were to b evening at a minime	 NA-E stated staff would set sares, then R9 would brush uld assist R9 to finish if she thought R9's oral cares had ortly after R9 got up that r partner, NA-D, had set R9 up E was not aware NA-D had not es either. 4/26/17, at 1:13 p.m. N)-B stated R9 only needed and supervision with oral cares. buld have expected the to go back, made sure R9 es, and provided assistance needed it. RN-B reported e suppose to be done every mg with cares. 4/27/17, at 1:59 p.m. the not supervision for the the to be done every and the to be done every the suppose to be done every be done every the to be done every and the to be done every the to be done every the to be done every and the tobs done every and the to be done eve	F 282			
F 312 SS=D	10/19/16, directed, with brushing his or individual needs." 483.24(a)(2) ADL C	led Teeth, Brushing, revised "A resident should be assisted her teeth based on his or her CARE PROVIDED FOR IDENTS	F 312			6/6/17
	activities of daily livi services to maintair personal and oral h	no is unable to carry out ing receives the necessary n good nutrition, grooming, and ygiene. NT is not met as evidenced				

Facility ID: 00629

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		AND HUMAN SERVICES			0		APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	СОМ	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	URSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 312	Continued From pa	ige 6	F3	312			
	review, the facility f provided assistance residents (R9) revie (ADLs). Findings include: R9's annual Minimu 11/15/16, identified impairment, needed personal hygiene in and was edentulous R9's MDS Dental A indicated she had u reported were loose appointment. R9's a concerns, and direct cares. [R9] is able to cares independent! R9's current care p ADL self-care defic and pain, indicating assistance from on but could complete set up. The care pla dentures and direct be done in the mort identified "[R9] is all mouth with mouthw setup."	assessment, dated 2/14/17, upper dentures, which R9 e, but declined a dental assessment identified no oral cted, "Staff assist in denture to complete the rest of her oral			R9 s care plan & care sheets hav reviewed and are current. All residents who are dependent or for ADL assistance with oral cares had their care plans reviewed and/ updated as needed. The policy and protocols on oral care was reviewed and is current. Care Managers will initially audit al plans to assure appropriate interver are in place for oral hygiene assists Thereafter, Care Managers will con daily audits of ADL s , focusing or hygiene timeliness through PCC documentation. Additionally, Care Managers will conduct observation audits of 10% of those residents id with oral needs to assure complian documentation & care plan interven daily for 7 days. Thereafter, these a will continue 2X weekly for 2 weeks then 1X/week on varied days for 30 or until 100% compliance s achieved Individual audits will be conducted ongoing basis at the time of the res MDS observational period. All staff providing personal care to residents shall be educated on the to complete care plan interventions directed by 5/22/2017 and 5/23/20 An oral cares tracking/audit tool wi used for monitoring. DON or desig shall compile audit data. Results of	al entified ace with ntions audits s & 0 days ed. on an sidents need s as 17.	
	identified she wore provided morning a	upper dentures, oral care was and evenings, and could independently after setup.			monitoring activities will be submitt monthly to the QA Committee for re and recommendations.	ed	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	• .,	
FOLEY N	IURSING CENTER				53 PINE STREET OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 7	F 3	12			
	stated she did not r oral cares and did r	4/24/17, at 6:40 p.m. R9 eceive any assistance with not have any dentures. During bserved without teeth or uth.					
	morning cares were assistant (NA)-D ar transfer R9 from he a PAL lift (mechanic was already dresse NA-E asked if R9 n was brought out of bathroom. After toili into her room, NA-E made R9's bed. R9 after giving R9 her ask R9's roommate complete oral cares returned with two ne and one for R28. N cares, then asked F teeth before or after wanted to brush aft During continuous of 8:37 a.m. R9 was ju dining room. A coup a.m. an unidentified the dining room bac were provided. At 9 her room, listening a.m. R9 was observ have dentures in her	observation on 4/26/17, at ust finishing breakfast in the ole of minutes later at 8:39 I staff member took R9 from ok to her room. No oral cares :12 a.m. R9 continued to sit in to music on a radio. At 9:40 wed in her room and did not er mouth. And at 9:59 a.m. R9 her room. No oral cares were					

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PRINTED: 05/31/2017

		AND HUMAN SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245325	B. WING	i			C 27/2017
NAME OF !	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY N	NURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	During interview on stated staff would g finish up brushing he and brushing her te own oral care arour breakfast, however bathroom during the toothbrush had not in the original wrapp basin sitting on top sink. NA-D reported new toothbrush tha had not gone back check with R9 to se been completed. Na dentures in white pl left of the sink, repor have been in there, NA-D went over to have dentures. During interview on stated R9 wore den to and was constan around in her room R9 up for her oral c some, and staff won needed help. NA-E been completed oral care nurses assistants d cares, just if ADLs f During interview on registered nurse (R dentures, staff did a	age 8 4/26/17, at 10:34 a.m. NA-D get R9 dressed, and R9 would her hair, applying her make up, beth. NA-D stated R9 did her and 9:00 a.m. that morning after by when NA-D observed R9's e interview, R9's new been touched, was still sealed per, and was out of reach in a of a metal shelf above the d she had just brought in the t morning for R9 to use, but to set up the toothbrush, or be if oral cares had in fact A-D searched for R9's lastic standing drawers to the orting the dentures should and R9 rinses them herself. R9 who stated she did not 4/26/17, at 11:31 a.m. NA-E ntures only when she wanted attly moving the dentures . NA-E stated staff would set cares, then R9 would brush uld assist R9 to finish if she thought R9's oral cares had ortly after R9 got up that if partner, NA-D, had set R9 up E was not aware NA-D had not es either. NA-E reported the lid not chart specifically on oral had been completed.	F	312			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245325	B. WING	i			C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY N	URSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	assistance and sup would have expected back, made sure R provided assistance it. RN-B reported R be done every more RN-B further report cares during certain periods of the MDS document oral care RN-B stated the exp assistants commun and both were resp cares. RN-B observed dentures and during her dentures out of table. RN-B stated sup update her of R9 not having pain or diffici- personal choice. During interview on director of nursing (dentures or teeth sh assistance as they The DON further st provided in the more minimum. The DON to let residents do at they could, to re-ap document care and A facility policy entit 10/19/16, directed "	R9 only needed set up ervision with oral cares, but ed the nursing assistants to go 9 completed oral cares, and e with brushing if she needed 9's oral cares were suppose to ning and evening with cares. ed staff only documented oral n times, before assessment , and would otherwise s under "as needed" cares. pectation was that nursing icated cares with one another, onsible for documenting yed R9 was not wearing g the observation, R9 pulled the top drawer of the bedside she would only expect staff to ot wearing dentures if R9 was outy eating, not if it was R9's 4/27/17, at 1:59 p.m. the DON) stated residents with nould have as much needed to complete oral care. ated oral cares were to be ning and evening at a N reported she expected staff as much for themselves as proach if refused, and to	F 3	312			
F 314	individual needs." 483.25(b)(1) TREA	TMENT/SVCS TO	FS	314	1		6/6/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		(X3) DATE	SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		(
		245325	B. WING				27/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 53 PINE STREET		
FOLEY N	IURSING CENTER				OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 SS=D	PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer professional standa healing, prevent info from developing. This REQUIREMEN by: Based on observat review, the facility fa pressure reduction stationary chair for	RESSURE SORES Based on the essment of a resident, the	F S	314	R47 s plan of care has been revier and updated to reflect the need for pressure reducing cushions on all h seating arrangements. R112 s plan of care was reviewed	is	
	residents (R112) at ulcers. Findings include:	risk for developing pressure			current. All residents who are at risk for skin impairment have had their care plar	าร	
	2/24/17, indicated F impairments and ne bed mobility, transfe	imum Data Set (MDS) dated A47 had severe cognitive beded extensive assistance for ers and toileting. The MDS			reviewed and/or updated as needed a focus on pressure relieving device repositioning.		
	(7 or more episodes at least 1 continent	requently incontinent of urine s of urinary incontinence, but void) and frequently I (2 or more episodes of bowel			The policy and protocols on skin monitoring and interventions was reviewed and is current. Care Managers will initially audit all	care	

Facility ID: 00629

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI		APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`́сом	E SURVEY PLETED
		245325	B. WING				C 2 7/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEYN	IURSING CENTER				53 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	movement). The M dementia. The MDS developing pressur pressure ulcer (par presenting as a sha pink wound bed, wi acquired. The MDS pressure reducing of R47's Braden Scale ulcer risk) dated 2/2 low risk for develop R47's Comprehens 2/24/17, indicated F pressure ulcers. Th factors of; "Require pressure relief, slid noncompliance with repositioning. Non of required, and assis summary indicated to the left side of he 0.2 cm [centimeters depth. Resident has surrounding the are and a foam dressin Resident is currentl mattress and cushi R47's Tissue Tolera to determine appro	t least one continent bowel DS included a diagnosis of S identified R47 was at risk for e ulcers and had one Stage 2 tial thickness loss of dermis allow open ulcer with a red or thout slough) that was facility b identified interventions of a device for chair and bed. e (tool used to predict pressure 24/17, indicated R47 was at bing pressure ulcers. sive Skin assessment dated R47 was at risk for developing he assessment identified risk es assist to move body for es down in bed and/or chair, n encouraged/ setup compliance with toileting's and t of two with transfer." The , "[R47] has a small open area er gluteal sulcus the opening is s] x 0.4 x less than 0.1 cm of s some maceration ea. Will apply cavilon to area ig. Change it every 2 days. ly using a pressure reducing on in her w/c [wheelchair]."	F3	314	plans to assure appropriate interve are in place for repositioning and pr relieving devices. Thereafter, Care Managers will conduct daily audits repositioning compliance, focusing timeliness and the presence of pres- relieving devices through PCC documentation. Additionally, Care Managers will conduct observations audits of 10% of those residents idd with repositioning needs to assure compliance with documentation & of plan interventions for pressure relie devices daily for 7 days. Thereafter audits will continue 2X weekly for 2 & then 1X/week on varied days for days or until 100% compliance is achieved. Individual audits wll be conducted on an ongoing basis at to time of the residents MDS observation period. All staff providing personal care to residents shall be educated on the to complete care plan interventions directed on 5/22/2017 and 5/23/201 A repositioning & device tracking/atti will be used for monitoring. DON or designee shall compile audit data. of monitoring activities will be subm monthly to the QA Committee for re- and recommendations.	ressure for on ssure al entified care eving r, these weeks 30 the tional need as 17. udit tool Results nitted	
		ted 3/6/17, at 1:31 p.m. area was located on the right ad of the left.					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 05/31/2017 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	LE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		245325	B. WING		0,	C 4/27/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
FOLEY	URSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 12	F 314			
	at risk for skin integ bladder incontinent fragile skin, history Interventions includ pressure reducing of reducing cushion in R47's fall risk care R47 should be assi throughout the day, address a pressure wheelchair or statio recliner. During observation 7:22 p.m. R47 was wheelchair without in place, the pressu wheelchair was in the During observation was observed in the stationary dining roor reducing cushion. During observation nursing assistants (R47 from the reclin wheelchair, without NA-A and NA-B wh and transferred her cares with R47. Aft and NA-B transferred wheelchair without cushion. At 8:15 a.r R47's room and station	ed 4/12/17, indicated R47 was prity related to infrequent ee, advancing dementia, thin of healed right buttock wound. ed GEO mattress as a device and a pressure the recliner when sitting in it. plan dated 11/16/16, indicated sted to a stationary chair The care plans did not reducing cushion in the nary chair other than the on 4/24/17, at 4:52 p.m. to observed to be seated in her a pressure reducing cushion a pressure reducing cushion re reducing cushion for the he recliner in the day room. on 4/25/17, at 8:09 a.m. R47 e dining room seated on a om chair without any pressure on 4/26/17, at 7:53 a.m. NA)-A and NA-B transferred er in the day room into her a pressure reducing cushion. eeled R47 into her bathroom to the toilet and did morning ter cares were finished NA-A ed R47 back into her any pressure reducing m. NA-C knocked and entered ted to NA-A that she would sit ing for her medications to be medications were				

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		AND HUMAN SERVICES			FORM	: 05/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245325	B. WING			C / 27/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	NURSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	administered R47 w room in her wheeld 8:58 a.m. NA-A whe and did oral cares f sit in the the wheeld 9:06 a.m. R47 was the dining room and R47 into a stationar pressure reducing of was finished eating and NA-C transferred wheelchair, the presseated on the wheel During interview on stated R47 was trans meals to reduce he cushion was not in was sitting in it. NA- the recliner a lot and planned to be in the transferred over to a During observation was seated in the d dining chair without cushion. During observation licensed practical n buttocks and it was R47's buttocks did it LPN-A applied a ba During interview on registered nurse (R Stage 2 pressure ut that R47 should not	was brought out to the day hair without the cushion. At eeled R47 back to her room for R47 and R47 continued to chair without a cushion. At transported via wheelchair to d NA-A and NA-B transferred ry dining chair without any cushion in place. When R47 breakfast at 10:29 a.m. NA-B ed R47 back into her ssure reducing cushion was elchair. 4/26/17, at 1:29 p.m. NA-A nsferred in a stationary chair at the falls and stated that the R47's wheelchair when she -A stated that since R47 sat in d the cushion was care e recliner it was forgot and not	F 314			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()			(X3) DATI	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	IURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	there is nothing to r could cause a press further stated R47 v stationary chair whi intervention. RN-A I tolerance assessme regular dining room stationary chair was needed to be re-eva During interview on director of nursing (relieving cushion sh	edistribute her weight and sure ulcer to develop. RN-A was to be transferred into a le in the dining room as a fall had never done a tissue ent for R47 while sitting on a o chair. RN-A added the s not pressure relieving and aluated. (27/17, at 1:46 p.m. the (DON) stated that a pressure hould be in the wheelchair at a stationary chair would not	F3	314	4		
	diagnoses of arthrit Alzheimer's disease R112 required exter mobility, transfers, a developing pressure cognitive impairmer R112's care plan re R112 had a deficit i dementia, confusion mobility, weakness bathing, bed mobilit every 2 hours and a R112's Braden Sca Score Risks dated 3 moderate risk for sk mobility was very lir	vised on 12/30/16, indicated n self care related to n, impaired balance, impaired and required assistance with ty, dressing and repositioning					

Facility ID: 00629

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FOLEY	URSING CENTER				53 PINE STREET OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	indicated R112 was During continuous of starting at 6:45 a.m wheelchair in the co and 400 units, close a.m. R112 was pus beauty shop, where wheelchair. At 8:20 to the dining room f breakfast, nursing s commons area still 10:07 a.m. NA-F br in the 400 hall. NA- her in toileting R112 with R112 along wit husband declined a observation of R112 her skin was intact. During interview on stated R112 was las approximately 6:30 the morning and the again until after 10: stated the reason th today was that the of memory care unit. I would have toileted breakfast and would every 2 hours. NA-F NA was pulled away the best she could. R112's care plan di repositioned every 2 breakdown. During interview on	a trisk for skin breakdown. bbservation on 4/26/17, . R112 was sitting in her bmmon area between the 300 to the nurses station. At 7:45 hed in her wheelchair to the e she remained in her a.m. nursing staff pushed her for breakfast. Following staff returned R112 back to the sitting in her wheelchair. At ought R112 into the tub room F asked another NA to assist 2. LPN-D entered the tub room h the 2 NAs. Although R112's llowing this surveyor direct 2's bottom, LPN-D reported	F 3	14			

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PRINTED: 05/31/2017

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245325	B. WING			C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY N	URSING CENTER			OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314 F 332 SS=D	care plan, R112 sho hours, however, that accordance with the R112 could be at riss she is not reposition addition, LPN-D stat reposition herself in not get to her becau During interview on DON stated it was " get repositioned. The risk due to possible breakdown. The DO staff for repositionin that the NAs either to assist when they cares and hoped the each other when the Facility policy Prever revision date of 6/9/ ulcers are usually for remains in the same period of time causi decrease of circulat 483.45(f)(1) FREE O RATES OF 5% OR (f) Medication Error that its- (1) Medication error greater; This REQUIREMEN by:	 b further stated that per the buld be repositioned every 2 at morning it was not done in a care plan. LPN-D stated sk for skin breakdown when hed at least every 2 hours. In ted R112 is not able to ther chair and that staff did use they were short an aide. 4/26/17, at 12:57 p.m. the not good" that R112 did not he DON stated R112 was at moisture and skin DN stated R112 depended on ug and it was her expectation walkie another NA or herself are not able to complete ey were communicating with ey cannot get to someone. ention of Pressure Ulcers (16, indicated, "Pressure or a cion" OF MEDICATION ERROR 	F 314		lers	6/6/17
	Dased on Observal				1013	

Facility ID: 00629

If continuation sheet Page 17 of 24

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
JILANC	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		C
		245325	B. WING			
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IURSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 332	Continued From pa	ge 17	F 332	2		
		ailed to ensure 2 of 7 residents		have been reviewed and are cu	rrent.	
		tion was given with food as his resulted in a facility		All residents that require specia	I	
	medication error rat	5		indications for taking their medi	cations	
	Findings include:			have had their MAR reviewed to special indications are address		
	1/26/17, indicated F impairment. The M	num Data Set (MDS) dated R57 had severe cognitive DS included a diagnosis of eflux disease and had a		The policy on Administering Me was reviewed and is current. D designee[s] will conduct daily observational audits during me on various shifts, documenting	ON or d passes, med	
	physician on 3/10/1 administer calcium milligrams (mg)/ 5 r or gastrostomy tube	ary Report signed by the 7, included an order to carbonate suspension 1250 nilliliters (mL) by mouth (PO) e (g-tube) three times a day mmary also included a alcemia.		administrations for residents the meds taken with food daily for 7 Thereafter, audits will be condu- weekly on various shifts for 2 w 100% compliance is achieved, observational audits will be con- monthly X90 days.	7 days. cted 3X eeks. If random,	
	licensed practical n ml of calcium carbo	on 4/25/17, at 11:08 a.m. urse (LPN)-B administered 5 nate suspension via R57's ot provided at the time the ninistered		The Nursing Department will be on Administering Medications, s administering medications to be with food. Education will be con nursing staff responsible for ad medications on 5/22/2017 and	specifically e given npleted for ministering	
	stated that the phys medication adminis directed staff to adr suspension three the further stated that b medication as direct	4/25/17, at 11:22 a.m. LPN-B sician's orders in the electronic tration record (EMAR) ninister the calcium carbonate mes a day with food. LPN-B by not administrating the ted it could make R57 medication was administered ch.		Results of the random bi-weekl will be submitted monthly to the meeting for review and recomm	QA	

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	-	AND HUMAN SERVICES					FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245325	B. WING _					C 2 7/2017
NAME OF I	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
FOLEY	URSING CENTER				53 PINE STREET OLEY, MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 332	Continued From pa	ige 18	F 3	32				
	error. The DON fur is ordered or direct the medication sho snack. The Drug Education	rere considered a medication ther stated that if a medication ed to be given with food then uld be given with a meal or n Monograph dated 2017, arbonate suspension be taken						
	with meals.	DS dated 11/09/16, indicated a						
		esophageal reflux disease						
	physician on 3/3/17 hypokalemia and in potassium chloride mouth one time a d	ary Report signed by the , indicated a diagnosis of included an order to administer 30 milliequivalents (mEq) by lay. The order included e potassium chloride was to be						
	LPN-C administere chloride by mouth t	on 4/26/17, at 7:10 a.m. d 30 mEq of potassium o R43, however, food was not e the medication was						
	LPN-C stated that F that he had not gon breakfast. LPN-C re potassium chloride ordered as 30 mEq EMAR indicate that given with food. LP noticed these instru stated her understa	4/26/2017, at 7:54 a.m. R43 was still in his room and the to the dining room yet for eviewed the order in EMAR for and stated the dose was and that the instructions in this medication should be N-C stated that she had never actions before. In addition, she anding of these instructions is should be given immediately						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245325	B. WING				C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY	IURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332 F 371 SS=E	 prior to eating and t some toast right no and returned shortly The facility policy M Drug Reaction Rep medication error as prescribed, dispens resident; an omissic prescribing, dispens medication adminis documented allergy 483.60(i)(1)-(3) FOO STORE/PREPARE/ (i)(1) - Procure food considered satisfac authorities. (i) This may include from local producer and local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and food (iii) This provision do from consuming food (i)(2) - Store, prepa accordance with pro- service safety. (i)(3) Have a policy foods brought to res 	hat she would go and get him w. LPN-C then left the area y after with toast for R43. ledication Error and Adverse ort dated 4/24/15, defined a , " An incorrect medication bed, or administered to a on of a vital medication due to sing, or administering error; tered to an individual with a v to the at medication." OD PROCURE, /SERVE - SANITARY If from sources approved or tory by federal, state or local	F	332			6/6/17

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		(X3) DATE	0938-039 SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à		PLETED
		245325	B. WING		04/2) 27/2017
NAME OF	PROVIDER OR SUPPLIER	240020		STREET ADDRESS, CITY, STATE, ZIP CODE	04/2	.//2017
	NURSING CENTER			253 PINE STREET		
FULETI				FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From pa	ae 20	F 371			
	handling, and cons	-				
	Based on observatively fin the kitchen for an manner which reduillness. This had the 65 residents who a families and visitors activity. Findings include: During observation therapeutic recreation observed deep fryin activity. Multiple raw donuts hole cut out on the counter to T ready to eat donuts were resting directly TRA-A wore a hairr gloves. TRA-A was donuts with her bar two deep fryer bask fryer oil with tongs, pour the fried donut took the metal pan with Without washing he dough, TRA-A proceat donuts which ha and dipped them in them on the metal pare. The metal pan with the metal pan which has and dipped them in them on the metal pane.	tion, interview and document ailed to ensure food prepared a activity was handled in a ced the risk of food borne e potential to affect 27 out of ttended the activity, their s who also attended the on 4/26/17, at 1:57 p.m. ion assistant (TRA)-A was ng donuts in the kitchen for an v donuts cut outs and raw s rested on a metal sheet pan RA-A's left and a sheet of fried with two bowels of sugar y in front of TRA-A. Although, net, she was not wearing observed picking up raw e hands, placing them in the tests, turned them around in the and used the basket handle to ts into a metal bowel. She then el and set it on the right side of the ready to eat donuts. er hands after touching raw eeded to pick up the ready to ad just come out of the fryer the sugar, before placing pan with the other ready to eat e approximately 15 donuts TRA-A was observed to begin gain before she was		 The policy on Authorized Personnel Kitchen was revised and is current of 11, 2017. The policy on Hand Wash and Glove Use was also reviewed a current. The policy on Temperatures Safe Food Handling was reviewed a updated on May 17, 2017. On-going compliance: Therapeutic Recreation Staff will be provided education on Authorized Personnel is kitchen, Hand Washing and Glove U and Temperatures and Safe Food Handling. Education was completed the Therapeutic Recreation Staff on 18, 2017. The Therapeutic Recreation Director do weekly audits on Handwashing and Glove Use and Safe Food Handling recreation department activities involotion of a weeks of all TR staff. Thereafter, random audits will be conducted at least monthly for three months. Results of the audits will be submitted monthly to the QA meeting for review recommendations. Therapeutic Recreation Director and designee will be responsible for ong compliance. 	on May ing nd is s and ind in the Jse for May r will nd during olving	

Facility ID: 00629

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245325	B. WING			C 04/27/2017	
NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE 253 PINE STREET		
FOLEY N	URSING CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 21	F3	371			
	stated the donuts w Wednesday of the n a band came to pla families. She further made from scratch contained raw eggs activities staff befor asked, "Am I suppo only doing it the wa stating activities sta donut day. She furt would be an issue to dough," reporting s don't transfer the ray During observation TRA-A was now ob gloves, however, sh donuts, placed ther baskets, turned the tongs, and used the fried donuts into a r pick up the ready to sugar without chang handling raw donut donuts. During interview on appeared confused same process and gloves on. TRA-A do process. During the certified dietary ma kitchen and assiste spatula and new to needed to wash he	 4/26/17, at 1:57 p.m. TRA-A vere made every fourth month, their "donut day," when y for the residents and their er stated the donut dough was for the activities staff and as in it. TRA-A stated the re her did not use gloves and use to?" TRA-A reported, "I'm y the person prior to me did it," aff always made the donuts for her stated,"I would suppose it to touch the donuts after raw he should wear gloves so "you aw ingredients." on 4/26/17, at 2:15 p.m. served wearing clear plastic he continued to pick up raw in in the two deep fryer maround in the fryer oil with basket handle to pour the metal bowel, and proceeded to be eat donuts to dip them in the ging gloves in between dough and ready to eat 4/26/17, at 2:15 p.m. TRA-A stating she was doing the touching raw dough, just with lid not know how to fix the e interview, at 2:21 p.m. the nager (CDM) walked into the dTRA-A to find a metal ngs to use, stating TRA-A r hands and change her ouching raw dough and ready 					

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PRINTED: 05/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER. DENTIFICATION NUMBER: 245325 (X2) MULTIPLE CONSTRUCTION A BUILING (X3) DATE SURVEY COMPLETE B. WING NAME OF PROVIDER OR SUPPLIER 245325 B. WING (X3) DATE SURVEY COMPLETE B. WING (X3) DATE			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/31/2017 APPROVED . 0938-0391		
245325 B. WING 04/27/2017 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 233 PME STREET CONTROL NURSING CENTER FOLEY NURSING CENTER PHEPK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) DI PREFIX TAG PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREFIX TAG PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREFIX TAG PREFIX (EACH DEFICIENCY MIST BALE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREFIX TAG PREFIX (EACH DEFICIENCY MIST BALE DURING INTERVIEW ON 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worn. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transferring the germs on your hands onto the food that is going to be eaten, stating she taught "If you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw food, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. Uring interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and Here A should a should and thand for the proving many for the prov	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DAT COM	E SURVEY		
SUMMARY STATEMENT OF DEFICIENCIES (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ORDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPARING DEFICIENCY) F 371 Continued From page 22 to eat donuts or use the utensils and not touch the dough at all. F 371 F 371 F 371 During interview on 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worm. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transtring the germs on your hands onto the food that is going to be eaten, stating she taught "if you are going to be atten, stating she taught "if you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw of od, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. During interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and Image: Staff make hands because of cross contamination director (TRD) stated the activity staff were in charge of making donuts and			245325	B. WING					
FOLEY NURSING CENTER FOLEY, MN 56329 ^{MA ID} ^{PRETIX} ^{SUMMARY STATEMENT OF DEFICIENCIES ^{ID} ^{ID} ^{ID} ^{ID} ^{ID} ^{IE} ^{EACH DEFICIENCY MUST BE PRECIDED BY FULL ^{REGULATORY OR LSC IDENTIFYING INFORMATION) ^{ID} ^{ID} ^{ID} ^{ID} ^{ID} ^{ID} ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY} ^{ID} ^{ID} ^{ID} ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY} ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY} ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY} ^{IEACH DEFICIENCY} ^{IEACH DEFICIENCY ^{IEACH DEFICIENCY MUST ^{IEACH DEFICIENCY} ^{IEACH DEFICIENCY <!--</sup-->}}}}}}}}}}}</sup></sup></sup></sup></sup></sup>	NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 371 Continued From page 22 to eat donuts or use the utensils and not touch the dough at all. F 371 F 371 During interview on 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worn. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transferring the germs on your hands onto the food that is going to be eaten, stating she taught "if you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw food, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. During interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and	FOLEY N	URSING CENTER							
 to eat donuts or use the utensils and not touch the dough at all. During interview on 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worn. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transferring the germs on your hands onto the food that is going to be eaten, stating she taught "if you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw food, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. During interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETION		
the staff were taught to wear gloves and a hairnet, but thought it was a bit hard to fry the donuts with the plastic gloves on due to the hot oil. The TRD stated everything else was pre-made for the activities except the donuts and she had not been aware of any issues with frying the donuts. A facility policy entitled Hand Washing And Glove Use, revised 4/26/17, directed, "Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching	F 371	to eat donuts or use the dough at all. During interview on CDM stated activitie every month and wa all afternoon so she staff make the donu The CDM stated the kitchen for donut da know that was not of activities supervisor worn. The CDM stated the contamination and hands onto the food stating she taught " touch it." The CDM food should not be food, and even if we raw then cooked fo eggs in the dough. During interview on therapeutic recreati activity staff were in the staff were taugh hairnet, but thought donuts with the plas oil. The TRD stated pre-made for the ad she had not been a the donuts. A facility policy entit Use, revised 4/26/1 used when working	4/26/17, at 2:38 p.m. the es puts on their donut day as usually in care conferences thad not seen the activities uts in the kitchen until that day. e activities staff only used the ay and TRA-A should have obay. The CDM reported the r knew gloves were to be ted ready to eat foods could bare hands because of cross transferring the germs on your d that is going to be eaten, if you are going to eat it don't further stated ready to eat touched after touching raw earing gloves cannot touch od, because there are raw 4/26/17, at 2:49 p.m. the on director (TRD) stated the n charge of making donuts and at to wear gloves and a to wear gloves on due to the hot everything else was ctivities except the donuts and ware of any issues with frying led Hand Washing And Glove 7, directed, "Gloves may be with food to avoid contact	F 371					

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		AND HUMAN SERVICES				FORM	05/31/2017 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245325			B. WING			C 04/27/2017			
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
FOLEY NURSING CENTER				253 PINE STREET FOLEY, MN 56329					
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 371	Continued From page 23			871					
	A facility policy entitled Temperatures And Safe Food Handling, undated, identified food-borne illnesses could be caused due to raw foods contaminating ready to eat or cooked foods. In addition, the policy directed to used tongs and not handle food with bare hands for proper food handling.								

Facility ID: 00629

If continuation sheet Page 24 of 24
		AND HUMAN SERVICES	5	FARMAN	FORM	05/23/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245325	B. WING		04/	26/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOLEY NURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КO	000		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Foley Health Cente compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, r, Building 01 was found not in e requirements for participation hid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EPOC		
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510	SHAL DIVISION STREET, SUITE 145				
	By e-mail to both:					
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 05/19/2017
				19. 19	a th ta al - t-	and a set the set

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.

		AND HUMAN SERVICES			FORM	0: 05/23/20 APPROVE 0: 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245325	B. WING		04	/26/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
FOLEY NURSING CENTER				253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	DEFICIENCY MUS FOLLOWING INFO	tate.mn.us n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:	KO	00		
	to correct the defici	what has been, or will be, done ency. oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency				
	Foley Nursing Cent partial basement. T 3 different times. The constructed in 1970 Type II(222) constru- was added to the n- of Type V(111). In 1 the west of Units 2 and Dining Room the Type II(000) constru- west of Unit 2 which V(111) construction added to the facility to be of type II(111)	pected as 1 building: er is a 1-story building with a the building was constructed at the original building was 0 and was determined to be of uction. In 1976, an addition orth that was determined to be 994 additions were added to & 4, additions to the Kitchen hat were determined to be of uction and a Chapel addition to h was determined to be Type . In 2008 two additions were r, the North wing determined construction and the PT/OT d to be of type II(111).			ŧ	
		tially fire sprinkler protected siency. The entire facility has a			continuation she	

					OMB NO. 0938 (X3) DATE SURV	
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	COMPLETED 04/26/2017	
		245325	B. WING			
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NURSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	X5) PLETIO ATE
K 000	Continued From pa	age 2 able fire alarm system with	K 00	0		
		the corridors and spaces				
		censed capacity of 89 beds of 66 at the time of the survey.				
	NOT MET as evide	t 42 CR, Subpart 483.70(a) is enced by: Occupancies - Construction	K 13	3	5/18/	/17
	Where separated of with 18/19.1.3.2 or construction type is building, unless a 2 accordance with 8 construction type is * The construction construction of the based on the story building in accorda 18/19.1.6.1 * The construction building enclosing based on the appli 18.1.3.5, 19.1.3.5, This STANDARD Based on observa- revealed that 1 of found not in compl Safety Code" 2012 19.1.1.4. These definition	ties - Construction Type occupancies are in accordance 18/19.1.3.4, the most stringent s provided throughout the 2-hour separation is provided in .2.1.3, in which case the s determined as follows: type and supporting health care occupancy is in which it is located in the ance with 18/19.1.6 and Tables type of the areas of the the other occupancies shall be cable occupancy chapters. 8.2.1.3 is not met as evidenced by: ations and staff interview, it was 4 - two hour fire separation was iance with NFPA 101 "The Life 2 edition (LSC) sections efficient conditions could allow mbustion to travel from one		Maintenance has applied Fire Ca the penetrations by the beauty sh around communication wires that passing through the fire barrier w section above ceiling tile over the barrier doors with a fire rated wal	iop t are vall e fire	

Facility ID: 00629

If continuation sheet Page 3 of 12

ATCARCAL		(X1) PROVIDER/SUPPLIER/CLIA	(VO) MULTIDI	E CONSTRUCTION	(X3) DAT	E SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01 B. WING		COMPLETED 04/26/2017	
		245325				
AME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OLEYN	URSING CENTER		1 -	53 PINE STREET OLEY, MN 56329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 133	Continued From pa	age 3	K 133			
:	20 of 66 residents, number of staff, an	as well as an undetermined d visitors.		residents, visitors and staff. A policy/procedure will be implem the Environmental Service Dire there is any above ceiling cons	ector when	
	Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on			done, that penetrates the barrie This was completed on: 5/18/2 This plan of correction constitu	er. 017	
	04/26/2017, observ door by the beauty communication wir	vations revealed that the fire shop had penetrations around es that are passing through section above the ceiling tile		allegation of compliance.		
14 000	Maintenance Supe		K 222			5/18/17
K ZZZ SS=D		Doors	R 222			0,10,17
	equipped with a lat use of a tool or key using one of the fo arrangements:	I means of egress shall not be ch or a lock that requires the r from the egress side unless llowing special locking OR SECURITY THREAT				
	clinical security nee only one locking de each door and pro- rapid removal of oc locks; keying of all	king arrangements for the eds of the patient are used, evice shall be permitted on visions shall be made for the occupants by: remote control of locks or keys carried by staff at				
r.	to the staff at all tin 18.2.2.2.5.1, 18.2.2	such reliable means available nes. 2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 LOCKING ARRANGEMENTS				

If continuation sheet Page 4 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/23/201 APPROVEI 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245325	B. WING	i		04/	26/2017	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
FOLEY N	FOLEY NURSING CENTER				253 PINE STREET FOLEY, MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 222	being met. In additi electrical locks that upon loss of power protected by a supe system and the lock complete smoke de constantly monitore within the locked sp and detection syste doors upon activation 18.2.2.2.5.2, 19.2.2 DELAYED-EGRES ARRANGEMENTS Approved, listed de installed in accorda permitted on door a ordinary hazard cor throughout by an ap fire detection system automatic sprinkler 18.2.2.2.4, 19.2.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled installed in accorda permitted. 18.2.2.2.4, 19.2.2.2 ELEVATOR LOBBY ARRANGEMENTS Elevator lobby exit accordance with 7.2 door assemblies in by an approved, su	Locking requirements are on, the locks must be fail safely so as to release to the device; the building is ervised automatic sprinkler ked space is protected by a etection system (or is ed at an attended location bace); and both the sprinkler ems are arranged to unlock the on. .2.5.2, TIA 12-4 S LOCKING layed-egress locking systems nce with 7.2.1.6.1 shall be assemblies serving low and neents in buildings protected oproved, supervised automatic m or an approved, supervised system. .4 DLLED EGRESS LOCKING Egress Door assemblies nce with 7.2.1.6.2 shall be		222				
					The Director of Environmental Se	ervices		

Facility ID: 00629

If continuation sheet Page 5 of 12

		& MEDICAID SERVICES			1	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245325	B. WING		04/2	26/2017
AME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IURSING CENTER		253 PINE STREET FOLEY, MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 222	Continued From pa	age 5	K 222			
	facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.2.2 and 7.2.1.6 and the 2015 MN State Fire Code, Appendix I. This deficient practice could affect 12 of 66 residents, as well as an undetermined number of staff, and visitors.			will place and monitor instructions to open the door with the keypad k exit door located at the stairwell by resident room 510. This was completed on: 5/18/2017 This plan of correction constitutes allegation of compliance.	by the /	
	Findings include:					
	04/26/2017, Obser door located at the 510 has a coded ke to the exit, but did r	veen 9:30 a.m. to 1:30 p.m. on vation revealed that the exit stairwell exit by resident room eypad used to unlock the door not have a the code or v to open the door posted at keypad.				
	Maintenance Supe					6/16/17
SS=F	Spinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automati accordance with NI Installation of Sprin In Type I and II con measures are pern sprinkler protection or local regulations In hospitals, sprink closets of patient s of the closet does r	d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the skler Systems. struction, alternative protection nitted to be substituted for	K 351			

If continuation sheet Page 6 of 12

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245225	B. WING		04/26/2017	
	PROVIDER OR SUPPLIER	245325		TREET ADDRESS, CITY, STATE, ZIP CODE	04/26/2017	
			2! F			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	
K 351	 Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, This STANDARD Based on observa system is not insta accordance with N Installation of Sprin The failure to main compliance with N being place out of the fire protection of an emergency t residents, as well a staff, and visitors. Findings include: On facility tour bet 04/26/2017, obser deficient condition The sprinkler pin maintenance office piping. The facility has is constructed of c construction attack exterior exit stainw room that is not fin 	13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 9.7, 9.7.1.1(1) is not met as evidenced by: ations, the automatic sprinkler illed and maintained in IFPA 13 the Standard for the hkler Systems 2010 edition. IFPA 13 (10) could allow system service causing a decrease in system capability in the event hat could affect 6 of 66 as an undetermined number of ween 9:30 a.m. to 1:30 p.m. on vations revealed the following s, ping that is located in the a enclosure type of canopy that ombustible wood frame hed to the building over the ell from the lower level boiler e sprinkler protected.	K 351	 Maintenance removed and will m the sprinkler piping that is located in maintenance office which had wires attached. This was completed on: 4/26/2017 This plan of correction constitutes o allegation of compliance. Summit Fire Protection will install monitor a sprinkler system in the enclosure type of canopy that is constructed of combustible wood fra construction attached to the building the exterior exit stairwell from the lo level boiler room that is not fire sprin Completion Date: 6/16/2017 This plan of correction constitutes o allegation of compliance. 	ur and g over wer nkled.	
K 372	This deficient cond Maintenance Supe NFPA 101 Subdivi		K 372		5/18/17	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245325	B. WING		04/2	26/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 253 PINE STREET		
				FOLEY, MN 56329 PROVIDER'S PLAN OF COF	PECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETIO DATE
	Continued From pa Smoke Barrie	age 7	K 37	2		
	Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to terr Smoke dampers an penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This STANDARD in Based on observa facility failed to mail barrier walls in acc of NFPA 101 "The sections 19-3.7.3 a could affect 20 of 6 undetermined num allowing smoke to compartment to an Findings include: On facility tour betw 04/26/2017, observa- were multiple pene conduit and commu- passing through the ceiling tiles in the of the smoke barrier was	anical smoke control system s not met as evidenced by: tion and staff interview, the intain 1 of 5 several smoke ordance with the requirements Life Safety Code" 2012 edition and 8.3. This deficient practice 66 residents as well as an ber of staff, and visitors by propagate from one smoke other.		Maintenance has applied F the penetrations found arou and communication wires th through the smoke barrier v ceiling tiles in the care man section of the barrier wall. A policy/procedure policy will implemented by the Enviror Director when there is any a construction done, that pen barrier. Completion Date: 5/18/2017 This plan of correction cons allegation of compliance.	nd the conduit nat are passing vall above the ager's office be nmental above ceiling etrates the	

Facility ID: 00629

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PRINTED: 05/23/2017

					IB NO: 0938-03 (X3) DATE SURVEY		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	01 - MAIN BUILDING 01	COMPLETED 04/26/2017		
		245325	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE			
OLEY N	URSING CENTER		253 PINE STREET FOLEY, MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
K 372	Continued From p	age 8	K 372				
K 511	Maintenance Supe NFPA 101 Utilities		K 511		4/26/17		
	complies with NFF electrical wiring an NFPA 70, National	as or related gas piping A 54, National Fuel Gas Code, d equipment complies with Electric Code. Existing ontinue in service provided no					
	Based on observative facility had mu affecting the facilit not in accordance Safety Code" 2012 and the NFPA 70 " edition. This defici	is not met as evidenced by: ation and interview with the staff Itiple deficient conditions y's electrical system that were with the NFPA 101 "The Life 2 edition (LSC) section 9.1.2 National Electrical Code" 2011 ient practice could affect 6 of ell as an undetermined number 's.		Maintenance has removed and will monitor the multi-plug adapters and multiple extension cord in the maintenance office. Completion Date: 4/26/2017 This plan of correction constitutes of allegation of compliance.			
	Findings include:						
	04/26/2017, obser were multi-plug ac	ween 9:30 a.m. to 1:30 p.m. on vations revealed that there laptors and multiple extension maintenance office.					
K 521	This deficient cond Maintenance Supe NFPA 101 HVAC	dition was verified by a ervisor.	K 521		5/19/17		

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	СОМ	PLETED	
		245325	B. WING		04/26/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FOLEY	URSING CENTER			253 PINE STREET FOLEY, MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
	Continued From pa	age 9	K 52	1			
	S=F HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2						
	Based on docume interview, the fire/s been maintained in requirements of NI 5.2. This deficient proper operation o could allow smoke 66 of 66 residents	is not met as evidenced by: entation review and staff moke damper system has not accordance with the FPA 90A(12) section 5-1.2 and practice does not ensure the f the fire/smoke dampers and migration to negatively affect as well as an undetermined ind visitors to the facility.		Summit Fire Protection will test the facility's fire and smoke dam documentation of the inspection test/inspection with documentati follow every 4 years there after. of Environmental Service will me insure that test/inspection is sch Completion Date: 5/19/2017 This plan of correction constitute allegation of compliance.	pers with . This on will Director onitor to eduled.		
	04/26/2017, it was the facility's fire an test/inspection doc an interview with th	ween 9:30 a.m. to 1:30 p.m. on revealed during the review of d smoke damper umentation and confirmed by ne Maintenance Supervisor, Id not provide any current					
	testing documenta smoke dampers ha within the last 4 yes	tion verifying that the fire and as been tested or inspected					

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY	
ID PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPLETED 04/26/2017		
		245325	B. WING				
IAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IURSING CENTER		253 PINE STREET FOLEY, MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
K 781	Continued From pa	age 10	K 781				
K 7 81 SS=F	NFPA 101 Portable	Space Heaters	K 781			4/26/17	
001	Portable Space He Portable space he prohibited in all he	ating devices shall be alth care occupancies, except,					
	areas where the he 212 degrees Fahre 18.7.8, 19.7.8 This STANDARD Based on observa used portable space areas and failed to	esleeping staff and employee eating elements do not exceed enheit (100 degrees Celsius). is not met as evidenced by: ation and interview, the facility be heaters in non-resident care provide a policy on the use of		Maintenance removed the space h with a temp reading of 227 degrees no UL Listing. Director of Environm Services has composed a policy for	s F and nental		
	the requirements of Safety Code" 2012 This deficient prac	aters in the facility that meets of the NFPA 101 "The Life edition (LSC) section 19.7.8. tice could affect 66 of 66 as an undetermined number of		Services has composed a policy to use of space heaters at Foley Nurs Center. Completion Date: 4/26/2017 This plan of correction constitutes allegation of compliance.	sing		
	Findings include:						
	04/26/2017, observed and that the far being used when the space hare also did not have a listing annotated a also discovered at Maintenance Super had a policy for the stated, "we don't have and the stated and the stated and the set the set the stated and the set the s	ween 9:30 a.m. to 1:30 p.m. on vations and staff interview acility has a fire place space in the medical records office. eater was turned on, a temp with a heat detection gun at screen of 227 degrees F. It a Underwriter's Laboratory (UL) nywhere on the device. It was the time of the discovery the ervisor was asked if the facility a use of space heaters and he ave a space heater use policy".					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/23/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DAT COM	TE SURVEY MPLETED
		245325	B. WING		04	/26/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
FOLEY N	FOLEY NURSING CENTER			253 PINE STREET FOLEY, MN 56329		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE
K 781	Continued From pa This deficient condi Maintenance Super	tion was verified by a	К 7	781		

Facility ID: 00629

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 10, 2017

Mr. Andrew Huhta, Administrator Foley Nursing Center 253 Pine Street Foley, MN 56329

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5325026

Dear Mr. Huhta:

The above facility was surveyed on April 24, 2017 through April 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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

Foley Nursing Center May 10, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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 Kathy Lucas at (320)223-7343 or Kathleen.Lucas@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

ato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		00629	B. WING	04	C 04/27/2017	
	PROVIDER OR SUPPLIER	253 PINE	STREET	STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC)	FOLEY, M TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet <http: td="" www.health.<=""><td>participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are</td><td></td><td>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.</td><td></td></http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are		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.		

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

TITLE

(X6) DATE

05/19/17

Electronically Signed

6899

If continuation sheet 1 of 27

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
		00629	B. WING		C 27/2017
	PROVIDER OR SUPPLIER	STREET AD 253 PINE FOLEY, M	STREET	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Department of Heal you electronically. J is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, the corrected prior to el Minnesota Departm On 04/24/2017 - 04 Department's staff, the following correc Please indicate in y correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	· =
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565		6/6/17
	by: Based on interview	ent is not met as evidenced , observation and document ailed to provide timely		Care plans for R112 & R9 have been reviewed and updated as needed to reflect	:t

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00629		·	TE SURVEY MPLETED C 1/27/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	
	IURSING CENTER	253 PINE FOLEY, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 565	Continued From pa	ige 2	2 565		
	failed to provide ora reviewed for followi Findings include: R112's admission M indicated R112 requirements developing pressur cognitive impairment R112's care plan re R112 had a deficit i dementia, confusio mobility, weakness toileting and reposit needed. During continuous of starting at 6:45 a.m wheelchair in the co and 400 units, close a.m. R112 was pus beauty shop, where wheelchair. At 8:20 to the dining room for breakfast, nursing R112 into the tub ro asked another NA to Licensed practical of room with R112 alo toileting/repositionin	Ainimum Data Set (MDS) uired extensive assist of two bed mobility, was at risk for e ulcers and had severe nt. evised on 12/30/16, indicated n self care related to n, impaired balance, impaired and required assistance with tioning every 2 hours and as observation on 4/26/17, . R112 was sitting in her ommon area between the 300 e to the nurses station. At 7:45 hed in her wheelchair to the e she remained in her a.m. nursing staff pushed her for breakfast. Following staff returned R112 back to the sitting in her wheelchair. At assistant (NA)-F brought oom in the 400 hall. NA-F to assist her in toileting R112. nurse (LPN)-D entered the tub ing with the 2 NAs and ng was provided.		current status. All residents who are dependent on staff for ADL assist and repositioning have have their care plans reviewed and/or updated as needed. The policy and protocols on repositioning and oral cares was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate interventions are in place for oral hygiene and needed repositioning assistance. Thereafter, Car Managers will conduct daily audits of ADL s and repositioning timeliness through PCC documentation. Additionally Care Managers will conduct observations audits of 10% of those residents identifie with oral & repositioning needs to assure compliance with documentation & care plan interventions daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance is achieved. Individual audits will be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need complete care plan interventions as directed on 5/22/2017 and 5/23/2017. A repositioning and oral cares	d i re v, al d
	stated R112 was la approximately 6:30	4/26/17, at 10:21 a.m. NAF st toileted and repositioned at a.m. when they got her up in ey were not able to get to her		tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00629		LE CONSTRUCTION	(X3) DATE S COMPL C 04/2	ETED
	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE	•	
	IURSING CENTER	253 PINE				
	IURSING CENTER	FOLEY, N	IN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 3	2 565			
2 202	again until after 10: stated the reason the today was that the of memory care unit. I would have toileted breakfast and would every 2 hours, but se away today, she (N could. NA-F further indicated R112 sho hours due to her rise During interview on stated R112 was to then normal. LPN-E care plan, R112 sho hours, however, that accordance with the R112 could be at rise she is not reposition During interview on director of nursing (that R112 did not ge stated R112 was at and skin breakdown depended on them her expectation that another NA or herse able to complete cat communicating with not get to someone Facility policy Comp	 00 a.m. (3.5 hours). NA-F ney were later in getting to her pother NA got pulled to the NA-F stated normally they R112 by 9:00 am, right after d have repositioned R112 since the other NA was pulled A-F) was doing the best she stated that R112's care plan puld be repositioned every 2 k for skin breakdown. 4/26/17, at 11:29 a.m. LPN-D ileted and repositioned later 0 further stated that per the puld be repositioned every 2 at morning it was not done in e care plan. LPN-D stated sk for skin breakdown when ned at least every 2 hours. 4/26/17, at 12:57 p.m. the DON) stated it was "not good" et repositioned. The DON risk due to possible moisture n. The DON stated R112 for repositioning and it was t the NA's either walkie elf to assist when they are not ures and hoped they were n each other when they can . 	2 303	QA Committee for review and recommendations. Date of Completion: June 6, 2017		
anagata D	comprehensive car for each resident ar rights, to ensure we	e plan that is person centered nd consistent with resident e provide the necessary care in or maintain the highest				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		СОМ	E SURVEY PLETED
		00629	B. WING		04/	27/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
FOLEY I	NURSING CENTER		STREET MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From par possible physical, m being, consistent w comprehensive ass R9's annual MDS d moderate cognitive extensive assistance including brushing H (had no teeth). R9's current care pl ADL (activities of da to muscle weakness needed extensive a personal hygiene, b independently once identified R9 had up oral cares were sup morning and evenir rinse dentures and independently after R9's Bedside Karde identified she wore provided morning a complete oral care During interview on stated she did not r oral cares and did r interview, R9 was o dentures in her mor During observation morning cares were NA-E were observe	ge 4 nental and psychosocial well ith the resident's sessment." ated 11/15/16, identified a impairment, needed se with personal hygiene ner teeth, and was edentulous and dated 2/14/17, identified ar aily living) self-care deficit due s and pain, indicating she assistance from one staff with but could complete oral cares set up. The care plan oper dentures and directed opose to be done in the ng, identified, "[R9] is able to rinse mouth with mouthwash setup." ex report, dated 4/27/17, again upper dentures, oral care was nd evenings, and could independently after setup. 4/24/17, at 6:40 p.m. R9 eceive any assistance with not have any dentures. During bserved without teeth or	2 565			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	`́сом	E SURVEY PLETED
		00629	B. WING		C 04/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	NURSING CENTER		STREET AN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 565	room into a larger k was brought back in room, and NA-D m her lipstick and after proceeded to ask F wanted to completer room and returned one for R9 and one with her oral cares, to brush her teeth k responded she war During continuous 6 8:37 a.m. R9 was ju dining room. A coup a.m. an unidentified the dining room bac were provided. At 9 her room, listening a.m. R9 was obsern have dentures in he continued to be in h provided after brea	bathroom. After toileting, R9 nto her room, NA-E left the ade R9's bed. R9 asked for er giving R9 her lipstick, NA-D R9's roommate (R28) if she e oral cares. NA-D left the with two new toothbrushes, e for R28. NA-D assisted R28 then asked R9 if she wanted before or after breakfast. R9 nted to brush after breakfast. observation on 4/26/17, at ust finishing breakfast in the ole of minutes later at 8:39 d staff member took R9 from ck to her room. No oral cares 9:12 a.m. R9 continued to sit in to music on a radio. At 9:40 wed in her room and did not er mouth. And at 9:59 a.m. R9 her room. No oral cares were kfast.	2 565			
	stated staff would g finish up brushing h and brushing her te own oral care aroun breakfast, however bathroom during th toothbrush had not	4/26/17, at 10:34 a.m. NA-D jet R9 dressed, and R9 would her hair, applying her make up, beth. NA-D stated R9 did her nd 9:00 a.m. that morning after , when NA-D observed R9's e interview, R9's new been touched, was still sealed				
	basin sitting on top sink. NA-D reported new toothbrush tha had not gone back check with R9 to se been completed. N	per, and was out of reach in a of a metal shelf above the d she had just brought in the t morning for R9 to use, but to set up the toothbrush, or ee if oral cares had in fact A-D searched for R9's lastic standing drawers to the				

If continuation sheet 6 of 27

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			С	
		00629	B. WING			04/27/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
	URSING CENTER		ESTREET MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	ige 6	2 565				
	have been in there,	orting the dentures should and R9 rinses them herself. R9 who stated she didn't have					
	stated R9 wore der to and was constant around in her room R9 up for her oral of some, and staff wo needed help. NA-E been competed sho morning, stating he	4/26/17, at 11:31 a.m. NA-E nures only when she wanted titly moving the dentures . NA-E stated staff would set eares, then R9 would brush uld assist R9 to finish if she thought R9's oral cares had ortly after R9 got up that r partner, NA-D, had set R9 up E was not aware NA-D had not es either.					
	registered nurse (R set up assistance a RN-A stated she wo nursing assistants t completed oral care with brushing if she	4/26/17, at 1:13 p.m. N)-B stated R9 only needed and supervision with oral cares build have expected the to go back, made sure R9 es, and provided assistance needed it. RN-B reported re suppose to be done every ng with cares.					
	DON stated resider should have as mu- to complete oral ca	4/27/17, at 1:59 p.m. the nts with dentures or teeth ch assistance as they needed re. The DON further stated be provided in the morning and um.					
	10/19/16, directed,	tled Teeth, Brushing, revised "A resident should be assisted r her teeth based on his or her					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00629	B. WING		C 04/27/2017	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	IURSING CENTER		STREET	,		
	IONSING CENTER	FOLEY,	MN 56329		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
2 565	Continued From pa	ge 7	2 565			
	director of nursing of /or revise policies a implementation of t provided as directe could be provided t	HOD OF CORRECTION: The or designee could review and nd procedures related to the he care plan to ensure care is d by the care plan. Education o the staff. The quality ee could develop a system to eness of the plan.				
2 900	(21) days. MN Rule 4658.0523	CORRECTION: Twenty-one 5 Subp. 3 Rehab - Pressure	2 900		6/6/17	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to ensure proper		R47 s plan of care has been review and updated to reflect the need for	red	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00629	B. WING		04/27/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
FOLEY	URSING CENTER	253 PINE FOLEY, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPI
2 900	Continued From pa	ge 8	2 900		
	stationary chair for failed to provide time	seating in the wheelchair and 1 of 2 residents (R47),and rely repositioning for 1 of 2 risk for developing pressure		pressure reducing cushions on all seating arrangements. R112 s plan of care was reviewed current. All residents who are at risk for ski	l and is
	2/24/17, indicated F	imum Data Set (MDS) dated R47 had severe cognitive		impairment have had their care pla reviewed and/or updated as neede focus on pressure relieving devices repositioning.	ns d with a
	bed mobility, transfe indicated R47 was (7 or more episodes at least 1 continent incontinent of bowe incontinence, but at movement). The M dementia. The MDS developing pressur pressure ulcer (par presenting as a sha pink wound bed, wi acquired. The MDS pressure reducing of R47's Braden Scale	eeded extensive assistance for ers and toileting. The MDS frequently incontinent of urine s of urinary incontinence, but void) and frequently el (2 or more episodes of bowel t least one continent bowel DS included a diagnosis of S identified R47 was at risk for e ulcers and had one Stage 2 tial thickness loss of dermis allow open ulcer with a red or thout slough) that was facility b identified interventions of a device for chair and bed.		The policy and protocols on skin monitoring and interventions was r and is current. Care Managers will initially audit al plans to assure appropriate interve are in place for repositioning and p relieving devices. Thereafter, Care Managers will conduct daily audits repositioning compliance, focusing timeliness and the presence of pre relieving devices through PCC documentation. Additionally, Care Managers will conduct observation audits of 10% of those residents id with repositioning needs to assure	l care entions ressure for on ssure al entified
	low risk for develop R47's Comprehens 2/24/17, indicated F pressure ulcers. Th factors of; "Require pressure relief, slide noncompliance with repositioning. Non o required, and assis summary indicated	24/17, indicated R47 was at ing pressure ulcers. ive Skin assessment dated R47 was at risk for developing te assessment identified risk s assist to move body for es down in bed and/or chair, n encouraged/ setup compliance with toileting's and t of two with transfer." The , "[R47] has a small open area er gluteal sulcus the opening is		compliance with documentation & plan interventions for pressure relia devices daily for 7 days. Thereafter audits will continue 2X weekly for 2 & then 1X/week on varied days for days or until 100% compliance is achieved. Individual audits wll be conducted on an ongoing basis at of the residents MDS observationa All staff providing personal care to residents shall be educated on the complete care plan interventions a directed on 5/22/2017 and 5/23/20	eving r, these 2 weeks 30 the time I period. need to s

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL		
		00629	B. WING			27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
	URSING CENTER	253 PINE FOLEY, N	-				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 9	2 900				
	depth. Resident has surrounding the are and a foam dressin Resident is current mattress and cushi R47's Tissue Tolera to determine appro- indicated R47 need two hours while sitt A progress note dat indicated the open gluteal sulcus inste R47's care plan dat at risk for skin integ bladder incontinent fragile skin, history Interventions includ pressure reducing or reducing cushion in	ea. Will apply cavilon to area g. Change it every 2 days. ly using a pressure reducing on in her w/c [wheelchair]." ance Assessment (assessment priate repositioning schedule) led to be repositioned every ing. ted 3/6/17, at 1:31 p.m. area was located on the right ad of the left. ted 4/12/17, indicated R47 was grity related to infrequent ee, advancing dementia, thin of healed right buttock wound. led GEO mattress as a device and a pressure o the recliner when sitting in it.		A repositioning & device tra will be used for monitoring. designee shall compile aud of monitoring activities will I monthly to the QA Committ and recommendations.	DON or it data. Results be submitted		
	R47 should be assi throughout the day. address a pressure wheelchair or statio recliner. During observation	plan dated 11/16/16, indicated sted to a stationary chair The care plans did not reducing cushion in the onary chair other than the on 4/24/17, at 4:52 p.m. to observed to be seated in her					
	wheelchair without in place, the pressu wheelchair was in t During observation was observed in the	a pressure reducing cushion are reducing cushion for the he recliner in the day room. on 4/25/17, at 8:09 a.m. R47 e dining room seated on a om chair without any pressure					

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00629	B. WING		C 04/27/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	NURSING CENTER		STREET MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 10	2 900			
	nursing assistants R47 from the reclin wheelchair, without NA-A and NA-B wh and transferred hei cares with R47. Af and NA-B transferr wheelchair without cushion. At 8:15 a. R47's room and sta with R47 while wait administered. After administered R47 w room in her wheel 8:58 a.m. NA-A wh and did oral cares sit in the the wheel 9:06 a.m. R47 was the dining room an R47 into a stationa pressure reducing was finished eating and NA-C transferr wheelchair, the pre- seated on the wheel During interview or stated R47 was tra meals to reduce he cushion was not in was sitting in it. NA the recliner a lot ar planned to be in the transferred over to During observation was seated in the observation	was brought out to the day chair without the cushion. At eeled R47 back to her room for R47 and R47 continued to chair without a cushion. At transported via wheelchair to d NA-A and NA-B transferred ry dining chair without any cushion in place. When R47 g breakfast at 10:29 a.m. NA-B red R47 back into her essure reducing cushion was elchair. A 4/26/17, at 1:29 p.m. NA-A nsferred in a stationary chair a er falls and stated that the R47's wheelchair when she A-A stated that since R47 sat in ad the cushion was forgot and not	t			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00629	B. WING		C 04/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	URSING CENTER		STREET MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	cushion.					
	licensed practical n buttocks and it was R47's buttocks did LPN-A applied a ba During interview on registered nurse (R Stage 2 pressure u that R47 should no without a pressure there is nothing to n could cause a pres further stated R47 y stationary chair whi intervention. RN-A tolerance assessm regular dining room	on 4/27/17, at 10:03 a.m. hurse (LPN)-A assessed R47's is slightly pink but blanchable. not have any pressure ulcers. arrier spray to her buttocks. A/27/17, at 12:52 p.m. RN)-A stated that R47 had a ulcer recently heal. RN-A stated t be sitting in her wheelchair reducing cushion because redistribute her weight and sure ulcer to develop. RN-A was to be transferred into a ile in the dining room as a fall had never done a tissue ent for R47 while sitting on a n chair. RN-A added the s not pressure relieving and aluated.				
	director of nursing relieving cushion sl	A 4/27/17, at 1:46 p.m. the (DON) stated that a pressure hould be in the wheelchair at a stationary chair would not ssure reducing.				
	diagnoses of arthrit Alzheimer's disease R112 required exte mobility, transfers,	MDS dated 12/21/16, indicated tis, osteoporosis and e. The MDS also indicated ensive assist of two with bed and locomotion, was at risk for re ulcers and had severe nt.				
mesota D	R112 had a deficit i	evised on 12/30/16, indicated in self care related to n, impaired balance, impaired				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00629		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/27/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
OLEYN	NURSING CENTER		STREET MN 56329			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 12	2 900			
		and required assistance with ty, dressing and repositioning as needed.				
	Score Risks dated moderate risk for sl mobility was very lin Comprehensive Sk	le For Predicting Pressure 3/20/17, indicated R112 was at kin breakdown and that mited. In addition, R112's in Assessment dated 3/20/17, at risk for skin breakdown.	t			
	starting at 6:45 a.m wheelchair in the co and 400 units, close a.m. R112 was pus beauty shop, where wheelchair. At 8:20 to the dining room f breakfast, nursing s commons area still 10:07 a.m. NA-F br in the 400 hall. NA- her in toileting R112 with R112 along with husband declined a	observation on 4/26/17, 1. R112 was sitting in her formon area between the 300 te to the nurses station. At 7:45 hed in her wheelchair to the te she remained in her a.m. nursing staff pushed her for breakfast. Following staff returned R112 back to the sitting in her wheelchair. At rought R112 into the tub room F asked another NA to assist 2. LPN-D entered the tub room th the 2 NAs. Although R112's allowing this surveyor direct 2's bottom, LPN-D reported				
	stated R112 was la approximately 6:30 the morning and the again until after 10: stated the reason the today was that the memory care unit. I would have toileted breakfast and would	4/26/17, at 10:21 a.m. NAF st toileted and repositioned at a.m. when they got her up in ey were not able to get to her 00 a.m. (3.5 hours) NA-F hey were later in getting to her other NA got pulled to the NA-F stated normally they I R112 by 9:00 a.m., right after d have repositioned R112 F added that since the other				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00629	B. WING			C 27/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	URSING CENTER	253 PINE FOLEY, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	the best she could. R112's care plan di	y today, she (NA-F) was doing NA-F further stated that id indicate that R112 should be 2 hours due to her risk for skin				
	stated R112 was to then normal. LPN-I care plan, R112 sh hours, however, tha accordance with th R112 could be at ri- she is not repositio addition, LPN-D sta reposition herself ir	n 4/26/17, at 11:29 a.m. LPN-D bileted and repositioned later D further stated that per the ould be repositioned every 2 at morning it was not done in e care plan. LPN-D stated sk for skin breakdown when ned at least every 2 hours. In ated R112 is not able to n her chair and that staff did use they were short an aide.				
	DON stated it was get repositioned. T risk due to possible breakdown. The Do staff for repositionin that the NAs either to assist when they cares and hoped th	n 4/26/17, at 12:57 p.m. the "not good" that R112 did not he DON stated R112 was at e moisture and skin ON stated R112 depended on ng and it was her expectation walkie another NA or herself or are not able to complete ney were communicating with ney cannot get to someone.				
	revision date of 6/9 ulcers are usually f remains in the sam	ention of Pressure Ulcers 1/16, indicated, "Pressure ormed when a resident ie position for an extended sing increased pressure or a tion"				
		THOD OF CORRECTION: sing or her designee could				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED C
		00629	B. WING	04/27/2017	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
	NURSING CENTER	253 PINE FOLEY, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 900	develop policies an residents have a co the risk for develop individualized interv implemented. The of designee could edu the polices and pro- ulcers. The director could develop a mo residents are asses to prevent the deve TIME PERIOD FOR	d procedure to ensure mprehensive assessment of ing pressure ulcers so that	2 900		
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ng receives the necessary ngood nutrition, grooming,	2 920		6/6/17
	by: Based on observati review, the facility fa provided assistance residents (R9) revie (ADLs). Findings include: R9's annual Minimu 11/15/16, identified	ent is not met as evidenced on, interview and document ailed to ensure residents were with oral cares for 1 of 3 wed for activities of daily living um Data Set (MDS) dated a moderate cognitive d extensive assistance with		R9 s care plan & care sheets have been reviewed and are current. All residents who are dependent on star for ADL assistance with oral cares have had their care plans reviewed and/or updated as needed. The policy and protocols on oral cares was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate intervention	ff e

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TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00629	B. WING			7/2017
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OLEYN	IURSING CENTER	253 PINE FOLEY, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 15	2 920			
2 320	personal hygiene in and was edentulous R9's MDS Dental A indicated she had u reported were loose appointment. R9's a concerns, and direct cares. [R9] is able t cares independent! R9's current care p ADL self-care defic and pain, indicating assistance from on but could complete set up. The care pla dentures and direct be done in the more identified "[R9] is al mouth with mouthw setup." R9's Bedside Karde identified she wore provided morning a complete oral care During interview on stated she did not r oral cares and did r interview, R9 was o dentures in her more During observation morning cares were assistant (NA)-D ar	actual provide the set of the set		are in place for oral hygien Thereafter, Care Manager daily audits of ADL s, foc hygiene timeliness through documentation. Additional Managers will conduct obs audits of 10% of those res with oral needs to assure of documentation & care plan daily for 7 days. Thereafter will continue 2X weekly for 1X/week on varied days fo until 100% compliance s a Individual audits will be con ongoing basis at the time of MDS observational period. All staff providing personal residents shall be educate complete care plan interve directed by 5/22/2017 and An oral cares tracking/aud used for monitoring. DON shall compile audit data. R monitoring activities will be monthly to the QA Commit and recommendations. Date of Completion: June for	s will conduct using on oral PCC y, Care ervational idents identified compliance with interventions r, these audits 2 weeks & then r 30 days or chieved. nducted on an of the residents care to d on the need to ntions as 5/23/2017. it tool will be or designee esults of submitted tee for review	

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00629	B. WING	B. WING		27/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	NURSING CENTER	253 PINE				
OLLII		FOLEY, N	AN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ae 16	2 920			
	was brought out of bathroom. After toil into her room, NA-E made R9's bed. R9 after giving R9 her ask R9's roommate complete oral cares returned with two ne and one for R28. N cares, then asked F	eeded to use the restroom. R9 her room into a larger eting, R9 was brought back E left the room, and NA-D asked for her lipstick and lipstick, NA-D proceeded to (R28) if she wanted to a. NA-D left the room and ew toothbrushes, one for R9 A-D assisted R28 with her oral R9 if she wanted to brush her r breakfast. R9 responded she er breakfast.				
	8:37 a.m. R9 was ju dining room. A coup a.m. an unidentified the dining room bac were provided. At 9 her room, listening a.m. R9 was observ have dentures in he	bbservation on 4/26/17, at ust finishing breakfast in the ole of minutes later at 8:39 I staff member took R9 from ck to her room. No oral cares :12 a.m. R9 continued to sit in to music on a radio. At 9:40 ved in her room and did not er mouth. And at 9:59 a.m. R9 her room. No oral cares were kfast.				
	stated staff would g finish up brushing her te own oral care arour breakfast, however bathroom during the toothbrush had not in the original wrapp basin sitting on top sink. NA-D reported new toothbrush tha had not gone back	4/26/17, at 10:34 a.m. NA-D et R9 dressed, and R9 would her hair, applying her make up, eth. NA-D stated R9 did her nd 9:00 a.m. that morning after , when NA-D observed R9's e interview, R9's new been touched, was still sealed per, and was out of reach in a of a metal shelf above the d she had just brought in the t morning for R9 to use, but to set up the toothbrush, or ee if oral cares had in fact				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00629	B. WING		04/	27/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
FOLEY N	IURSING CENTER		STREET MN 56329			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 17	2 920			
	been completed. NA-D searched for R9's dentures in white plastic standing drawers to the left of the sink, reporting the dentures should have been in there, and R9 rinses them herself. NA-D went over to R9 who stated she did not have dentures.					
	stated R9 wore den to and was constant around in her room R9 up for her oral c some, and staff wor needed help. NA-E been competed sho morning, stating he for oral cares. NA-E completed oral care nurses assistants d	4/26/17, at 11:31 a.m. NA-E atures only when she wanted ttly moving the dentures . NA-E stated staff would set cares, then R9 would brush uld assist R9 to finish if she thought R9's oral cares had ortly after R9 got up that r partner, NA-D, had set R9 up was not aware NA-D had not es either. NA-E reported the lid not chart specifically on oral had been completed.				
	registered nurse (R dentures, staff did a assessments, and visits. RN-B stated assistance and sup would have expected back, made sure R provided assistance it. RN-B reported R be done every more RN-B further report cares during certain periods of the MDS document oral care	4/26/17, at 1:13 p.m. N)-B stated R9 just had upper a quarterly and annual R9 always refused dental R9 only needed set up ervision with oral cares, but ed the nursing assistants to go 9 completed oral cares, and e with brushing if she needed 9's oral cares were suppose to ning and evening with cares. ed staff only documented oral n times, before assessment a and would otherwise res under "as needed" cares.				
	assistants commun and both were resp	pectation was that nursing licated cares with one another, onsible for documenting ved R9 was not wearing				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00629	B. WING			C 04/27/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	IURSING CENTER		E STREET MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 920	Continued From pa	ge 18	2 920				
	her dentures out of table. RN-B stated update her of R9 no	g the observation, R9 pulled the top drawer of the bedside she would only expect staff to ot wearing dentures if R9 was sulty eating, not if it was R9's					
	director of nursing (dentures or teeth sl assistance as they The DON further st provided in the mor minimum. The DON to let residents do a	4/27/17, at 1:59 p.m. the (DON) stated residents with hould have as much needed to complete oral care. ated oral cares were to be ning and evening at a N reported she expected staff as much for themselves as proach if refused, and to I refusals.					
	10/19/16, directed '	led Teeth, Brushing, revised A resident should be assisted her teeth based on his or her					
	The director of nurs review policies and care needs as direc residents and provi to follow cares as d	THOD OF CORRECTION: sing (DON) or designee could procedures for providing oral cted by the assessed needs of de education to nursing staff irected by the care plan. The op and implement an auditing ngoing compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
21015	MN Rule 4658.0610 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			6/6/17	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	X3) DATE SURV COMPLETED	
		00629	B. WING		C 04/27/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	URSING CENTER	253 PINE FOLEY, N	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CON	(X5) MPLET DATE
21015	Continued From pa	age 19	21015			
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.					
	by: Based on observative review, the facility find the kitchen for an manner which reduillness. This had the 65 residents who a	ent is not met as evidenced ion, interview and document ailed to ensure food prepared n activity was handled in a uced the risk of food borne e potential to affect 27 out of ttended the activity, their s who also attended the		The policy on Authorized Personnel Kitchen was revised and is current of 11, 2017. The policy on Hand Wash and Glove Use was also reviewed a current. The policy on Temperatures Safe Food Handling was reviewed a updated on May 17, 2017.	on May ing nd is s and	
	therapeutic recreat observed deep fryin activity. Multiple ray donuts hole cut out on the counter to T ready to eat donuts were resting directl TRA-A wore a hairr gloves. TRA-A was	on 4/26/17, at 1:57 p.m. ion assistant (TRA)-A was ng donuts in the kitchen for an w donuts cut outs and raw s rested on a metal sheet pan RA-A's left and a sheet of fried with two bowels of sugar y in front of TRA-A. Although, net, she was not wearing observed picking up raw re hands, placing them in the		On-going compliance: Therapeutic Recreation Staff will be provided education on Authorized Personnel kitchen, Hand Washing and Glove L and Temperatures and Safe Food Handling. Education was completed the Therapeutic Recreation Staff on 18, 2017. The Therapeutic Recreation Directo do weekly audits on Handwashing a Glove Use and Safe Food Handling recreation department activities invo food for 3 weeks of all TR staff.	Jse for May r will nd during	
	two deep fryer bask fryer oil with tongs, pour the fried donu took the metal bow the metal pan with Without washing he dough, TRA-A proc eat donuts which he	kets, turned them around in the and used the basket handle to ts into a metal bowel. She then el and set it on the right side of the ready to eat donuts. er hands after touching raw seeded to pick up the ready to ad just come out of the fryer the sugar, before placing		Thereafter, random audits will be conducted at least monthly for three months. Results of the audits will be submitte monthly to the QA meeting for review recommendations. Therapeutic Recreation Director and	ed w and	

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/27/2017	
		00629	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	URSING CENTER	253 PINE FOLEY, N	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
21015	Continued From pa	ge 20	21015			
	them on the metal pan with the other ready to eat donuts. There were approximately 15 donuts already prepared. TRA-A was observed to begin the process over again before she was interrupted by the surveyor.			designee will be responsible for compliance. Date or Correction: June,6,20		
We a ba fam mad con acti ask only stat don wou dou don Dur TR/ glov don bas tong fried pick sug han	Wednesday of the a band came to pla families. She furthe made from scratch contained raw eggs activities staff befor asked, "Am I suppo only doing it the wa stating activities sta donut day. She furt would be an issue t dough," reporting s don't transfer the ra	vere made every fourth month, their "donut day," when y for the residents and their or stated the donut dough was for the activities staff and is in it. TRA-A stated the re her did not use gloves and ose to?" TRA-A reported, "I'm y the person prior to me did it," off always made the donuts for her stated,"I would suppose it o touch the donuts after raw he should wear gloves so "you tw ingredients."				
	TRA-A was now ob gloves, however, sh donuts, placed ther baskets, turned the tongs, and used the fried donuts into a r pick up the ready to sugar without change	served wearing clear plastic ne continued to pick up raw in in the two deep fryer m around in the fryer oil with be basket handle to pour the netal bowel, and proceeded to be eat donuts to dip them in the ging gloves in between dough and ready to eat				
	appeared confused same process and gloves on. TRA-A d process. During the	4/26/17, at 2:15 p.m. TRA-A stating she was doing the touching raw dough, just with lid not know how to fix the interview, at 2:21 p.m. the nager (CDM) walked into the				

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		00629	B. WING			C 04/27/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	IURSING CENTER		STREET MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21015	Continued From pa	age 21	21015				
	spatula and new to needed to wash he gloves in between to to eat donuts or use the dough at all. During interview on CDM stated activitie every month and w all afternoon so she staff make the dom The CDM stated th kitchen for donut da know that was not activities superviso worn. The CDM state not be touched with contamination and hands onto the food stating she taught " touch it." The CDM food should not be food, and even if w raw then cooked fo eggs in the dough.	ad TRA-A to find a metal ngs to use, stating TRA-A r hands and change her touching raw dough and ready e the utensils and not touch a 4/26/17, at 2:38 p.m. the es puts on their donut day as usually in care conferences e had not seen the activities uts in the kitchen until that day e activities staff only used the ay and TRA-A should have okay. The CDM reported the r knew gloves were to be ated ready to eat foods could n bare hands because of cross transferring the germs on your d that is going to be eaten, 'if you are going to eat it don't further stated ready to eat touched after touching raw earing gloves cannot touch od, because there are raw					
	the staff were taugh hairnet, but though donuts with the plas oil. The TRD stated pre-made for the ad	n charge of making donuts and ht to wear gloves and a t it was a bit hard to fry the stic gloves on due to the hot d everything else was ctivities except the donuts and ware of any issues with frying					
		tled Hand Washing And Glove 7, directed, "Gloves may be					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00629	B. WING			27/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NURSING CENTER		STREET MN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21015	Continued From pa	age 22	21015			
		with food to avoid contact must be worn when touching od."				
	Food Handling, und illnesses could be of contaminating read addition, the policy	tled Temperatures And Safe dated, identified food-borne caused due to raw foods ly to eat or cooked foods. In directed to used tongs and no are hands for proper food	t			
	The administrator a and revise food ser to assure that food manner. Staff coul The certified dietary	THOD FOR CORRECTION: and the dietician could review rvice policies and procedures is served in a sanitary d be trained as necessary. y manager could monitor the paration on a periodic basis.				
	TIME PERIOD FOR One (21) days.	R CORRECTION: Twenty-				
21545	MN Rule 4658.132	0 A.B.C Medication Errors	21545			6/6/17
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepan prescribed and what administered to res	ust ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of ns Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually sidents in the nursing home; or stration of expired				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED C 04/27/2017	
		00629	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	URSING CENTER	253 PINE FOLEY, N				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE DATE
21545	Continued From pa	ige 23	21545			
	error. A significant (1) an error of discomfort or jeopa safety; or (2) medication requires the medication be titrated to a spece medication error con- precipitate a reoccut toxicity. All medication prescribed. An inco- error report must be that occurs. Any si resident reactions r physician or the phy- resident or the resid designated represe must be made in th C. All medication prescribed. An inco- report must be filed occurs. Any signific resident reactions r physician or the phy- resident or the resid designated represe must be made in th This MN Requirement by: Based on observation review, the facility f (R57, R43) medication	any significant medication medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single buld alter that level and urrence of symptoms or ions are administered as cident report or medication e filed for any medication error gnificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ons are administered as ident report or medication error I for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record.		R57 & R43 s MAR & provider or have been reviewed and are curr All residents that require special indications for taking their medica	ent.	
	Findings include:			have had their MAR reviewed to a special indications are addressed		

5PIE11

If continuation sheet 24 of 27

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00629	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 04/27/2017	
	STREET AD 253 PINE	STREET	STATE, ZIP CODE	04/27/2017	
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
		TAG			
Continued From pa	ge 24	21545			
 R57's annual Minimum Data Set (MDS) dated 1/26/17, indicated R57 had severe cognitive impairment. The MDS included a diagnosis of gastroesophageal reflux disease and had a feeding tube. R57's Order Summary Report signed by the physician on 3/10/17, included an order to administer calcium carbonate suspension 1250 milligrams (mg)/ 5 milliliters (mL) by mouth (PO) or gastrostomy tube (g-tube) three times a day with meals. The summary also included a diagnosis of hypocalcemia. During observation on 4/25/17, at 11:08 a.m. licensed practical nurse (LPN)-B administered 5 ml of calcium carbonate suspension via R57's g-tube. Food was not provided at the time the medication was administered 			The policy on Administering Medications was reviewed and is current. DON or designee[s] will conduct daily observational audits during med passes, on various shifts, documenting med administrations for residents that require meds taken with food daily for 7 days. Thereafter, audits will be conducted 3X weekly on various shifts for 2 weeks. If 100% compliance is achieved, random, observational audits will be continued monthly X90 days. The Nursing Department will be educated on Administering Medications, specifically administering medications to be given with food. Education will be completed for nursing staff responsible for administering medications on 5/22/2017 and 5/23/2017.		
stated that the phys medication adminis directed staff to adr suspension three the further stated that b	sician's orders in the electronic tration record (EMAR) minister the calcium carbonate mes a day with food. LPN-B by not administrating the				
nauseated and the	medication was administered				
director of nursing (given as directed w error. The DON furt is ordered or directed	(DON) stated medications not ere considered a medication ther stated that if a medication ed to be given with food then				
	OF CORRECTION PROVIDER OR SUPPLIER JURSING CENTER JURSING CENTER JURSING CENTER JURSING CENTER JURSING CENTER JURSING CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From participation 1/26/17, indicated F impairment. The Mi gastroesophageal r feeding tube. R57's Order Summ physician on 3/10/1 administer calcium milligrams (mg)/ 5 r or gastrostomy tube with meals. The sur- diagnosis of hypoca During observation licensed practical n ml of calcium carbo g-tube. Food was n medication was adr During interview on stated that the physis medication adminis directed staff to adr suspension three till further stated that b medication as direct nauseated and the too soon before lun During interview on director of nursing (given as directed w error. The DON fur- is ordered or director the medication sho	OF CORRECTION IDENTIFICATION NUMBER: 00629 00629 PROVIDER OR SUPPLIER STREET AD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 R57's annual Minimum Data Set (MDS) dated 1/26/17, indicated R57 had severe cognitive impairment. The MDS included a diagnosis of gastroesophageal reflux disease and had a feeding tube. R57's Order Summary Report signed by the physician on 3/10/17, included an order to administer calcium carbonate suspension 1250 milligrams (mg)/ 5 milliliters (mL) by mouth (PO) or gastrostomy tube (g-tube) three times a day with meals. The summary also included a diagnosis of hypocalcemia. During observation on 4/25/17, at 11:08 a.m. licensed practical nurse (LPN)-B administered 5 ml of calcium carbonate suspension via R57's g-tube. Food was not provided at the time the medication was administered During interview on 4/25/17, at 11:22 a.m. LPN-B stated that the physician's orders in the electronic medication administration record (EMAR) directed staff to administer the calcium carbonate suspension three times a day with food. LPN-B further stated that by not administrating the medication as directed it could make R57 nauseated and the medication was administered too soon before lunch. During interview on 4/27/17, at 1:44 p.m. the director of nursing (DON) stated medications not given as directed were considered a medication error. The DON further stated that if a medication is ordered or directed to be given with food the	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00629 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00629 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR USCIDENTIFYING INFORMATION) ID REGULATORY OR USCIDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION ACTOR SHOULD CROSS-RENCED TO THE APPROPRI DEFICIENCY) Continued From page 24 21545 R57's annual Minimum Data Set (MDS) dated 1/26/17, indicated R57 had severe cognitive gastroscophageal reliux disease and had a feeding tube. The policy on Administering Medicati was reviewed and is current. DON on designee(5) will conduct daily observational audits during med pas on various shifts, documenting med diministre calcium carbonate suspension 1250 milligrams (mg) /5 milliliters (mL) by mouth (PO) or gastroscopmy tube (g-tube) three times a day with meals. The summary also included a diagnosis of hypocalcemia. The Nursing Department will be conducted weekly on various shifts for 2 weeks. During observation on 4/25/17, at 11:28 a.m. licensed practical nurse (LPN)-B administered 5 m l of calcium carbonate suspension via R57's or low as ond provided at the time the medication was administered Results of the random bi-weekly aud be submitted monthly to the QA mee for review and recommendations. During interview on 4/25/17, at 11:22 a.m. LPN-B stated that the physician's orders in the electronic medication as directed it could make R57 nauseated and the medication was administered too soon before lunch. Results of the rando	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
					С		
		00629			04/	27/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
	NURSING CENTER		STREET MN 56329				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21545	Continued From pa	age 25	21545				
	directed calcium ca with meals.	arbonate suspension be taken					
		DS dated 11/09/16, indicated a esophageal reflux disease	ı				
	physician on 3/3/17 hypokalemia and in potassium chloride mouth one time a c	hary Report signed by the 7, indicated a diagnosis of included an order to administer 30 milliequivalents (mEq) by day. The order included e potassium chloride was to be					
	LPN-C administere chloride by mouth t	on 4/26/17, at 7:10 a.m. d 30 mEq of potassium o R43, however, food was not e the medication was					
	LPN-C stated that I that he had not gor breakfast. LPN-C re potassium chloride ordered as 30 mEq EMAR indicate that given with food. LP noticed these instru- stated her understa that the medication prior to eating and some toast right no	A 4/26/2017, at 7:54 a.m. R43 was still in his room and be to the dining room yet for eviewed the order in EMAR for and stated the dose was and that the instructions in t this medication should be N-C stated that she had never uctions before. In addition, she anding of these instructions is a should be given immediately that she would go and get him by. LPN-C then left the area y after with toast for R43.					
	Drug Reaction Rep medication error as	Medication Error and Adverse port dated 4/24/15, defined a s, " An incorrect medication sed, or administered to a					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
AND PLAN OF GURREGTION		IDENTIFICATION NUMBER.	A. BUILDING:			
		00629	B. WING			C 27/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	IURSING CENTER	253 PINE FOLEY, M	STREET AN 56329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
21545	prescribing, dispen medication adminis documented allergy SUGGESTED MET The facility adminis (DON) or designee and procedures, ec ongoing monitoring orders are correctly physician orders.	age 26 on of a vital medication due to sing, or administering error; stered to an individual with a y to the at medication." THOD OF CORRECTION: strator and director of nursing could review facility policies ducate staff and implement an y system to ensure all resident y implemented as directed by R CORRECTION: Twenty one	21545	DEFICIENC	Y)	