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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60CL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245491**

2.STATE VENDOR OR MEDICAID NO.
(L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **09/01/2010**

6. DATE OF SURVEY **07/11/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kim Settergren, NFE NE II 08/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 08/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/19/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245491 August 18, 2017

Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Dear Ms. Peterson:

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 23, 2017 the above facility is certified for or recommended for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2017

Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: Project Number S5491026

Dear Ms. Peterson:

On June 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 18, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 18, 2017, effective June 23, 2017 and therefore remedies outlined in our letter to you dated June 1, 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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60CL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

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(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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

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(L9) **09/01/2010**

6. DATE OF SURVEY **05/18/2017** (L34)

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

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01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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13.Total Certified Beds **72** (L17)

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR Senior-Social Work Specialist 06/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/17/2017 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2017

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: Project Number S5491026

Dear Ms. Peterson:

On May 18, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 27, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 18, 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 November 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a bathroom sink was provided at the appropriate height for 1 of 3 residents (R67) reviewed for accommodation of needs. Findings include: R67's Face Sheet printed 5/18/17, identified diagnoses that included cerebral infarction	F 246	It is the policy of Augustana Care Moose Lake to ensure that all reasonable needs and preferences are accommodated for each resident in the facility. A new policy and procedure was developed by the facility to ensure the requirement is met. Resident R67 will have a new occupational therapy evaluation completed with recommendations made for accommodation of sink height and	6/23/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 (stroke), injury of lumbar, sacral and pelvic nerves, and hemiplegia (paralysis) affecting left side. R67's care plan revised 4/7/17, indicated staff to provide set up at wheel chair height for grooming and provide supervision for oral hygiene. On 5/16/17, at 9:38 a.m. R67 stated her bathroom sink was high. R67 stated while brushing her teeth, she can't spit into the sink, "The sink is too high for short people." On 5/18/17, at 2:15 p.m. during a tour with the director of maintenance (DOM), R67's bathroom was observed. R67 stated her sink and bathroom mirror were too high for her. The DOM verified the sink and mirror would be too high for someone in a wheel chair. On 5/18/17, at 2:46 p.m. nursing assistant (NA)-C stated R67 was not able to stand at the sink for hygiene, and had to remain seated in her wheel chair. The facility was unable to provide a policy on accommodation of needs.	F 246	cares to ensure the resident□s needs are met. Resident R67 will be provided with basin and mirror at bedside to ensure she is able to complete self cares with minimal assistance. All residents in the facility will be assessed to ensure reasonable accommodation of needs using an environmental checklist. All new residents will also be assessed upon admission to the facility using the environmental checklist. DON or designee will audit 10% of resident□s records per week for four weeks and then monthly for three months to ensure all needs are being reasonably accommodated. Results of audits will be reviewed by facility quality assurance committee to ensure compliance. DON is responsible for plan of correction. Corrected by: 6/23/17.	
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 248		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 2 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided for 1 of 3 residents (R17) reviewed for activities. Findings include: R17's Face Sheet printed 5/18/17, identified diagnoses that included Alzheimer's disease, vascular dementia, major depressive disorder, and episodic mood disorder. R17's quarterly Minimum Data Set (MDS), dated 2/19/17, indicated R17 had severe cognitive impairment. R17's annual MDS dated 11/27/16, indicated it was very important for R17 to listen to music he liked. The MDS indicated it was important for R17 to have books, newspapers, and magazines to read. The MDS also indicated it was somewhat important for R17 to be around animals such as pets, keep up with the news, do things with groups of people, and participate in religious services or practices. R17's care plan dated 6/24/16, indicated R17 was at risk for isolation due to Alzheimer's disease and dementia. The care plan further identified R17 had not been initiating independent leisure activities (R17 had a history of drawing) and had shown little interest even when drawing material was set-up for him. The care plan also indicated	F 248	It is the policy of Augustana Care Moose Lake to ensure that each resident□s activity interests are met through our therapeutic recreation program. Resident R17 activity assessment and therapeutic recreation care plan was updated to include his risk for isolation and interventions to encourage participation in activities of interest including one-one visits with staff and volunteers. Through use of attendance records the facility will identify other residents who are at high risk for isolation and update their assessments and care plans as indicated. Activity director or designee will audit 10% of resident records weekly for four weeks then monthly for three months to ensure high risk residents are participating in activities of interest. Results of audits will be reviewed by facility quality assurance committee to ensure compliance. Facility activity director responsible for plan of correction. Corrected by: 6/23/17.	

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	245491	A. BUILDING _____ B. WING _____	05/18/2017

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R17 required encouragement, reminders and direction to attend activities of interest.

R17's Client/Resident Activities Participation records printed on 5/17/17, indicated R17 attended six group activities between 2/1/17, and 5/17/17.

R17's quarterly Activity Assessment, dated 5/17/17, indicated R17 was alert to the present, and had difficulty recalling prior events unless prompted. The assessment indicated R17 had been napping between meals, and was no longer involved in drawing (even with set-up & coaching). The assessment further indicated R17's hearing was impaired, and staff needed to increase volume and decrease background noise when speaking, and may also need to repeat and rephrase sentences due to R17's cognition. The assessment also indicated R17 had been attending bingo on occasion. The assessment indicated during entertainment events, staff would bring R17 his concertina, and encourage R17 play along with entertainer on occasion. R17 was on the 1:1 list, and staff had been notified to visit more frequently and encourage socialization. The assessment directed staff was to continue to offer reminders of activities, and escort R17 to activities of prior interest. The assessment indicated it was beneficial for R17 to be brought to entertainment events once they had started.

On 5/17/17, at 8:34 a.m. R17 was observed finishing eating breakfast in the dining room. R17 propelled himself in his wheel chair out of the dining room, and was transported to his room by staff, where he was assisted to bed. R17 was observed in bed with the lights off, no radio or TV on until lunchtime. Following lunch, at 1:16 p.m.

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R17 was observed in bed with the lights off, no radio or TV on.

On 5/18/17, at 9:08 a.m. R17 was observed in his room, in bed. The lights were off, the window shades were pulled shut, and no TV or radio was on. At 10:02 a.m. NA-B entered R17's room and asked R17 if he wanted to use the bathroom. R17 declined. NA-B left R17's room and R17 remained in bed.

On 5/18/17 at 8:38 a.m. NA-B was interviewed and stated R17 was not interested in activities, and never had been very interested. NA-B stated R17 used to draw/color, but didn't do that any longer.

On 5/18/17, at 10:05 a.m. R17 was asked what he did to keep from getting bored. R17 stated, "Not much." When asked what interested him, R17 stated, "Not much."

On 5/18/17, at 12:53 p.m. the activities director (AD) was interviewed and verified R17 participated in activities less and less. AD stated they were trying to engage R17, but he slept a lot, so they currently weren't seeing him. The AD verified R17 no longer visited with his brother or wife, who were also residing in the facility. The AD verified R17 used to paint and draw and play accordion, but he didn't do that anymore. AD verified R17 was brought to activities, but often left. The AD stated R17 was on the list to be seen by activities for 1:1 visits, but was unable to provide documentation.

The facility policy on Group Activity Programming dated 5/17, directed group activity programming will be provided for all residents based upon

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F 248	Continued From page 5 assessed needs, interests and past lifestyle. The policy further directed a resident refusing group activity programs or demonstrating low tolerance for for group activity programs will be assessed for one to one activity programming.	F 248		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		6/23/17

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F 309	Continued From page 6 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure optimal table height for 2 of 3 residents (R6, R67) reviewed for dining. In addition, the facility failed ensure optimal wheelchair positioning for 1 of 1 residents (R37) reviewed for wheelchair positioning. Findings include: R6's Face Sheet printed 5/18/17, identified diagnoses that included chronic pain, osteoarthritis, and depression. R6's quarterly Minimum Data Set (MDS) dated 2/12/17, indicated R6 required supervision with eating (oversight, encouragement, or cueing). R6's MDS also indicated R6 felt frequent pain that interfered with her day to day activities, and R6 received scheduled and as needed mediations to assist with managing her pain. R6's care plan dated 10/21/16, directed staff to monitor R6's level of comfort, and to offer non-pharmacological interventions, such as positioning. On 5/17/17, at 12:06 p.m. R6 was observed sitting in her wheelchair at her dining room table eating lunch. The tabletop was above R6's chest, but below her shoulder level. On 5/18/17, at 9:03 a.m. R6 was interviewed and stated the dining room table was "Too high" for	F 309	It is the policy of Augustana Care Moose Lake to ensure that all residents have an optimal table height at each meal to ensure pleasant dining experience and adequate nutritional intake. In addition it is the policy that the facility will ensure optimal wheelchair positioning for each resident to ensure comfort and optimal mobility. Residents R6 and R67 tables were adjusted to optimal height for eating. Table heights for all dining rooms in facility were measured and tables in all dining halls are to be labeled with numbers and height of table and adjustable table will have string placed underneath table to show optimal height warranted. Table position will be documented using table assignment chart. Upon admission resident will be assessed by LN who will get input from team members for initial dining placement of resident. Placement will be temporary seating in dining area until care conference takes place five days after admission. During care conference, seating at meals will be discussed with resident/family to see if there are any concerns. If any concerns, referral for occupational therapy will be obtained. Resident R37 had an occupational therapy evaluation completed with recommendations made for optimal w/c positioning. All residents in the facility who utilize a wheelchair will	

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F 309	Continued From page 7 her. R67's Face Sheet printed 5/18/17, identified diagnoses that included cerebral infarction (stroke), injury of lumbar, sacral and pelvic sympathetic nerves, and diabetes. R67's quarterly MDS dated 3/16/17, indicated R67 had moderately impaired cognition, and occasional pain that limited her day to day activities. R67's MDS also indicated R67 required supervision with eating (oversight, encouragement, or cueing). R67's care plan dated 10/28/15, indicated R67 had an alteration in comfort related to her stroke, with left sided paralysis and diabetes. The care plan directed staff to monitor R67's level of comfort and to offer non-pharmacological interventions, such as positioning. On 5/17/17, at 12:06 p.m. R67 was observed sitting in her wheelchair at her dining room table eating lunch. The tabletop was well above R6's chest, almost at her shoulder level. When asked if the table height was comfortable, R67 stated it wasn't too comfortable. On 5/18/17 at 9: 33 a.m. R67 was interviewed and stated the table was too high. R67 stated she had "Gotten used to it," as it had been like that since she moved to the facility. R67 did not think anyone had ever asked her if the table height was comfortable for her. R67 stated she wouldn't want to move to another table, as she likes her table mates. On 5/18/17, the administrator stated the facility does not have a process of assessing proper	F 309	have a screening completed by nursing staff to ensure that positioning is optimal with referrals made to occupational therapy as needed. All new residents admitted to the facility will have a LN assess wheelchair fit upon admission and obtain occupational therapy orders as needed for positioning. DON or designee will audit 10% of resident□s for wheelchair fit weekly for four week□s then monthly for three months. DON or designee will audit four meals in the dining room weekly for four weeks then monthly for three months to ensure adequate table assignments and optimal table eating height for residents. DON responsible for plan of correction. Corrected by: 6/23/17. Results of audits will be reviewed by facility quality assurance committee to ensure compliance.	

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dining table height for residents but added, "We should be doing it." The administrator stated this assessment was not a typical occupational therapy assessment nor did they assess dining comfort for each resident. The administrator stated some of the dining room tables were adjustable, but the tables where R6 and R67 sit were not adjustable.

On 5/18/17, the administrator confirmed the facility did not have a policy or a procedure for ensuring proper dining room table height.

R37's Face Sheet dated 2/6/17, indicated R37's diagnoses that included pressure ulcer of left buttock and low back pain.

R37's annual Minimum Data Set (MDS) dated 2/13/17, indicated R37 had no cognitive impairment. The MDS further indicated R37 needed limited assistance of one staff to physically assist with guided maneuvers of limbs or other non-weight bearing assistance for locomotion on the unit. R37 required supervision and oversight of one staff for locomotion off the unit.

R37's care plan dated 2/6/17, indicated skin breakdown related to Stage 3 pressure ulcer and actual alteration in comfort. Interventions included therapy consult for wheelchair positioning if appropriate, and offering of repositioning.

R37's physician standing orders dated 2/6/17, included ok for consults.

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R37's Care Area Assessment (CAA) dated 2/13/17, for activities of daily living functional status rehabilitation potential included that R37 was not steady but able to stabilize without staff assistance while moving from seated to standing position, moving on and off toilet and surface transfers.

Occupational Therapy treatment encounter notes dated 2/6/17, 2/7/17, 2/10/17, 2/27/17 all lacked wheelchair positioning evaluation or assessment.

A progress note dated 5/6/17, indicated an intervention to involve therapies as needed for support and evaluation in effort to minimize fall risk

A progress note dated 5/17/17, indicated R37 had completed recent therapies with continued overall weakness related to poor posture and attitude.

On 5/16/17, at 8:48 a.m. R37 was observed propelling her wheelchair into her room independently. R37's right arm was dangling off the right side of her wheelchair, with her right armpit positioned on top of the right arm rest. R37 was seated on her right hip, and she was leaning over to the right.

On 5/17/17, at 8:04 a.m. R 37 was observed seated at the dining table leaning over to the right. Nursing assistant (NA)-G stated to R37, "You are leaning over." R37 agreed to the statement and continued to place a clothing protector on herself independently. NA-G did not attempt to reposition R37. Following breakfast, on 5/17/17, at 8:44 a.m. NA-G asked R37 if it was ok to put something on the right side of her wheelchair arm rest to help R37 with sitting up

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straighter in the wheelchair. R37 asked NA-G to get a pillow from room. NA-G invited R37 to meet in R37's room, to assist with the pillow placement as requested.

On 5/17/17, at 8:44 a.m. NA-G was interviewed and stated that upon speaking to licensed practitioner nurse (LPN)-A, a rolled up draw sheet or any other item was not to be used to assist with R37's wheel chair positioning.

On 5/17/17, at 12:12 p.m. R37 was observed to ask the administrator to place something on the right upper back part of her wheelchair, behind her right shoulder as it was causing pain. The administrator rolled up a bath towel, and placed it behind R37's right shoulder area. The administrator
asked R37 if better support was required in that area.

On 5/18/17, at 1:46 p.m. certified occupational therapy assistant (COTA)-D stated a referral for wheel chair positioning had not been received from nursing for R37. COTA stated R37 had been provided with a wheelchair for comfort, and a cushion for the wheelchair to promote wound healing. COTA-D stated nothing else had been provided to R37 related to wheelchair positioning. COTA-D stated R37 had been known to have the strength to sit up straight, but if there had been a change, it would warrant re-evaluation by occupational therapy to determine why R37 was leaning.

On 5/18/17, at 2:52 p.m. the director of nursing (DON) and administrator were interviewed. The DON verified R37 was leaning in the current wheelchair, and warranted an evaluation for

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F 309	Continued From page 11 wheelchair positioning. The administrator verified that R37's wheel chair positioning was not noticed until yesterday. The facility was unable to provide policy and procedure for wheel chair positioning or referral process to occupational therapy for wheel chair positioning.	F 309		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		6/15/17

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F 441	Continued From page 12 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean dressing	F 441	It is the policy of Augustana Care Moose Lake to ensure infection control standards	

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F 441	Continued From page 13 change technique was followed for 1 of 1 residents (R37) reviewed for dressing change. Additionally, appropriate hand hygiene was not performed before handling food for 3 of 3 residents (R44, R23, R27) observed with dining. Findings include: R37's Face Sheet dated 2/6/17, indicated R37's diagnoses included pressure ulcer of left buttock, methicillin resistant staphylococcus aureus (MRSA) infection, active in the urine, and history of MRSA in wound. R37's annual Minimum Data Set (MDS) dated 2/13/17, indicated R37 was cognitively intact. The MDS also indicated R37 required assistance of one staff with dressing, transfers, bed mobility, toilet use and personal hygiene. R37's care plan dated 2/6/17, indicated skin breakdown related to Stage 3 pressure ulcer, with a history of MRSA in the wound, and directed to provide treatment to the wound per physician orders. R37's Physician's Orders dated 4/28/17, indicated wound vac dressing change three times a week. Special instructions: may place vaseline gauze along with foam into wound to prevent it from sticking. On 5/17/17, at 11:41 a.m. registered nurse (RN)-C was observed to conducted R37's dressing change to the left buttock. The administrator assisted with positioning of R37 to allow for easier access to the pressure ulcer. RN-C had supplies set up on a clean surface on top of the bed linens. This included a bandage	F 441	of practice are followed for all residents to decrease risk for infection. Proper Hand Hygiene and Infection control policy will be reviewed with all facility staff. All nursing staff will be educated on proper feeding techniques, hand washing and use of gloves when assisting residents with eating. Resident R37 was monitored for signs and symptoms of wound infection following the noted incident no signs of infection have been noted. All LN staff were re-educated on wound vac dressing changes with return demonstration completed including dressing change-clean technique and hand washing/sanitizing procedure. DON or designee will audit 10% of resident wound dressing changes weekly for four weeks then monthly for three months to ensure compliance. DON or designee will audit four meals in the dining areas weekly for four weeks then monthly for three months to ensure compliance with infection control practices during meals. Results of all audits will be reviewed by facility quality assurance committee to ensure compliance. Director of Nursing responsible for plan of correction. Corrected by: 6/15/17.	

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scissors, wound cleanser, skin prep pad, clear plastic dressings, foam dressing, and new wound vac dressing with attached tubing. RN-A sanitized her hands and donned gloves. RN-C used bandage scissors to cut various pieces of the clear transparent dressing. These pieces were set on the clean surface. The administrator assisted with removing R37's clothing out of the way for dressing change. RN-C removed the soiled dressing, and disposed it in the trash can at the foot of the bed. The soiled dressing was noted on the top of the trash and saturated with drainage pink and red in color. RN-C proceeded to cleanse the pressure ulcer with wound cleaner spray. RN-C changed gloves, sanitized her hands and donned clean gloves. R37's pressure ulcer began to bleed, and RN-C cleansed the area again, patting gently inside the open area. RN-C measured the pressure ulcer, and applied skin prep to the edges. RN-C placed the precut clear dressing strips to the skin around the pressure ulcer. RN-C cut open a green foam dressing approximately 5 centimeters (cm) long and 2.5 cm wide from its coiled packaged state. RN-C removed her soiled gloves, sanitized her hands and donned clean gloves. RN-C then the cut green foam dressing, wrapped it in a vaseline gauze, and inserted it into the pressure ulcer. RN-C placed a clear dressing over the top and surrounding areas of the pressure ulcer. RN-C then used the bandage scissors to cut a hole in the center of the green foam dressing (to allow suction to occur from the wound pump thru the tubing attached on the wound vac dressing). The wound vac dressing was placed, and the pump vacuum was turned on. RN-C picked up garbage, placed the wound supplies in R37's drawer, and placed the bandage scissors on top of the counter above the drawer. RN-C and the

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	245491	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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administrator removed personal protective equipment, sanitized their hands and exited the room.

On 5/17/17, at 12:28 p.m. RN-C stated the wounds supplies are kept in the resident's room, and housekeeping cleans the wound cleanser bottle and the bandage scissors. RN-C verified a new piece of green foam dressing should have been cut with clean gloves prior to insertion into the pressure ulcer, as the precut pieces were cut with dirty gloves.

On 5/17/17, at 12:42 p.m. housekeeper (H)-A was interviewed and stated the garbage had been taken out of the room after the dressing change, and she had not disinfected the scissors or any other wound care related equipment. H-A stated the nursing staff tend to cleaning of care items.

On 5/17/17, at 1:34 p.m. the administrator stated it is nursing's responsibility to disinfect wound care equipment including the bandage scissors.

On 5/18/17, at 11:05 a.m. RN-D verified that the green dressing foam should have been cut and prepared for the wound after the wound was cleansed, her hands were sanitized and clean gloves were in place.

The facility's Dressing Change - Clean Technique policy reviewed on 4/16, directed staff to complete dressing changes using aseptic (clean) technique and standard precautions which includes removing soiled dressing and gloves, washing or sanitize hands, apply clean gloves, cleanse wound per protocol and perform treatment, remove gloves, wash or sanitize hands, sanitize scissors with disinfecting wipe.

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The facility Negative Pressure Wound Therapy policy revised in 2000, directed staff to identify and size the wound to be treated, wash hands, apply gloves, clean wound, remove gloves, wash hands, apply clean gloves and then cut sponge dressing to size.

On 5/15/17, at 6:24 p.m. nursing assistant (NA)-A was feeding R23. NA-A then proceeded to assist R27 by cutting up a sandwich, holding down the top of the bun with bare hands. NA-A handed R27 the cut meat sandwich. NA-A assisted in cutting R23's sandwich with bare hands in the same manner, handing the sandwich to R23 with bare hands. NA-A did not perform hand hygiene during the continuous dining room observation.

On 5/15/17, at 6:47 p.m. NA-A picked up a fork that had been dropped on the floor by R44. NA-A returned a clean fork to R44, and assisted R44 by cutting a sandwich with bare hands. NA-A verified she had not done hand hygiene, and she should have.

On 5/17/17, at 1:35 p.m. the administrator stated hand hygiene should have been performed prior to handling food with bare hands.

On 5/18/17, at 11:05 a.m. RN-D stated hand hygiene should be preformed prior to handling of food.

The facility's Handwashing Sanitizing Procedure revised on 4/16, directed staff to wash or sanitize hands before passing meal trays and before and after handling food.

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F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper freezer temperatures for 1 of 1 freezers in the service kitchen. On 5/15/17, at 12:47 p.m. during tour of the service kitchen with the dietary director (DD)-E, the lower freezer compartment was found to be at 12 degrees Fahrenheit (F). The freezer contained eight single serving containers of ice cream that were not frozen. The DD-E verified the freezer temperature was not cold enough, and the ice cream needed to be thrown out. Additionally, DD-E reported the freezer had not been working properly, and would have it serviced. On 5/16/17, at 10:28 a.m. the freezer was observed undergoing repair by maintenance staff. On 5/18/17, at 9:11 a.m. a new freezer was	F 456	It is the policy of Augustana Care Moose Lake to ensure that all facility equipment is in safe operating condition. The facility has replaced the freezer in the serving kitchen which is now noted to hold the appropriate temperature without concern. The facility equipment repair policy was reviewed and updated and all staff will be educated regarding procedure for equipment repair. New policy includes removing and destroying all food when temperature is out of range, placing out of order sign on the equipment and notifying the maintenance department. The facility dietary manager or designee will audit the freezer temperature log four times per week for four weeks then monthly for three months to ensure adequate temperature is maintained. Results of all audits will be reviewed by facility quality	6/15/17

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F 456	Continued From page 18 observed in the service kitchen and was found to be at 19 degrees F. Ten single cups of ice cream were in the freezer, and were not frozen. At this time, DD-E verified that initial freezer was taken out of order, and the new freezer was not keeping the proper temperature. DD-E verified freezer temperature at 20 degrees F on the internal freezer thermometer. Additionally, DD-E verified the ice cream was not frozen, and disposed of them. Temperature log for the freezer located in the resident service kitchen dated May 2017, identified seven days in the month when the freezer temperature was not below zero degrees F. During the month of April 2017, for eighteen days the freezer did not keep proper temperature range of zero degrees F or below. The facility's Freezer/Refrigerator policy dated 10/11, directed staff to ensure freezer temperature of zero degrees F or below, and to contact maintenance immediately for repair when temperatures are not within recommended levels, discarding any questionable foods.	F 456	assurance committee to ensure compliance. Dietary Manager responsible for plan of correction. Corrected by: 6/15/17.	
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas,	F 465		6/15/17

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F 465	Continued From page 19 and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure cleanliness of the kitchen floor. On 5/15/17, at 12:47 p.m. during tour of the kitchen with dietary director (DD)-E, an area of 45 inches x 16 inches under the sink was observed to have a buildup of white crusty matter, and dark food crumbs of variable sizes. DD-E stated the area was affected by hard water buildup. On 5/18/17, at 9:23 a.m. an area of 45 inches x 16 inches under the sink was again observed to have a buildup of white crusty matter, and dark food crumbs of variable sizes. DD-E verified verified debris remained in this area. DD-E verified the area needed to be swept and mopped, stating that afternoon shift was responsible for washing and sweeping in this area. Additionally, DD-E verified that the sink had a water leak, and was dripping onto this area from the ninety degree bend at the pipe that left the sink drain. The facility's Floor Safety policy dated 11/09, directed staff to keep floors clean and dry.	F 465	It is the policy of Augustana Care Moose Lake to ensure that the facility is safe, functional and sanitary for all residents, employees and guests. The three compartment sink in the kitchen had the noted leak repaired and the floor area under the sink was cleaned to remove water scale build up. All dietary staff will be educated regarding need to report maintenance needs as soon as they are noted. Hard water cleaner was ordered for cleaning of the floor daily by afternoon dietary staff. Dietary manager or designee will audit cleanliness of kitchen three times per week for four weeks then monthly for three months to ensure compliance. Results of all audits will be reviewed by facility quality assurance committee to ensure compliance. Dietary Manager responsible for plan of correction. Corrected by: 6/15/17.	

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Augustana Mercy Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Augustana Mercy Care Center was inspected as one building. Augustana Mercy Care Center is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity 72 beds and had a census of 71 at the time of the survey.	K 000		

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

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

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

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K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		