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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 706W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00235

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245546**

2.STATE VENDOR OR MEDICAID NO.
(L2) **121742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MISSION NURSING HOME**
(L4) **3401 EAST MEDICINE LAKE BOULEVARD**
(L5) **PLYMOUTH, MN** (L6) **55441**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/04/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (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
	97			
(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 :
Brenda Fischer, Unit Supervisor — 06/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(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) **00**

VOLUNTARY
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
06/26/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245546
July 22, 2015

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

Dear Mr. Meyer:

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 4, 2015 the above facility is certified for or recommended for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 10, 2015

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

RE: Project Number S5546025

Dear Mr. Meyer:

On June 17, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 16, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of , in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on April 16, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 25, 2015, the Minnesota Department of Public Safety 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 April 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 4, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 16, 2015, as of June 4, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 17, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 16, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 16, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 16, 2015, is to be rescinded.

In our letter of June 17, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 16, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 4, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245546	A. Building B. Wing	6/4/2015

Name of Facility	Street Address, City, State, Zip Code
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **06/03/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/03/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/03/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **06/03/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/03/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **05/11/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **06/03/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/03/2015**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/17/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	07/10/2015	10562	06/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/16/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245546	01 - MAIN BUILDING 01	6/25/2015

Name of Facility	Street Address, City, State, Zip Code
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/24/2015	ID Prefix Reg. # NFPA 101 LSC K0043	Correction Completed 04/24/2015	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 06/04/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 07/10/2015	Signature of Surveyor: 28120	Date: 06/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/20/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 706W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00235

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245546**

2.STATE VENDOR OR MEDICAID NO.
(L2) **121742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MISSION NURSING HOME**
(L4) **3401 EAST MEDICINE LAKE BOULEVARD**
(L5) **PLYMOUTH, MN** (L6) **55441**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/16/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(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 :
Bruce Melchert, HFE II 06/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(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
06/26/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1543
April 29, 2015

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

RE: Project Number S5546025

Dear Mr. Meyer:

On April 16, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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>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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
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 May 26, 2015, 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 May 26, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 16, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 16, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Mission Nursing Home

3401 East Medicine Lake Blvd.
Plymouth, MN 55441

(763) 559-3123 Ext. 11
(763) 559-0604

Fax

To: Minnesota Department of Health Attn: Jessica Sellner, Unit Supervisor	From : Tim FunkMeyer, Administrator
Fax: 1-320-223-7348	Pages: 40 - Including Cover
Phone: 1-320-223-7343	Date: 22~~1~~4 May 2015
Re: Plan of Correction for Survey completed on April 16, 2015	cc:

Comments: Attached is the Plan of Correction for your review. If you do not receive all 40 pages, please contact Anna Niesen at 763-559-3123 ext. 11.

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

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245648	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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	**F000** It is the policy of Mission Nursing Home to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		

Approved 5/25/15

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

ADMINISTRATOR 5/14/15

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

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	**F 156** It is the policy of Mission Nursing Home that each resident receiving Medicare Services will be issued a Skilled Nursing Facility Advance Beneficiary Notice form (SNFABN) if they will be remaining in the facility and have Medicare days remaining. This form will be signed and issued by the nurse manager along with the Medicare Denial form at least forty-eight hours prior to Medicare coverage ending We acknowledge the SNFABN was not completed for R47 and R28. Due to the elapsed time there is no further action for these residents at this time. Quarterly audits will be conducted to ensure proper forms are completed until Quality Assurance Committee determines compliance. The Clinical Nurse Manager is responsible for compliance. The SNFABN will be kept with the medicare denial letter. This entire process has been in effect as of 05/12/15.	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely provide a liability and appeal rights notice or denial letter, prior to discharge from Medicare services, for 1 of 3 residents (R28) reviewed in the sample. Additionally, the facility failed to provide the proper liability notices for 2 of 3 residents (R28 and R47) reviewed for liability notices, who had Medicare benefit days remaining, and whose skilled services ended, but remained in the facility. Findings include: R28 was discharged from Medicare services on 2/2/2015, as indicated on a Notice of Medicare Non-Coverage (form CMS 10123), signed by him on 2/2/2015. R28 remained in the facility. There was no evidence in the medical record that R28 received a Skilled Nursing Facility Advance	F 156		

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F 156	Continued From page 3 Beneficiary Notice (SNFABN, form CMS 10155), to allow him to chose to continue to receive non-covered, skilled services at his own cost, and inform R28 of his right to appeal Medicare's decision. During an interview on 4/15/2015 at 2:08 p.m., registered nurse (RN)-A said she was unable to determine exactly when the generic notice (CMS 10123) was signed by R28, as the date on the form next to his signature "was confusing." RN-A added that since R28's Medicare benefit ended on a Monday, (February 2, 2015) he should have received and signed the notice "at least by the prior Friday, (January 30, 2015) and clearly he did not." RN-A stated that when a resident's medicare benefit days are ending, he would be given "the CMS 10123, the generic notice." RN-A further stated, that if a resident remained in the facility, with remaining benefit days, he would also be given "the generic notice of non-coverage and the SNFABN form." RN-A said both notices were to be given "at least 48 hours prior to the end of their services ending." RN-A said, "Regarding [R28], he should have also been given the SNFABN, but was not." "I can't say why he did not get the notice." RN-A said. R47 was discharged from Medicare services on 10/23/2014, as indicated on a Notice of Medicare Non-Coverage, signed by him on 10/21/2014. R47 remained in the facility. There was no evidence in the medical record that R47 received a SNFABN, to allow him to chose to continue to receive non-covered, skilled services at his own cost, and inform R47 of his right to appeal Medicare's decision.	F 156		

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F 156	Continued From page 4 During an interview on 4/15/2015 at 2:10 p.m., RN-A said if R47 had remaining benefit days, and stayed in the facility, "He should have received the SNFABN notice." RN-A acknowledged that R47 did not receive this notice. During an interview on 4/15/2015 at 2:55 p.m., the controller reviewed R28's and R47's records, and said both residents had remaining medicare benefit days when their skilled services ended, and also, that both residents remained in the facility. The controller said he noticed residents "were not being given the proper [denial] forms when he was preparing for an audit." The controller said, "I don't know what happened," for whatever reason, the "residents didn't get the right form." We are doing the right forms now, the controller said. A facility policy "Medicare Advance Beneficiary Notice (ABN-SNF) Denial Notices, undated, indicated "The facility representative will issue a timely and appropriate advance beneficiary notice..." The policy did not indicate when the notices were to be given.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157		

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F 157	Continued From page 5 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely notify the nurse practitioner about elevated blood glucose levels for 1 of 1 residents (R62) reviewed in the sample, who had elevated blood glucose (BG) levels that required physician notification. Findings include: R62's diagnoses, as indicated on the quarterly Minimum Data Set (MDS) dated 1/22/2015, included diabetes. A physician's order, dated 12/25/14, directed staff to administer R62 Humalog Solution (Insulin) 100u/ml (units per milliliter) per sliding scale, for the following blood	F 157	**F 157** It is the policy of Mission Nursing Home to notify the resident's physician, legal representative, or any interested family member when there is a change in condition or an accident involving a resident resulting in injury and/or has the potential for requiring physician intervention. Resident 62 received new physician orders with blood sugar parameters and indicating when to notify physician. (Medical provider is now aware of the blood glucose levels of 400+ that were not previously reported to her.) Change in Condition Policy and Procedure has been reviewed and revised to include the Stop and Watch Tool. Education: licensed & unlicensed staff members will be educated the use of the Stop and Watch Tool. Nurse managers will run the 24 hour progress note report every morning (72 hour report on Mondays) to check for changes in conditions and ensure follow up has been initiated. Director of Nursing or designee will be responsible for compliance. Date of Completion: 06/03/15.	

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F 157	Continued From page 6 glucose levels: 150-200 = 3 units 201-250 = 6 units 251-300 = 9 units 301-350 = 12 units 351-400 = 15 units The physician's order also included: If blood glucose is less than 90 or greater than 400, two times in a row, report to primary nurse practitioner (NP) on next working day. A normal BG level is 80-120. A review of the February 2015 Weights and Vitals report indicated on 2/04/15 that R62's blood glucose (BG) was above 400 three times, and on 2/22/15 R62's BG was above 400 two times. A review of R62's nursing progress notes for February 2015, indicated the NP was only updated on 2/17/15 regarding his elevated BG levels. A review of the March 2015 weights and vitals report indicated from 3/10/15 to 3/31/15, R62 had eight instances of blood glucose levels greater than 400, twice in a row. A review of R62's nursing progress notes for March 2015, indicated the NP was not notified of R62's elevated BG levels until 3/25/15, even though he had three consecutive BG levels above 400 on 3/26 and 3/27/2015 which ranged from 407-588. A review of the April 2015 weights and vitals report, indicated on 4/8/15, R62 had a blood glucose level was 451 at 5:03 p.m. The scheduled evening blood glucose was recorded in the medication administration record as "HI." The manufacturer owner's manual for the	F 157		

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F 157	Continued From page 7 TRUEresult Blood Glucose Meter, manufactured by Nipro Diagnostics, included that a reading of "Hi" indicated a blood glucose level greater than 600. A review of R62's nursing progress notes for April 2015, did not indicate the NP was notified of this elevated BG level. Further, a review of R62's BG levels on 4/9/15 indicated the following: 480 at 7:25 a.m.; 553 at 11:42 a.m.; 580 at 5:54 p.m.; and 411 at 8:11 p.m. On 4/10/15, R62's BG at 7:29 a.m. was 538. A review of R62's nursing progress notes for April 2015 indicated that no NP or physician notification were completed for these blood glucose levels. R62's nursing progress notes also indicated he had five incidents of blood glucose readings greater than 400, at least two times in a row, without an update to the NP or physician until 4/12/15. On 4/11/15, R62 had a blood glucose level of 500 at 7:40 a.m. and a blood glucose level of 459 at 11:40 a.m., review of the facilities progress notes indicated that the NP was not notified. Also, a review of R62's medical record on 4/12/15, indicated he had a blood glucose level of 484 at 7:30 a.m., and a blood glucose level of 470 at 11:40 a.m. The record indicated the NP was not notified until 4/14/15, two days later. During an interview on 04/15/2015 at 7:44 a.m., registered nurse (RN)-B stated that when R62's blood glucose levels are over 400 two shifts in a row, staff should give insulin, and then call NP to update on high blood glucose levels. RN-B also stated, the NP will call back with instructions for further insulin if needed. RN-B said R62 was "noncompliant" with his diet, and that he "eats a lot of candy bars and drinks a lot of Pepsi."	F 157		

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F 157	Continued From page 8 In an interview on 4/15/15, at 8:16 a.m. the director of nursing (DON) stated that nurses should contact the practitioner when a resident's blood sugars are elevated, and "especially when they are over 400." The DON further stated this was something "we need to re-educate the staff on." The DON said the facility was "working on a new program" for updating the NP and physicians regarding changes in resident's condition. A facility policy, dated 5/20/05, entitled Change in Condition directed staff to react to changes in condition in order to have the most optimal outcome for the resident. The policy further indicated "If a change in condition can be addressed and dealt with in the nursing home, the nurse is to call MD to notify of change in condition."	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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F 225	Continued From page 9 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure allegations of verbal abuse were immediately reported to the administrator and state agency for 2 of 2 residents (R65 and R120) whose verbal abuse allegations were observed during the survey. In addition, the results of verbal and physical abuse allegations that were investigated, were not submitted within 5 workings of the incident to the state agency for 8 of 15 resident investigations (R45, R53, R17,R116,R24,R16,R69 and R60). Further, the facility did not complete reference checks for 5 of 5 newly hired staff (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-A and dietary aide (DA)-A.	F 225	**F 225** Mission Nursing Home is the only all male nursing home in Minnesota and thus deals with residents with behavioral issues on a daily basis. Resident swearing and using inappropriate language tends to be a part of the dynamic. Staff members use their judgment on what is reportable verbal abuse between residents and follow the Vulnerable Adult Policy with respect to verbal abuse definitions. The verbal altercation in the dining room between residents R65 and R120 was witnessed by health department surveyors. The two residents' comments, although offensive, were not threatening or meant to cause harm to each other. Mission Nursing Home's policy defines verbal abuse as "the use of words to cause harm to the person being spoken to". This incident was investigated according to facility policy. It was not reported to Common Entry Point/Office of Health Facility Complaints as it was viewed as not threatening or harmful during a resident to resident interaction. Verbal abuse is reported per facility policy Education will be provided for staff members regarding the Abuse Prohibition Policy, abuse identification (including verbal abuse) and reporting.	

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F 225	Continued From page 10 Findings include: ALLEGED INCIDENTS OF ABUSE NOT REPORTED TO STATE AGENCY: R65's quarterly Minimum Data Set (MDS) dated 2/2/15, indicated he was moderately cognitively impaired, and had verbal behavioral problems. R120's admission MDS dated 3/27/15, indicated he has moderately cognitively impaired. During an observation on 4/13/15, at 5:41 p.m., two residents were in the first floor dining room eating their evening meals with other residents from the floor. R65 was sitting at a table beside R120's table. R65 turned his head and yelled "Fuck you, you are a cock sucker" towards R120. R120 then yelled back at him "No, you are the cock sucker." Dietary aide (DA)-A who was serving the meal, observed the altercation. The social worker (SW)-A and the director of nursing (DON) then entered the dining room, and attempted to deescalate the situation. The SW-A and DON were able to calm the residents down so they could continue to eat and finish their meal. During interview 4/15/15, at 9:15 a.m. (2 days after the incident) SW-A stated she was responsible for and normally reported incidents to the state agency. SW-A said she had not reported the incident that occurred on 4/13/15 to the state agency because R65 and R120 had not made any threats to harm each other. The SW stated, she did not feel verbal altercations was a reason to report an incident. SW-A stated she felt the two residents were being verbally abusive	F 225	The Inter-Disciplinary Team (IDT) reviews all incidents. During these daily reviews, the IDT ensures all reportable incidents have been reported. This is in place and will remain ongoing. Results will be reported quarterly to the Quality Assurance Committee. The Director of Social Services or her designee will be responsible for compliance. Date of Completion: 06/03/15	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(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 225	Continued From page 11 to each other, but also said if she had to report that incident, and similar occurrences, she would be reporting "all of the time." Although R65 and R120 were verbally abusive to each other, no report was made to the state agency. INVESTIGATIONS REPORTED LATE TO THE STATE AGENCY: R45's quarterly MDS dated 1/21/15, indicated he was cognitively intact and had physical and behavioral symptoms directed towards others. R53's quarterly MDS dated 3/28/15, indicated he was severely cognitively impaired and had behavioral symptoms. Review of Mission Nursing Home incident report dated 1/3/15, indicated on 1/3/15, at 12:00 p.m. R45 had pushed R53 because he was in his spot. The report indicated R53, "became upset and started swinging at him and hit him." The Minnesota Department of Health Investigative Submission report indicated the incident was reported to the state agency on 1/3/15. The subsequent investigative report was not submitted to the State Agency (SA) until 1/12/15, nine days later. R17's quarterly MDS dated 3/25/15, indicated he had modified independence in decision making, and had verbal and behavioral symptoms. R116's discharge MDS dated 4/4/15, indicated he had altered level of consciousness with physical	F 225	**F 225 (continued)** Mission Nursing Home follows the policy that all incidents of abuse or neglect must be reported to the Office of Health Facility Complaints (OHFC) immediately. Then within five working days the review of the ensuing investigation must be received by them. In four incidents (involving eight residents), although the investigation was started immediately, the actual review of the investigation was not received by OHFC within the five working days. In the incident between R45 and R53, and also the incident between R69 and R60 the investigation report was due on a Friday but not done until the following Monday thereby making it one day late. All four of the incidences (R45 & R53, R69 & R60, R17 & R116, R24 & R16) occurred on a Friday, Saturday or Sunday.	

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F 225	Continued From page 12 and behavioral symptoms. Mission Home Incident Report dated 3/28/15, at 1:00 a.m. that R17 and R116 were arguing and R17 "had shoved him and threw water on him. Residents shirt wet with water and water on the the floor (It did appear that water was thrown on resident)." R116 did not fall and did not sustain any injures from resident shoving him. The report further indicated the residents were separated but had continued agitation and anger. The report indicated the administrator was notified of the event. The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 3/28/15. The subsequent investigative report was not submitted to the SA until 4/9/15, fifteen days later. R24's quarterly MDS dated 1/24/14, indicated he was moderately impaired cognitively and that he had verbal and behavioral symptoms. R16's quarterly MDS dated 3/23/15, indicated he was cognitively intact with no behaviors. Mission Home Incident Report dated 1/30/15, at 7:00 p.m. indicated while in the smoke room R16 stated R24 took the remote and changed the television channels and said he wanted to finish what he is watching. R24 grabbed his (R16's) shirt by the left arm and stated "I'm watching what I want and grabbed him again." The Minnesota Department of Health Investigative Submission report indicated the	F 225	To ensure that all investigation reports are timely the Director of Social Service and/or the Director of Nursing will check each Monday morning for the due dates of any current investigations. The Director of Social Services and/or Director of Nursing will audit each investigation weekly to ensure submissions are completed within time requirements. This audit will be performed weekly for four weeks then monthly until compliance is determined by the Quality Assurance Committee. The Director of Social Services will be responsible for compliance. Date of Completion: 06/03/15	

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F 225	Continued From page 13 Incident was reported on 1/30/15. The subsequent investigative report was not submitted to the SA until 2/9/15, ten days later. R69's quarterly MDS dated 3/3/25, indicated he was moderately impaired in decision making, and had no behavior problems. R60's admission MDS dated 2/10/15, indicated he had moderate impaired decision-making and had verbal behaviors. Mission Home Incident Report dated 2/15/15, at 8:55 a.m. indicated R69 kicked R60 "in the lower leg in the smoke room and struck him on the left cheek, knocking the residents glasses off. Staff was present and removed this resident from the sight sending him to his room. The Resident is in an agitated state; but is in his room. Given time to calm. Message left for Administrator and DON. Was able to contact Social Services Director. Will ask Resident to not attend his 10:00 a.m.. smoking time but because of his poor memory may allow to attend other times. Staff will observe behavior at those times. Staff will attend to other resident to ensure no other confrontations occur." The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 2/15/15. The subsequent investigative report was not submitted to the SA until 2/23/15, eight days later. During interview on 4/15/15, at 9:30 a.m., SW-A acknowledged she was aware the investigative reports were to be submitted within five working	F 225		

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F 225	Continued From page 14 days of the incident, and she was late in submitting the final investigations. NEW EMPLOYEE REFERENCE CHECKS NOT COMPLETED: A review of the newly hired employee files indicated the following: RN-D was hired 3/31/15, and no reference check was completed. RN-C was hired 3/17/15, and no reference check was completed. LPN-A was hired 1/19/15, and no reference check was completed. NA-A was hired 3/27/15, and no reference check was conducted. During interview 4/15/15, at 2:42 p.m. human resource director (HR) stated "no reference checks" for newly hired staff had been done since the new DON started. The HR director stated the DON assume the staffing coordinator completed them. The facilities ABUSE PREVENTION and PROHIBITION policy revised 9/10/12, indicated Mission Nursing Home (MNH) "will not tolerate the maltreatment of its residents, whether overtly by abuse, through omission by neglect or financial exploitation of a resident's property or funds. Persons found to be maltreating residents will be dealt with to the limits permitted by the law." The policy further indicated, "the supervisor hiring the candidate must conduct reference checks of	F 225	It is the policy of Mission Nursing Home to only employ individuals who have not been found guilty of abuse, neglect, or mistreatment of residents or have had findings entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment, or misappropriation of resident's property. 1. New employee reference checks were identified as not being completed at the time of the survey. Verification of Licenses for RN's, LPN's and Certificates for NAR's and TMA's had been completed. 2. Each Department Head or designee is responsible to check references. 3. The Human Resource Department will now verify that reference checks have been completed and other required pre-employment information has been received prior to employment start date for new staff members. Random audits will be completed until compliance is determined by the Quality Assurance Committee. The Human Resource Department will be responsible for compliance. Date of Completion: 06/03/15	

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F 225	Continued From page 15 the candidates prior employment and position held.".. The policy also indicated "Verbal Abuse: the use of words to cause harm to the person being spoken to. Examples: name-calling, shouting, insulting, intimidating, threatening, shaming, demeaning, or derogatory language among other forms of communication." And the policy further indicated "After investigation is completed, the results will be reported to the common entry point/office of facility complaints (CEP/OHFC) via (by) Minnesota Department of Health (MDH) Internet reporting system within 5 working days of the initial report. Information will be reported by the DON, director of social services (SS) or assistant director of nursing (ADON)."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow their policy to ensure allegations of verbal abuse were immediately reported to the administrator, and state agency for 2 of 2 residents (R65 and R120) involved in a verbal altercation during the survey. In addition, the results for 8 of 15 resident (R45, R53, R17, R116, R24, R16, R69 and R60) allegations of abuse were submitted within 5 working days of the incident to the state agency.	F 226		

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F 226	Continued From page 16 The facility also, did not complete reference checks for 5 of 5 newly hired staff (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-A and dietary aide (DA)-A) according to the facility policy. Findings include: The facilities ABUSE PREVENTION and PROHIBITION policy revised 9/10/12, indicated Mission Nursing Home (MNH) " will not tolerate the maltreatment of its residents, whether overtly by abuse, through omission by neglect or financial exploitation of a resident's property or funds. Persons found to be maltreating residents will be dealt with to the limits permitted by the law." The policy further indicated, "the supervisor hiring the candidate must conduct reference checks of the candidates prior employment and position held.".. The policy also indicated "Verbal Abuse: the use of words to cause harm to the person being spoken to. Examples: name-calling, shouting, insulting, intimidating, threatening, shaming, demeaning, or derogatory language among other forms of communication." And the policy stated "After investigation is completed, the results will be reported to the common entry point/office of facility complaints (CEP/OHFC) via (by) Minnesota Department of Health (MDH) Internet reporting system within 5 working days of the initial report. Information will be reported by the DON, director of social services (SS) or assistant director of nursing (ADON)." ALLEGED INCIDENTS OF ABUSE NOT REPORTED TO STATE AGENCY: R65's quarterly Minimum Data Set (MDS) dated	F 226	**F 226** Mission Nursing Home the only all male nursing home in Minnesota and thus deals with residents with behavioral issues on a daily basis. Resident swearing and using inappropriate language tends to be a part of the dynamic. Staff members use their judgment on what is reportable verbal abuse between residents and follow the Vulnerable Adult Policy with respect to verbal abuse definitions. The verbal altercation in the dining room between residents R65 and R120 was witnessed by health department surveyors. The two residents' comments although offensive, were not threatening or meant to cause harm to each other. Mission Nursing Home's policy defines verbal abuse as "the use of words to cause harm to the person being spoken to". This incident was investigated according to facility policy. It was not reported to Common Entry Point/Office of Health Facility Complaints as it was viewed as not threatening or harmful during a resident to resident interaction. Verbal abuse is reported per facility policy Education will be provided for staff members regarding the Abuse Prohibition Policy, abuse identification (including verbal abuse) and reporting.	

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F 226	Continued From page 17 2/2/15, indicated he was moderately cognitively impaired and had verbal behavioral problems. R120's MDS admission MDS dated 3/27/15, Indicated he was moderately cognitively impaired. During an observation on 4/13/15, at 5:41 p.m., two residents were observed in the dining room eating there evening meal on the first floor with all of the other residents. R65 was sitting at a table beside R120's table. R65 turned his head and yelled "Fuck you, you are a cock sucker" towards R120. R120 then yelled back at him "No, you are the cock sucker." A dietary aide (DA)-A was serving the meals observing the altercation and the social worker (SW)-A and the director of nursing (DON) entered the dining room and attempted to deescalate the altercation. The SW-A and DON were able to calm the residents down so they could continue to eat. During interview 4/15/15, at 9:15 a.m. SW-A stated she was responsible for and normally reported incidents to the state agency. SW-A said she had not reported the incident that occurred on 4/13/15 to the state agency because R65 and R120 had not made any threats to harm each other. The SW stated, she did not feel verbal altercations was a reason to report an incident. SW-A stated she felt the two residents were being verbally abusive to each other, but also said if she had to report that incident, and similar occurrences, she would be reporting "all of the time. " Although R65 and R120 were verbally abusive to each other, no report was made to the state agency.	F 226	The Inter-Disciplinary Team (IDT) reviews all incidents. During these daily reviews, the IDT ensures all reportable incidents have been reported. This is in place and will remain ongoing. Results will be reported quarterly to the Quality Assurance Committee. The Director of Social Services or her designee will be responsible for compliance. Date of Completion: 06/03/15	

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F 226	Continued From page 18 INVESTIGATIONS REPORTED LATE TO THE STATE AGENCY: R45's quarterly MDS dated 1/21/15, indicated he was cognitively intact and had physical and behavioral symptoms directed towards others. R53's quarterly MDS dated 3/28/15, indicated he was severely cognitively impaired and had behavioral symptoms. Review of Mission Nursing Home Incident report dated 1/3/15, indicated on 1/3/15, at 12:00 p.m. R45 had pushed R53 because he was in his spot. The report indicated R53 " became upset and started swinging at him and hit him." The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 1/3/15. The subsequent investigative report was not submitted to the State Agency (SA) until 1/12/15, nine days later. R17's quarterly MDS dated 3/25/15, indicated he had modified independence in decision making and had verbal and behavioral symptoms. R116's discharge MDS dated 4/4/15, indicated he had altered level of consciousness with physical and behavioral symptoms. Mission Home Incident Report dated 3/28/15, at 1:00 a.m. that R17 and R116 were arguing and R17 "had shoved him and threw water on him. Residents shirt wet with water and water on the the floor (it did appear that water was thrown on	F 226	Mission Nursing Home follows the policy that all incidents of abuse or neglect must be reported to the Office of Health Facility Complaints (OHFC) immediately. Then within five working days the review of the ensuing investigation must be received by them. In four incidents (involving eight residents), although the investigation was started immediately, the actual review of the investigation was not received by OHFC within the five working days. In the incident between R45 and R53, and also the incident between R69 and R60 the investigation report was due on a Friday but not done until the following Monday thereby making it one day late. All four of the incidences (R45 & R53, R69 & R60, R17 & R116, R24 & R16) occurred on a Friday, Saturday or Sunday. To ensure that all investigation reports are timely the Director of Social Service and/or the Director of Nursing will check each Monday morning for the due dates of any current investigations. The Director of Social Services and/or Director of Nursing will audit each investigation weekly to ensure submissions are completed within time requirements. This audit will be performed weekly for four weeks then monthly until compliance is determined by the Quality Assurance Committee.	

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F 226	Continued From page 19 resident)." R116 did nor fall and did not sustain any injures from resident shoving him. The report further indicated the residents were separated even though they continued agitation and anger. The report indicated the administrator was notified. The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 3/28/15. The subsequent investigative report was not submitted to the SA untll 4/9/15, fifteen days later. R24's quarterly MDS dated 1/24/14, indicated he was moderately impaired cognitively and that he had verbal and behavioral symptoms. R16's quarterly MDS dated 3/23/15, indicated he was cognitively intact with no behaviors. Mission Home Incident Report dated 1/30/15, at 7:00 p.m. Indicated while in the smoke room R16 stated R24 took the remote and changed the television channels and said he wanted to finish what he is watching. R24 grabbed his (R16's) shirt by the left arm and stated "I ' m watching what I want and grabbed him again." The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 1/30/15. The subsequent investigative report was not submitted to the SA until 2/9/15, ten days later. R69's quarterly MDS dated 3/3/25, indicated he was moderately impaired in decision making and had no behavior problems.	F 226	The Director of Social Services will be responsible for compliance. Date of Completion: 06/03/15	

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F 226	Continued From page 20 R60's admission MDS dated 2/10/15, indicated he had moderate impaired decision making and had verbal behaviors. Mission Home Incident Report dated 2/15/15, at 8:55 a.m. indicated R69 kicked R60 "in the lower leg in the smoke room and struck him on the left cheek, knocking the residents glasses off. Staff was present and removed this resident from the sight sending him to his room. The Resident is in an agitated state; but is in his room. Given time to calm. Message left for Administrator and DON. Was able to contact Social Services Director. Will ask Resident to not attend his 10:00 a.m.. smoking time but because of his poor memory may allow to attend other times. Staff will observe behavior at those times. Staff will attend to other resident to ensure no other confrontations occur." The Minnesota Department of Health Investigative Submission report indicated the incident was reported on 2/15/15. The subsequent investigative report was not submitted to the SA until 2/23/15, eight days later. During interview with SW-A 4/15/15, at 9:30 a.m. indicated she was aware the investigative reports were to be submitted within five working days of the incident she was late. NEW EMPLOYEE REFERENCE CHECKS NOT COMPLETED: Review of the newly hired employee files indicated the following: RN-D was hired 3/31/15, and no reference check was completed.	F 226	It is the policy of Mission Nursing Home to only employ individuals who have not been found guilty of abuse, neglect, or mistreatment of residents or have had findings entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment, or misappropriation of resident's property. 1. New employee reference checks were identified as not being completed at the time of the survey. Verification of Licenses for RN's, LPN's and	

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F 226	Continued From page 21 RN-C was hired 3/17/15, and no reference check was completed. LPN-A was hired 1/19/15, and no reference check was completed. NA-A was hired 3/27/15, and no reference check was conducted. During interview 4/15/15, at 2:42 p.m. human resource director (HR) stated no reference checks had been done since the new DON started. The HR director then stated the DON assumed the staffing coordinator completed them. Although the facility's abuse prevention policy indicated they must report allegations of verbal abuse, submit investigative reports within five working days and complete reference checks the facility failed to.	F 226	Certificates for NAR's and TMA's had been completed. 2. Each Department Head or designee is responsible to check references. 3. The Human Resource Department will verify that reference checks have been completed and other required pre-employment information has been received prior to employment start date for new staff members. Audits will include review of personnel records of new hires to ensure reference checks have been completed. These audits will be conducted weekly for four weeks, then random until compliance is determined by the Quality Assurance Committee. The Human Resource Department and Department heads will be responsible for compliance. Date of Completion: 06/03/15	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	245546	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(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 278	Continued From page 22 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess for functional limitations in range of motion (ROM) on the Minimum Data Set (MDS), for 2 of 3 residents (R59 and R99) who were reviewed for ROM. Findings include: R59 ' s quarterly MDS dated 11/21/14, indicated he had no functional limitations in ROM. However, the significant change MDS dated 12/28/14, had indicated R59 now had functional limitations in ROM of bilateral upper and lower extremities. R59 ' s ROM Assessment dated 11/15/14, showed no limits to his ROM. However, the ROM Assessment dated 12/23/14, showed he had moderate limitations in ROM of his shoulders, elbows, wrists, hips, knees, and ankles. When interviewed on 4/16/14, at 2:38 p.m. registered nurse (RN)-A stated the nurses who work with the resident ' s code the ROM	F 278	**F 278** Mission Nursing Home utilizes the Centers for Medicare and Medicaid Services Resident Assessment Instrument (CMS RAI) manual as policy for MDS completion. R99 has been reassessed for range of motion to ensure accuracy. R59 expired on 12/31/14, therefore unable to complete reassessment. Mandatory training sessions will be scheduled to re-train all licensed staff on ROM assessment technique. This will also be added to new employee checklist to ensure new hires are trained on accurate data collection for ROM assessments. The MDS nurse will review documentation for accuracy and clarify through further assessment and or staff interview. Nurse Managers will select two of the Range of Motion assessments completed each week for review for accuracy. This will be done weekly for four weeks and then re-evaluated. Results will be reported to the Quality Assurance Committee. RN Clinical Managers will be responsible for compliance. Date of Completion: 06/03/15	

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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

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F 278	Continued From page 23 Assessments into the computer system, the computer system then automatically places the coding onto the MDS. She then ensures the MDS is completed and signs it. However, she does not check the coding for accuracy or changes. RN-A stated the computer system does not flag when there is a change such as no limitations in ROM to actually having limitations in ROM, so she had not assessed R59 for this change. However, RN-A stated R59 did not have any actual functional limitations in ROM at the time of the 12/28/14, MDS, and this was coded incorrectly. RN-A stated the nurses must need training in how to assess residents for ROM. R99 ' s annual MDS dated 11/11/14, included he had no functional limitations in ROM. However, the quarterly MDS dated 2/9/15, indicated he had bilateral lower extremity functional limitation in ROM. R99 ' s ROM Assessment dated 11/6/14, showed no limits to his ROM. However, the ROM Assessment dated 2/3/15, indicated he now had moderate limitations in ROM to his hips, knees and ankles. When interviewed on 4/16/14, at 2:48 p.m. RN-A stated R99 ' s quarterly MDS dated 2/9/15, was also coded incorrectly as R99 has no functional limitations in ROM. RN-A stated the nurses who fill out the ROM Assessments have not been trained on how to assess functional limitations of ROM per the Resident Assessment Instrument (RAI) guide, and training would have to be done.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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

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F 329	Continued From page 24 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document a "risk verses benefit" for the use of nicotine cessation product while continuing to smoke for 1 of 4 residents (R63) who continued to smoke while using a smoking cessation patch. Findings include: R63's electronic medical record indicated diagnoses of nondependent tobacco use	F 329	F 329 It is the policy of Mission Nursing Home for residents to be free from unnecessary drugs. A risk vs. benefit review was done on 05/13/15 with R63. An audit was done of Risk vs. Benefit forms for all residents who have nicotine patches. Informing those residents identified will be completed by 05/18/15. Education for licensed nursing staff will include a review of the Risk vs. Benefits form. Audits will be conducted on all resident with nicotine patches to ensure if they are smoking that a current Risk vs. Benefit form is done monthly for three months and ongoing until compliance is met as determined by the Quality Assurance Committee. Director of Nursing or designee will be responsible for compliance. Date of Completion: 06/03/15	

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OMB NO. 0938-0391

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

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F 329	Continued From page 25	F 329		

disorder, neoplasm of the oral cavity. R63's quarterly Minimum Data Set (MDS) dated 02/12/15, indicated this resident has long and short term memory concerns.

During morning observation on 4/14/15 at 6:02 a.m., R63 was noted to be eating breakfast in the first floor dining room. During conversation, one pack of cigarettes, one pack of cigarillos, and 3 lighters dropped out of R63's coat pocket, all landing on the floor. R63 stated that he smokes throughout the day.

In review of both R63's electronic and hard copy medical records, R63's signed Physician Order Report dated 4/7/15, indicated this resident was ordered "Nicotine Patch 24 Hour 14 milligram (mg)/24 Hour patch, apply 1 patch transdermally one time a day." The order identified R63's smoking cessation patch were initiated on 11/06/14 (approximately 22 weeks ago).

A review of the physician and nurse practitioners progress notes, there was no indication that any of the providers, including facility staff, had documented the risks verses benefit of continued smoking while utilizing a smoking cessation patch. During interview on 4/14/15 at 10:00 a.m., R63 stated that he was unaware that wearing the patch and smoking at the same time was a concern.

During a interview on 04/14/2015 at 3:59 p.m., the facility medical director (FMD) stated that there should be no one smoking with a 14 mg nicoderm patch. The FMD further stated that if a resident continued to smoke while wearing a patch, it would be expected that there was discussion and documentation of the risk -vs-

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 26 benefit of this practice. An Interview on 04/16/2015 at 3:45 p.m., with a registered nurse (RN)-B stated that the physician and the nurse practitioners normally cover the risks verses benefit of smoking and wearing a nicotine patch at the time of admission. RN-B stated that after reviewing progress notes from all disciplines, that this was not completed. During interview on 04/16/2015 4:20 p.m., R63's attending physician stated that she has had people in toxicology review this issue and did not feel there was a true concern utilizing not a nicotine patch and continuing to smoke. However stated that there should be documentation in R63's records indicating there was a discussion of the risk verses benefits of doing both. A pharmaceutical reference indicated the following: "Do not smoke while you are using nicotine. Stop smoking as soon as your treatment begins. Smoking while using this medication can be dangerous." Side effects included severe rash/swelling, seizures, abnormal heartbeat or rhythm, difficulty breathing, and toxicity.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 356	Continued From page 27 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to include the actual hours worked by nursing staff on the facility staff posting. This had the potential to affect all 93 residents residing in the facility and all staff and visitors who may wish to view this information. During initial tour of the facility on 4/13/15, at 1:30 p.m. the Mission Nursing Home Report of Nursing Staff Direct Care was posted on the 1st floor near the nurses station. The staff posting displayed the name of the facility, the date, the resident census, the number of registered nurses (RN), licensed practical nurses (LPN) and the number of nursing assistants (NA) per shift. But	F 356	**F 356** Mission Nursing Home will revise the staff hours form to include the actual times that staff are scheduled for each shift. Residents will be made aware of this update at the next Resident Council meeting. The policy and procedure for posting hours has been revisited and revised to reflect actual hours worked. A new form to display staff schedule has been created and is in use. Director of Nursing or designee will be responsible for compliance. Date of Completion: 05/11/15	

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

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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F 356	Continued From page 28 the form did not display designated start and end times for each of these direct care staff shifts. During an interview on 4/16/15, at 10:12 a.m., the director of nursing (DON) stated that the day shift RNs, LPNs and NAs worked from 6:00 to 2:30 pm, the evening shift RN's, LPN's and NA's worked from 2:00 p.m. to 10:30 p.m. and the night shift RN's, LPN's and NA's worked from 10:00 p.m. to 6:30 a.m. The DON stated that he was not aware that the actual hours needed to be listed on the staff posting. A facility policy for staff posting was requested, but none was provided.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F 425** It is the policy of Mission Nursing Home to administer medications as ordered by the physician, and in accordance with applicable manufacturers' guidelines. Manufacturers' guidelines regarding time of administration of insulin varies according to product ordered. While short-acting insulins are generally given prior to meals, FDA product labeling for Humalog does include provision for administration immediately after meals. A medication error report was completed for each of the residents identified (R19, R68, R62).	

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OMB NO. 0938-0391

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

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F 425	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to have procedure in place regarding the administration of insulin which affected 3 of 3 clients (R19, R68 and R62) who received insulin after there evening meal. Findings include: R19's admission Minimum Data Set (MDS) dated 2/2/15, indicated he had diabetes mellitus and received insulin. R19's current physician orders dated 3/07/15, indicated he had diabetes mellitus and was to receive novolog 100 units/ml (milliliter) 2 units (fast acting meal time insulin which should be received 5 to 10 minutes before a meal), in addition he received lantus (long acting insulin) 100units/ml 12 units. During observation on 4/13/15, at 5:49 p.m. after R19 ate his evening meal at 5:00 p.m. R19 received his insulin novolog 100 units/ml 2 units (for sliding scale blood sugar) in addition he received lantus 100 units/ml 12 units which was administered by registered nurse (RN)-E. During interview on 4/13/15, at 6:00 p.m. RN-E stated she had just completed all of the residents (R19, R68, R62) blood glucose checks and had just started to giving their insulin, even though the blood glucose checks and insulin were completed after the resident had finished eating this evening meal.	F 425	Current staff will be reeducated, and information will be provided to new staff regarding standard times of administration of all medications, including insulin products. Education has been initiated and will be completed by 06/03/15. If nursing staff determines that standard times of administration are not appropriate for an individual, the physician will be contacted to evaluate / update orders to meet individual needs. The Director of Nursing or designee will observe insulin administration two times per week for four weeks, then monthly until compliance is determined by the Quality Assurance Committee. The Director of Nursing or designee will monitor staff performance for compliance with expected times of administration	

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FORM APPROVED
OMB NO. 0938-0391

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

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F 425	Continued From page 30 R68 physician orders dated 3/4/15, indicated he had diabetes and was to receive 16 units of humalog (long acting insulin) at 5:00 p.m. Per the medical administration record R68 did not receive his insulin until after 6:00 p.m. on 4/13/15. R62's physician orders dated 3/07/15, indicated he had diabetes mellitus and was to receive 15 units of humalog. Per the medication administration record R62 did not receive his 15 units of insulin until after 6:00 p.m. on 4/13/15. During interview 4/13/15, at 6:30 p.m. RN-B stated that they had a temporary nurse come who had not worked at the facility before. RN-B stated she received a brief orientation and must have gotten behind so these residents did not receive there insulin until after 6:00 p.m. During interview 4/24/15, with the facilities consultant pharmacist who stated the residents should have received there insulin before they eat. A policy was requested for timing of giving insulin but was not provided.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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

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F 428	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that the consultant pharmacist requested the facility for document of a "risk verses benefit " for the use of nicotine cessation product while continuing to smoke for 1 of 4 residents (R63) who continued to smoke while using a smoking cessation patch. In addition, the facility failed to take action when drug regimen review irregularities were reported by the consultant pharmacist, for 1 of 5 residents (R99) who were reviewed for unnecessary medications. Findings include: R63's electronic medical record indicated diagnoses of nondependent tobacco use disorder, neoplasm of the lip and oral cavity, and malignant neoplasm of tonsil. R63's quarterly Minimum Data Set (MDS) dated 02/12/15, indicated this resident has long and short term memory concerns. During morning observation on 4/14/15 at 8:02 a.m., R63 was noted to be eating breakfast in the first floor dining room. During conversation, one pack of cigarettes, one pack of cigarillos, and 3 lighters dropped out of R63's coat pocket, all landing on the floor. R63 stated that he smokes throughout the day. In review of both R63's electronic and hard copy	F 428	F 428 It is the policy of Mission Nursing Home for residents to be free from unnecessary drugs. A risk vs. benefit review was done on 05/13/15 with R63. An audit was done of Risk vs. Benefit forms for all residents who have nicotine patches. Informing those residents identified by the audit will be completed by 05/18/15. Education for licensed nursing staff will include a review of the Risk vs. Benefits form.	

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OMB NO. 0938-0391

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

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F 428	Continued From page 32 medical records, R63's signed Physician Order Report dated 4/7/15, indicated this resident was ordered "Nicotine Patch 24 Hour 14 milligram (mg)/24 Hour patch, apply 1 patch transdermally one time a day." The order identified R63's smoking cessation patch were initiated on 11/06/14 (approximately 22 weeks ago). A review of the physician and nurse practitioners progress noted, there lack evidence that any of the providers, including facility staff, have documented the risks verses benefit of continued smoking while utilizing a smoking cessation patch. During interview on 4/14/15 at 10:00 a.m., R63 stated that he was unaware that wearing the patch and smoking was a concern. In review of the facility's policy, entitled: Consultant Pharmacist Duties (Merwin LTC Pharmacy - Policy and Procedure Manual, LTC2, Ver. C, 10.22.13), "The Consulting Pharmacist agrees to perform the following: 1. Reviewing the medication regimen of each resident, utilizing state and/or federal standards of car in addition to other applicable standards, and documenting the reviews and findings." During a interview on 04/14/2015 at 3:59 p.m., the facility medical director (FMD) stated that there should be no one smoking with a 14 mg nicoderm patch. The FMD further stated that if a resident continued to smoke while wearing a patch, it would be expected that there was discussion and documentation of the risk -vs- benefit of this practice. An interview on 04/16/2015 at 3:45 p.m., with a registered nurse (RN)-B stated that the physician and the nurse practitioners normally cover the	F 428	For all residents with nicotine patch ordered, nurse will observe if resident continues to smoke. If so, it will be discussed with the resident's physician to determine to continue patch or not. If resident smoking with patch is negotiated, a Risk vs. Benefit form will be completed. Director of Nursing or designee will be responsible for compliance. Date of Completion: 06/03/15	

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F 428	Continued From page 33	F 428		

risks verses benefit of smoking and wearing a nicotine patch at the time of admission. RN-B stated that after reviewing progress notes from all disciplines, that this was not completed.

During interview on 04/16/2015 4:20 p.m., R63's attending physician stated that she has had people in toxicology review this issue and did not feel there was a true concern utilizing not a nicotine patch and continuing to smoke. However stated that there should be documentation in R63's records indicating there was a discussion of the risk verses benefits of doing both.

In a telephone interview on 4/17/15 at 10:15 a.m., the consulting pharmacist (PharmD) stated that no one should be smoking and utilizing a nicotine cessation patch, due to potential toxicity. The PharmD further stated that nicotine replacement products should not be used for more that 10 weeks, before either discontinuation or a step down to a lower dose. The PharmD was not aware of the continued smoking nor the long duration (approximately 22 weeks) of the same dose being used.

A pharmaceutical reference indicated the following: "Do not smoke while you are using nicotine. Stop smoking as soon as your treatment begins. Smoking while using this medication can be dangerous." Side effects: severe rash or swelling seizures, abnormal heartbeat or rhythm, difficulty breathing, and toxicity.

R99 ' s quarterly Minimum Data Set (MDS) dated 2/9/15, included diagnoses of dementia and psychotic disorders with severe cognitive impairment and delusions. R99 received

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245646	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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F 428	Continued From page 34 antipsychotic and antidepressant medications. R59's Order Summary Report dated 3/31/15, included orders for Trileptal (an antiseizure medications, sometimes used for psychosis) for, "dementia/psychosis/agitation/anxiety." Another order was for Olanzapine (an antipsychotic medication, also sold under the brand name Zyprexa) for a diagnosis of dementia with behavioral disturbances. Also, Citalopram (generic for Celexa, an antidepressant) for anxiety. R59's Consultant Pharmacist Communication to Nursing dated 9/17/14, included, "In progress notes, NP [nurse practitioner] mentioned that she spoke w/[with] psychiatrist about taper of Trileptal. But no other information was noted. Please ask NP to explain if a taper would be appropriate." The NP responded on this form, on 10/23/14, "This medication was increased from 150 mg [milligrams] to 300 mg due to increased aggression on 4/7/14. Will ask nursing to address this with psychiatrist when next sees patient." R59's medical record did not contain any information that the nurses had addressed this with the psychiatrist. When interviewed on 4/16/15, at 2:58 p.m. the health unit coordinator (HUC)-C stated no staff had noted the NP's comments, "if they had, they would have initialed it." R59 had not seen a psychiatrist since the 10/23/14, recommendation, therefore this had not been followed up on. R59's Consultant Pharmacist Communication to Physician dated 2/10/15, included, "Zyprexa 5 mg twice daily & 10 mg daily at 2 pm continues since	F 428	It is the policy of Mission Nursing Home that a licensed pharmacist complete a drug regimen review at least monthly on each resident The reports that have irregularities are submitted to the attending physician, Director of Nursing, and Clinical Nurse Managers. The nurse practitioner addressed the pharmacist recommendation on 04/16/15 with a gradual dose reduction order for R99. Audits will be completed monthly for timely responses to consulting pharmacist. Reviews will be completed for four months then randomly as determined by the Quality Assurance Committee. The Director of Nursing or designee is responsible to monitor for compliance. Completion Date: 06/03/15	

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FORM APPROVED
OMB NO. 0938-0391

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F 428	Continued From page 35	F 428		

January 2014 when he failed a trial dose reduction attempt. Trileptal increased to 450 mg twice daily in April 2014 and Celexa 20 mg daily added in May 2014. Nursing notes wandering behavior, but no delusions or paranoia. Would a reduction of the Zyprexa to 5 mg three times daily be appropriate? Or please document reasons why such an attempt would not be warranted at this time." This communication form was not addressed by the physician or facility at all.

R59's Consultant Pharmacist Communication to the Physician dated 4/13/15, repeated the recommendation made on 2/10/15.

When interviewed on 4/16/15, at 10:50 a.m. the consultant pharmacist (CP)-A stated a previous pharmacy consultant had made the recommendations on 9/17/14, and did not know why this had not been followed up on. However, she had made the 2/10/15, recommendation and when this had not been followed up on by the facility, she re-issued it on 4/13/15. CP-A stated the nurse manager misunderstood that she would be responsible for sending the Consultant Pharmacist Communication to the Physician to the physician herself, and thought CP-A would do that. This had caused the delay in the physician getting the pharmacist recommendations.

When interviewed on 4/16/15, at 2:52 p.m. the director of nursing (DON) stated he thought he gave the February 2015, pharmacy consultant recommendations to the health unit coordinator to send out to the physicians. He did not know what had happened to the September 2014 NP note. At 3:00 p.m. the health unit coordinator (HUC)-C stated she did not receive the February 2015, pharmacy consultant recommendations. At 3:05

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

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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F 428	Continued From page 36 p.m. registered nurse (RN)-A found the February 2015, pharmacy consultant recommendations, they had not been sent to the physicians. The DON stated they were developing a new system where the nurse managers would get the recommendations directly from the consultant pharmacist, which should improve the system. A facility policy and procedure entitled Monthly Medication Review, dated 10/22/13, included, "Recommendations are acted upon and documented by the facility staff/and/or the prescriber."	F 428		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a working call light for 1 of 4 residents (R89) on the 2nd floor south unit, whose call light was not working. Findings include: R89's diagnoses, as indicated in the quarterly Minimum Data Set (MDS) dated 2/15/2015, included Alzheimer's dementia and Parkinson's. The MDS also indicated he had severely impaired cognition. A call light use and safety data collection and analysis form, dated 2/14/2015, indicated R68 "did not seem to understand call	F 463	**F 463** It is the policy of Mission Nursing Home to insure that facility equipment is in proper working order. The call light for R68 was immediately repaired when problem was identified. All resident call lights in the building were checked to insure working order on 04/15/15. Maintenance has added monthly call light inspections to the preventative maintenance program. The Environmental Services Director or designee will be responsible for compliance. Completion Date: 04/17/15.	

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

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FORM APPROVED
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F 463	Continued From page 37	F 463		

light system." Further, the analysis included: "Staff still should keep call light within reach, as [R68's] functions seems to fluctuate."

During observation on 4/14/2015 at 8:17 a.m., in the presences of registered nurse (RN)-F, the call light button switch next to R68's bed would not activate the call light. The call light was not working.

In an interview on 4/14/2015 at 8:17 a.m., RN-F stated [R68's] call light "should be going, and it should be functional." RN-F also said that R68 "sometimes" used his call light, but that he still needed to have it available.

In an interview on 4/16/2015 at 1:58 p.m., the maintenance assistant (MA) said there were some routine equipment checks in the nursing home, "... like the electric generator, emergency power, and the boilers, and the temps, that gets checked every day." The MA said he only checked call lights while in a resident's room, "If I was there, fixing something else," and that he typically responded to requests from nursing that a call light was not working. The MA said "maintenance" was responsible for the call lights, but that "anyone, nurse aides, housekeeping" could check lights when they're in resident rooms." The MA said, "Right now, we do not have a routine schedule where we check the call lights."

During an interview on 4/16/2015 at 3:50 p.m., the director of nursing (DON) stated "a review of call lights" was one of the tasks of the safety committee was currently addressing. The DON added, he thought there should be a regular check of call lights to make sure they are

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

PRINTED: 04/29/2015
FORM APPROVED
OMB NO. 0938-0391

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F 463	Continued From page 38 functioning. The DON said "I think this would be a good safety directive." A facility policy regarding the use and maintenance of resident call lights was requested, but none provided.	F 463		

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Mission Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us	K 000	**K 000** It is the policy of Mission Nursing Home to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	

DC: 5-26-15
EXIT: 4-16-15

POC ok
6-25-15

RECEIVED
JUN 24 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

RECEIVED 6/1/15 - NEVER RECEIVED IN MDH DEFICIENCIES

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

ADMINISTRATOR 6/3/15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building was constructed in 1995 and was determined to be of Type II (111) construction. It has a full basement and is automatic sprinkler protected throughout. The facility has a fire alarm system that is monitored for fire department notification. The facility has a capacity of 94 and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018		

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

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K 018	Continued From page 2 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect some residents. Findings include: During facility tour between 10:00 AM and 11:30 AM on 04/20/2015, observation revealed that the corridor door leading to resident room 118 and B35 do not latch closed. This deficient practice was verified by the maintenance director the time of the inspection.	K 018	**K 018** It is the policy of Mission Nursing Home to insure all doors are in proper working order. The doors to room 118 and B35 were repaired on 04/24/15 by contractor, Mobile Lock and Safe. They were verified by Rodney Beach to be in proper working condition after repairs were made. Inspection of all doors to ensure they close and latch properly was initiated on 04/21/15 and will be completed monthly. The Director of Environmental Services will be responsible for Compliance. Date of Completion: 04/24/15.	
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2	K 043		

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K 043	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the door locks in accordance with Life Safety Code Section 18.2.2.4. This deficient practice could affect the residents. Findings include: On facility tour between 10:00 AM and 11:30 AM on 04/20/2015, record review revealed that there is no documentation of testing for the stairwell delayed egress doors. This deficient practice was verified by the maintenance director at the time of the inspection.	K 043	**K 043** It is the policy of Mission Nursing Home to insure all doors are in proper working order. . Documentation of previous inspections was found. Renewed Inspection of all doors was initiated on 04/21/15 and will be completed monthly. The Director of Environmental Services will be responsible for Compliance. Date of Completion: 04/24/15.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient	K 052	**K 052** It is the policy of Mission Nursing Home to follow all federal, state, and local guidelines, laws, regulations, and statutes. This includes quarterly DACT testing and maintenance of fire alarm systems . Mission Nursing Home contracted with Total Fire Alarm on 06/04/15 to complete quarterly DACT testing of the fire alarm system The Director of Environmental Services will be responsible for Compliance. Date of Completion: 06/04/15.	

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K 052	Continued From page 4 practice could affect the residents. Findings include: On facility tour between 10:00 AM and 11:30 AM on 04/20/2015, record review revealed that there is no documentation of the quarterly DACT testing. This deficienct practice was verified by the maintenance director at the time of the inspection.	K 052		