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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 70EO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 April 15, 2013 (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)
06/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 05/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 05/30/2013 (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
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 6/4/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5465
Page #2

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective April 9, 2013, the facility is certified for 52 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5465 May 30, 2013

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

Dear Mr. Carlson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 9, 2013, the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

May 30, 2013

RE: Project Number S5465023

Dear Mr. Carlson:

On March 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 28, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 15, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2013, effective April 9, 2013 and therefore remedies outlined in our letter to you dated March 14, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Enclosure
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
245465	A. Building B. Wing	4/15/2013

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0154 Reg. # 483.10(b)(3), 483.10(d)(2) LSC	03/04/2013	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	04/09/2013	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	04/09/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	SG/cbl	05/30/2013	28589	04/15/2013
Reviewed By CMS RO				

Followup to Survey Completed on: 2/28/2013

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: 70EO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

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(L1) **245465**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **02/28/2013** (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)
06/30

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From (a) :
To (b) :

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

see Attached Remarks

17. SURVEYOR SIGNATURE Date :
Nicolle Marx, HFE NII 04/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/18/2013 (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:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5465

At the time of the Standard survey completed on February 28, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Documentation in support of the facility's request for a continuing waiver is being forwarded to the CMS RO for review and approval.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4351

March 14, 2013

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

RE: Project Number S5465023

Dear Mr. Carlson:

On February 28, 2013, 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;

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7365

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 April 9, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 9, 2013 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 May 28, 2013 (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 August 28, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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	RECEIVED APR 01 2013 MN Dept of Health St.Cloud	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure that 3 of 10 residents (R20, R51, R34) who were taking psychotropic medications were fully informed about the risks and benefits of treatment, and expected outcomes of the treatment and failed to have a system in place to discuss with residents and family the risk vs benefits of psychotropic medications	F 154	F154- Failure to complete Informed Consents with use of psychotropic medication The family representatives for residents #20, #51, and #34 were contacted and informed of the risks, benefits, potential side effects and goals for the use of the psychotropic medications that were ordered for them. Consent forms were signed by family representatives for resident #20 on 3/7/13, resident #51 on 3/4/13, and for resident #34 on 3/1/13. OK 4.2.13 SG Per administrator dates for correction on F248 of F 280 will be 4/9/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David E Carlson	Administrator	3-29-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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 154	Continued From page 1 Findings include: R20 received psychotropic medications without evidence that risks and benefits were reviewed with R20 or R20's family. R20 received Klonopin (a medication that can be used for anxiety) 0.25 milligrams (mg) every morning and 0.5 mg at bedtime. R20 had an additional physician order that authorized staff to administer additional doses of Klonopin 0.25 mg as needed for anxiety. R20 also received Seroquel (a medication generally used to treat psychosis) 12.5 mg twice a day, which was started on 10/21/12. R20 had diagnoses that included dementia with behavioral disturbance, unspecified psychosis, depressive disorder and anxiety state. An admission minimum data set (MDS) completed on 10/28/12, indicated R20 was severely cognitively impaired and would be unable to make decisions for herself. The MDS further indicated R20 had symptoms of delusions, and specifically was inattentive with disorganized thinking at times. R20 also had behavioral issues and had episodes of being physically/verbally aggressive and at times was resistive with staff performing her personal cares. The admission care area assessment (CAA) completed on 10/28/12, noted "psych medications" were used due to long history of "combative behaviors with resisting cares, spitting;/striking out at those near by." The CAA also indicated R20's dementia had progressed and the ability to comprehend what was being	F 154	On 3/4/13, a licensed nurse reviewed the medication lists on all residents residing in the facility. The licensed nurse contacted the family representatives for all residents that could not sign for themselves and verbal informed consents were obtained via telephone on 3/4/13. Again, as with the residents affected in this deficiency, the nurse reviewed risk, benefits, potential side effects and goals for use of the medication(s) with the family members. Family members were encouraged to come in at their next convenient time to sign the consent form.	

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F 154	Continued From page 2 explained or said to was limited. The staff had documented R20 may be striking out related to fear due to not comprehending. An interview with registered nurse (RN)-A was completed on 2/27/13, at 12:47 p.m. RN-A reported she was unsure as to who or how informed consent was obtained in regards to the use of psychotropic medication. RN-A reported she thought after the medications were ordered, the nurse, who would work, with the physician would have contacted the family or it would have been discussed in care conferences. RN-A also reported she thought the facility's social worker (SW) or RN care manager addressed the issue but was unsure. A request was made of RN-A to provide documented evidence the family of R20 were aware of the use of psychotropic medication and that risk/benefits were discussed. RN-A was unable to provide any documentation. An interview with the social worker (SW) was completed on 2/28/13, at 8:15 a.m. SW reported she was unsure who met with the resident/family and discussed the use of psychotropic medication, to include the risks versus benefits but assumed nursing staff addressed it. SW indicated although medications were discussed in care conferences, she was unsure if the risk versus benefits of psychotropic medications were reviewed with the resident or family. An interview with the director of nurses (DON) was completed on 2/27/13, at 2:15 p.m. DON reported she expected the informed consent would be completed for psychotropic medications but was unable to describe how it was done. DON reported in the past, they had a very formal	F 154	The Psychotropic Medication Protocol Policy was reviewed and revised on 3/4/13 and posted for staff to review. The Psychotropic Consent Forms were also revised and put into place on 3/4/13. The Psychotropic policy will be reviewed again during the upcoming nurse's meeting on 4/11/13. Written minutes from the meeting will be posted. This deficiency was reviewed at the Quality Assurance Meeting on 3/19/13. The DON or her delegate will audit all residents weekly from 3/4/13 through 6/4/13 using the care conference schedule to assure that all family members have been informed and have signed the Informed Consent form. Corrective action was completed on 3/4/13 for this deficiency.	

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F 154	Continued From page 3 process, which changed when the facility changed it's psychiatric provider. R51 received psychotropic medications without evidence that risks versus benefits had been reviewed with R51 or R51's family. R51 received Seroquel (a medication generally used to treat psychosis) 37.5 mg daily at bedtime prescribed by the physician with the indication of dementia with behavioral disturbance. Per review of the medical record, it was unclear when the medication was started. R51 was admitted on 3/28/12, with diagnoses that included but were not limited to delusional disorder and dementia with behavioral disturbances. The quarterly minimum data set (MDS) dated 12/13/12, indicated R51 had disorganized thinking, and was severely cognitively impaired with both physical and verbal behavioral symptoms. The Admission Care Area Assessment (CAA) completed 4/9/12, indicated R51 had dementia with short and long term memory deficits. The CAA also indicated R51 had periods of verbal and physical behaviors and refused staff assistance or intervention. Further, the CAA identified, "She does have behavioral episodes with verbal/physical aggression. She is on Seroquel with no obvious adverse effect. Lenth [sic] of use is unclear from record. MD [medical doctor] prn [as needed]. Proceed. " When interviewed on 2/28/13, at 8:10 a.m. RN-A indicated they generally did not get consent when	F 154		

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F 154	Continued From page 4 residents transfer in to the on medications. RN-A stated she would call the family with any increase, and the medications were reviewed in care conferences quarterly, but she was not involved in the care conferences and could not state to what extent they were discussed. RN-A was unable to provide any documentation which indicated the information was discussed with R51's family. A care conference progress note dated 12/19/12, under medication review stated, "MD [medical doctor] decreased Seroquel dose on recent visit. This has been tolerated without change in mood/behaviors. Bowels regular. Comfortable with scheduled Tylenol." No indication noted regarding the risk versus benefits of the utilization of Seroquel was noted. R34 received psychotropic medications without evidence that risks versus benefits had been reviewed with R34 or R34's family. R34 had diagnoses which included but were not limited to unspecified psychosis, anxiety, and dementia with behavioral disturbances. R34 received risperidone (a medication generally used to treat psychosis) 0.125 mg every night at bedtime. The quarterly MDS dated 12/13/13, indicated R34 was severely cognitively impaired, had difficulty focusing attention, disorganized thinking, and physical/verbal behavioral symptoms. The CAA dated 6/19/12, indicated R34 "has dx of dementia. She is medicated to manage	F 154		

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F 154	Continued From page 5 behavioral symptoms." The CAA also indicated, "Will hit at staff and holler during at them during cares" as well as, "is on antipsychotic. She is admitted with hx of use. She has had stays in behavioral units in the past for behavior/medication management. " A care conference progress note dated 12/19/12, did not indicate the risk versus benefits of the use of risperidone had been discussed. An interview with the DON was completed on 2/28/13 at 9:15 a.m. and the above findings were verified. An undated policy identified as, "Anti-psychotic Medications" directed staff to obtain a consent for residents admitted on anti-psychotic medications as soon as possible (within 72 hours maximum) for the use of these medications and for resident started on anti-psychotic medications, after their admission, informed consent was to be obtained prior to the starting of these medication. If staff were unable to obtain written consent, they were instructed to obtain telephone consent and to obtain written consent as soon as possible. It also directed the staff to annually review the informed consent with the resident/family.	F 154		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	F248 Failure to provide individualized activity interventions	

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F 248	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide individualized activities or interventions for those residents who were cognitively impaired for 2 of 3 residents (R29 and R34) reviewed in the sample for activity needs. Findings include: R29 was not observed to participate in activities that were individualized to meet the needs of a resident who was cognitively impaired. R29 had diagnosis of anxiety, Alzheimer disease, unspecified psychosis, depressive disorder, dementia and hallucinations. R29 needed assistance from staff to participate in activities. The quarterly MDS dated 12/27/12, indicated R29 was severely cognitively impaired and never/rarely made decisions regarding tasks of daily life. The MDS identified inattention and disorganized thinking were continuously present and did not fluctuate. Further, the MDS indicated R29 was totally dependent with locomotion on and off the unit, and required one person physical assist. The annual MDS dated 7/12/12, indicated R29 should not be interviewed for daily and activity preferences as resident was rarely/never understood. The staff portion of the MDS for daily and activity preferences was completed by staff an indicated R29 had an interest in listening to music, family, snacking, staying up past 8:00 p.m. and receiving tub baths. During observation on 2/25/13, at approximately	F 248	Both resident #29 and #34 will have a comprehensive activity review completed by 4/5/13 by the Wellness Director or his delegate. Individualized activities will be assigned to both residents pending the activity review. The resident's care plans will also be updated at this time reflecting the changes to activities. All residents in the facility will have an activity review completed by the Wellness Director or his delegate by 4/30/13. Changes to activity interventions in the care plan will be made pending the results of the activity review. A special focus will be placed on those residents with cognitive impairments to assure that 1:1 activities are assigned and are documented in their care plans.	

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F 248	Continued From page 7 2:30 p.m. R29 sat in front of a mirror at the nurses station. R29 touched/pulled at her her pant legs, socks and shoes. R29 vocalized words to herself and anyone who passed by. Staff stopped periodically to straighten R29's pants, socks and shoes. At 4:17 p.m. R29 continued to sit in front of the mirror, and continued to pull at her pants, socks and shoes. R29 was given medications at 5:06 p.m. and then brought to dinner at 5:37 p.m. At 6:50 p.m. R29 was placed at the mirror again. A music performer was singing in the dining area at the time. R29 proceeded to move away from the mirror toward the dinning area and at 7:05 p.m. nursing assistant (NA)-C returned R29 to the mirror from the position in the hall where R29 had moved. At 7:21 p.m. R29 still sat in front of the mirror. R29 was not observed to participate in any activities other than sitting in front of the mirror and touch/pull with her lower pants, socks, and shoes. During an interview on 2/26/13, at 2:19 p.m., registered nurse (RN)-B stated R29 spent time in front of the mirror and seemed to enjoy it. RN-B stated R29 did not consistently attend other activities, did not do well with crowds and did better with 1:1 interaction. The care area assessment (CAA) worksheet dated 7/24/12, indicated staff would continue to take R29 to activities such as live music or other activities that she could listen to or watch. The CAA stated other then taking R29 to these activities and providing her with snacks, staff would make sure R29 was able to wander safely and do what she wanted during the day. Time for 1:1 activities was not noted on the activity CAA dated 7/24/12.	F 248	Continued- A new electronic form of a Comprehensive Activity Review will be developed and put into place by 4/5/13. This review will be complete by the Wellness Director or his delegate with all new admissions, and annually thereafter or with significant changes in resident condition. All residents residing in the facility by 4/30/13 will have an initial Comprehensive Activity Review completed to help assure current activity interventions in the residents care plans are up to date and reflective of their activity preferences and cognitive abilities to partake in the activities assigned to them. This deficiency was reviewed at the Quality Assurance Meeting on 3/19/13.	

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F 248	Continued From page 8 Review of the care plan last reviewed 1/21/13, the activity focus, indicated mail was opened and read to R29 per request or determined need, but did not indicate any specific 1:1 activities following the assessment of activity interest. The behavior/mood focus indicated 1:1 attention with simple conversation and hand holding may calm R29 if displayed symptoms of restlessness or agitation but no plan for scheduled 1:1 time was noted. During interview on 2/28/13, at 8:30 a.m. The wellness director (WD)-A stated interests were assessed on the MDS and placed in the care plan. WD-A stated staff would try to cue and assist residents to scheduled activities. WD-A stated residents may be re-asked about there interest in participating in an activity because their feelings on participating may change day to day. During a second interview 2/28/13, at 9:00 a.m. WD-A verified no individualized assessment for activities had been completed for R29. R34 was not observed to participate in activities that were individualized to meet the needs of a resident who was cognitively impaired. On 2/25/13, at 7:00 p.m. R34 was observed sitting in her room in the wheelchair with a photo album in her hands, while a singing activity was occurring in the dining room. There were no observations of staff interacting with R34 to show R34 the pictures or inviting R34 to the music activity. On 2/25/13, at 7:20 p.m. R34 was observed sitting in the wheelchair in her room, and stated to	F 248	Continued – The Wellness Director or his delegate will audit all residents from 4/5/13 through 7/5/13 that are new admissions or are due for an annual or significant change MDS. The audit will assure that a Comprehensive Activity Review has been completed on these residents and that the care plan interventions are reflective of the results of the review. Corrective action for this deficiency will be completed by ~~4/30/13.~~ 4/9/13 See front page 5b	

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F 248	Continued From page 9	F 248		

writer, "Hello pretty baby." The music activity continued and there was no attempt by staff to interact with R34 or an invitation for R34 to go to the music activity.

On 2/26/13, at 2:55 p.m. R34 was observed sitting in the recliner in her room talking to herself.

On 2/27/13, at 9:20 a.m. R34 was alone, sitting by the nursing station, in a wheelchair (w/c), and became loud/verbal. R34 was approached by clinical manager (CM)-A, who attempted to redirect. R34 agreed to go with CM-A for a "walk." CM-A took R34 for a "walk" and pushed her in the w/c back to R34's room. After R34 was relocated to her room there was no further loud verbalizations overheard in the hall.

The quarterly minimum data set (MDS) dated 12/13/12, indicated R34 had difficulty focusing, disorganized thinking, and verbal/physical behavioral symptoms. No notations were made in the section labeled Preferences for Customary Routine and Activities.

The activity schedule for 1/13, indicated R34 attended 23 activities to include: spiritual (six times), crafts/hobbies (once), group D (three times), music (twice), physical activity (once), food related (four times), general/special (five times), and media (once). The activity schedule for 2/13, indicated R34 attended eight activities to include: spiritual (two times), music (once), food related (three times), and general/special (twice).

When interviewed on 2/27/13. at 12:45 a.m. nursing assistant (NA)-B and NA-A indicated they talked with R34 often. Both nursing assistants

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F 248	Continued From page 10 indicated R34 enjoyed talking with others. NA-B and NA-A described how R34 also enjoyed putting lotion on staff's hands and folding towels. When interviewed on 2/28/13, at 8:30 a.m. The wellness director (WD)-A indicated on admission, specific questions would be asked of residents regarding interests which were communicated on the care plan. WD-A further described staff attempted to get residents up and transferred to an activity approximately one half an hour prior to the activity. WD-A revealed for residents with cognitive difficulties the staff had tried, "Tactile things," but it was, "Hit or miss" and staff would attempt to talk with residents, but behaviors could be disruptive. WD-A listed other interventions which included going for walks, conversation back and forth, coffee and cookies, and a "Rollie bollie" game (where the resident rolled a ball and try to knock down pins). WD-A indicated 1:1 (one to one) interactions were included on the care plans if needed. WD-A did not indicate if R34 would benefit from 1:1 interactions. When interviewed again on 2/28/13, at 9:00 a.m. WD-A stated the facility staff wanted residents to be involved in regular groups but if the residents were not able, attempts were made to do other activities individually that were not scheduled. WD-A was unable to provide any documentation which indicated R34 was individually assessed or had an individual plan developed for activities.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	F280 Failure to revise care plans to include individual activity needs	

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F 280	Continued From page 11 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan for 2 of 3 residents (R29 and R34) reviewed in the sample for activity needs. Findings include: R29's care plan was not revised to include individualized need for activities for a resident that was cognitively impaired. R29 had diagnoses of anxiety, Alzheimer disease, unspecified psychosis, depressive disorder, dementia and hallucinations. Review of the quarterly minimum data set (MDS) dated 12/27/12, indicated R29 was severely	F 280	Both resident #29 and #34 will have a comprehensive activity review completed by 4/5/13 by the Wellness Director or his delegate. Individualized activities will be assigned to both residents pending the activity review. The resident's care plans will be updated at that time reflecting the changes to activities. All residents in the facility will have an activity review completed by the Wellness Director or his delegate by 4/30/13. Changes to activity interventions in the care plan will be made pending the results of the activity review. A special focus will be placed on those residents with cognitive impairments to assure that 1:1 activities are assigned and are documented in their care plans.	

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F 280	Continued From page 12 cognitively impaired and never/rarely made decisions regarding tasks of daily life. During an observation on 2/25/13, at approximately 2:30 p.m. R29 sat in front of a mirror at the nurses station. R29 touched/pulled at her her pant legs, socks and shoes. R29 vocalized words to herself and anyone who passed by. Staff stopped periodically to straighten R29's pants, socks and shoes. At 4:17 p.m. R29 continued to sit in front of the mirror, and continued to pull at her pants, socks and shoes. R29 was given medications at 5:06 p.m. and then brought to dinner at 5:37 p.m. At 6:50 p.m. R29 was placed at the mirror again. A music performer was singing in the dining area at the time. R29 proceeded to move away from the mirror toward the dinning area and at 7:05 p.m. nursing assistant (NA)-C returned R29 to the mirror from the position in the hall where R29 had moved. At 7:21 p.m. R29 still sat in front of the mirror. R29 was not observed to participate in any activities other than sitting in front of the mirror and touch/pull with her lower pants, socks, and shoes. During interview on 2/26/13, at 2:19 p.m. registered nurse (RN)-B stated R29 spent time in front of the mirror and seemed to enjoy it. RN-B stated R29 did not consistently attend other activities, did not do well with crowds and did better with one to one interaction. Review of care plan last reviewed 1/21/13, activity focus, indicated mail was opened and read to R29 per request or determined need, but did not indicate any specific one to one activities following an assessment of activity interest. The	F 280	A new electronic form of a Comprehensive Activity Review will be developed and put into place by 4/5/13. This review will be complete by the Wellness Director or his delegate with all new admissions, and annually thereafter or with significant changes in resident condition. The activity review will address current care planned activities and will also address changes that will be made in the care plan. All residents residing in the facility by 4/30/13 will have an initial Comprehensive Activity Review completed to help assure current activity interventions in the residents care plans are up to date and reflective of their activity preferences and cognitive abilities to partake in the activities assigned to them. This deficiency was reviewed at the Quality Assurance Meeting on 3/19/13.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 behavior/mood focus indicated one on one attention with simple conversation and hand holding may calm R29 if displayed symptoms of restlessness or agitation but no plan for scheduled one on one time was noted. R34's care plan was not revised to include individualized need for activities for a resident that was cognitively impaired. R34 had diagnoses that included but were not limited to anxiety disorder and unspecified psychosis. On 2/25/13, at 7:00 p.m. R34 was observed sitting in her room in the wheelchair with a photo album in her hands, while a singing activity was occurring in the dining room. There were no observations of staff interacting with R34 to show R34 the pictures or inviting R34 to the music activity. On 2/25/13, at 7:20 p.m. R34 was observed sitting in the wheelchair in her room, and stated to writer, "Hello pretty baby." The music activity continued and there was no attempt by staff to interact with R34 or an invitation for R34 to go to the music activity. On 2/26/13, at 2:55 p.m. R34 was observed sitting in the recliner in her room talking to herself. The plan of care last reviewed 10/15/12, indicated R34 had limited involvement in supervised/organized recreation related to her cognitive impairment and impaired mobility. Goals included resident would participate in activities of interest daily or as scheduled and R34 would verbalize enjoyment or opinion after	F 280	The Wellness Director or his delegate will audit all residents from 4/5/13 through 7/5/13 that are new admissions or are due for an annual or significant change MDS. The audit will assure that a Comprehensive Activity Review has been completed on these residents and that the care plan interventions are reflective of the results of the review. Corrective action for this deficiency will be completed by ~~4/30/13.~~ 4/9/13 SC See front page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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 280	Continued From page 14	F 280		

participation in the activity. Interventions included but were not limited to allowing R34 ample time to respond, assist with mobility to and from activities, provide encouragement to attend, provide reminders in advance of upcoming activities, praise positive behaviors, provide assistance with reading mail, offer social activities, provide overhead announcements daily of prayer at noon meal, post a calendar in room, and respect wishes when activites were offered.

When interviewed on 2/27/13, at 12:45 a.m., nursing assistant (NA)-B and NA-A indicated they talk with R34 a lot, as she enjoys talking. NA-B and NA-A described how R34 also enjoyed putting lotion on staff's hands and folding towels.

When interviewed again on 2/28/13, at 9:00 a.m. The wellness director (WD)-A stated the facility staff wanted residents to be involved in regular groups but if the residents were not able, attempts were made to do other activities individually that were not scheduled. WD-A was unable to provide any documentation which indicated R29 and R34 had an individual plan revised for 1:1 activities.

Review of the policy titled Care Conferences and Careplan Process last updated 1/20/2010, indicated that "The care conference team is responsible for reviewing each care plan. This includes all needs identified for each resident to ensure interdisciplinary measures possible are included in each plan. The care plan is a joint effort which the Case Manager is responsible for completing." It also indicates "Careplan will be reviewed monthly, quarterly, and PRN."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok w/ AW for K67 4-2-13 RECEIVED APR – 1 2013	

DC: 04.09.2013

EXIT: 02.28.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David E. Carlson	Administrator	3-29-13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

(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
K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility	K 000		

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
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(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
K 000	Continued From page 2 has a capacity of 52 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: During the facility tour between 9:00 AM and 11:30 AM on 02/27/13, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the	K 067	K 067 - A waiver continuation for K067 is being requested for which justification dated 3/28/13 on forms CMS 2786R is attached.	

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

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 067	Continued From page 3 resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum. This was confirmed by the Assistant Director of Environmental Services (TM) An annual waiver has been previously granted.	K 067		

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
	245465	A. BUILDING **02 - 2 BLDG PT/OT WELLNESS CENTER** B. WING _____	**02/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 2008 Wellness Center Addition of Community Memorial Home was found to be 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 18 New Health Care. Community Memorial Home was surveyed as two separate buildings. The 2008 Wellness Center addition is a 2-story building with no basement, and was determined to be of Type II (111) construction. The building is fully fire sprinklered throughout and has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	PB 4-2-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-29-13

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.

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, April 02, 2013 12:59 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Anderson, James A (DPS); 'Dave Carlson'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Community Memorial Home (245466) K67 Annual Waiver Request

This is to inform you that Community Memorial Home is requesting an annual waiver for K67, corridors as a plenum. The exit date was 2-28-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility **2000 CODE**

Community Memorial Home (CMH) at Osakis, MN Inc.

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC(00) Section 9.2 and NFPA 90A, 1999 Edition because the corridors are used as a plenum.	A continuing waiver is being requested for K067 for the following reasons... A. An extreme and unreasonable financial hardship on CMH will result from compliance because: 1. Revised estimates (3-25-2013, attached) show that compliance with NFPA 90A will cost between $434,000 and $558,480. These dollars are not available under current reimbursement rules. 2. The electrical system at CMH would need to be modified at a cost ranging from $36,050 to $41,600. 3. Asbestos abatement, alone, during installation would cost between $57,750 and $78,750. 4. Non-complying systems are allowed to be used under LSC(00), 9.2.1. B. If this waiver is approved, the safety of building occupants will not be compromised because: 1. CMH was built under Type II construction standards. 2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke. 3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13. 4. HVAC ventilation fans automatically shut down upon activation of a fire alarm or upon detection of smoke. 5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors. 6. The property of CMH is smoke and tobacco free with signs posted to that effect. 7. All CMH corridors are equipped with a compliant UL listed smoke detection system. 8. The local fire department is located close by and can respond to an alarm in less than 15 minutes. 9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements. 10. A continuing waiver has been approved annually in the past for Community Memorial. Requested by: David E. Carlson, Administrator David E. Carlson, Administrator 3-28-2013

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	Fire Safety Supervisor	State Fire Marshal	4-2-13

PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 3/25/2013

morton
CONSTRUCTION MANAGERS
"right from the start"
3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

	Low Range 24,000 S.F. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 25,750	$ 1.07	$ 31,200	$ 1.30
INTERIOR FINISHES / DEMO	$ 18,540	$ 0.77	$ 28,080	$ 1.17
MECHANICAL	$ 197,760	$ 8.24	$ 249,600	$ 10.40
FIRE SPRINKLER	$ 5,150	$ 0.21	$ 10,400	$ 0.43
ELECTRICAL	$ 36,050	$ 1.50	$ 41,600	$ 1.73
CONTINGENCY	$ 30,000	$ 1.25	$ 38,000	$ 1.58
SUBTOTAL CONSTRUCTION COSTS	$ 313,250	$ 13.05	$ 398,880	$ 16.62
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 63,000	$ 2.63	$ 80,850	$ 3.37
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 63,000	$ 2.63	$ 80,850	$ 3.37
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
OTHER- ASBESTOS ABATEMENT	$ 57,750		$ 78,750	
SUBTOTAL OWNER ITEMS COSTS	$ -		$ -	
V. TOTAL PROJECT COST	$ ~~370,250~~ 434,000	$ 15.68	$ ~~479,730~~ 558,480	$ 19.99

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4351

March 14, 2013

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5465023

Dear Mr. Carlson:

The above facility was surveyed on February 25, 2013 through February 28, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

PRINTED: 03/14/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, February 25, 26, 27, 26, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David E. Carlson — TITLE: Administrator — (X6) DATE: 4-2-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557,	2 560		

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	00109	A. BUILDING: _____ B. WING _____	02/28/2013

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2 560	Continued From page 2 subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan for 2 of 3 residents (R29 and R34) reviewed in the sample for activity needs. Findings include: R29's care plan was not revised to include individualized need for activities for a resident that was cognitively impaired. R29 had diagnoses of anxiety, Alzheimer disease, unspecified psychosis, depressive disorder, dementia and hallucinations. Review of the quarterly minimum data set (MDS) dated 12/27/12, indicated R29 was severely cognitively impaired and never/rarely made decisions regarding tasks of daily life. During an observation on 2/25/13, at approximately 2:30 p.m. R29 sat in front of a mirror at the nurses station. R29 touched/pulled at her her pant legs, socks and shoes. R29 vocalized words to herself and anyone who passed by. Staff stopped periodically to straighten R29's pants, socks and shoes. At 4:17 p.m. R29 continued to sit in front of the mirror, and continued to pull at her pants, socks and shoes. R29 was given medications at 5:06 p.m. and then brought to dinner at 5:37 p.m. At 6:50 p.m. R29 was placed at the mirror again. A music performer was singing in the dining area at the time. R29 proceeded to move away from the mirror toward the dinning area and at 7:05 p.m. nursing assistant (NA)-C returned R29 to the	2 560		

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2 560	Continued From page 3 mirror from the position in the hall where R29 had moved. At 7:21 p.m. R29 still sat in front of the mirror. R29 was not observed to participate in any activities other than sitting in front of the mirror and touch/pull with her lower pants, socks, and shoes. During interview on 2/26/13, at 2:19 p.m. registered nurse (RN)-B stated R29 spent time in front of the mirror and seemed to enjoy it. RN-B stated R29 did not consistently attend other activities, did not do well with crowds and did better with one to one interaction. Review of care plan last reviewed 1/21/13, activity focus, indicated mail was opened and read to R29 per request or determined need, but did not indicate any specific one to one activities following an assessment of activity interest. The behavior/mood focus indicated one on one attention with simple conversation and hand holding may calm R29 if displayed symptoms of restlessness or agitation but no plan for scheduled one on one time was noted. R34's care plan was not revised to include individualized need for activities for a resident that was cognitively impaired. R34 had diagnoses that included but were not limited to anxiety disorder and unspecified psychosis. On 2/25/13, at 7:00 p.m. R34 was observed sitting in her room in the wheelchair with a photo album in her hands, while a singing activity was occurring in the dining room. There were no observations of staff interacting with R34 to show R34 the pictures or inviting R34 to the music activity.	2 560		

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2 560	Continued From page 4 On 2/25/13, at 7:20 p.m. R34 was observed sitting in the wheelchair in her room, and stated to writer, "Hello pretty baby." The music activity continued and there was no attempt by staff to interact with R34 or an invitation for R34 to go to the music activity. On 2/26/13, at 2:55 p.m. R34 was observed sitting in the recliner in her room talking to herself. The plan of care last reviewed 10/15/12, indicated R34 had limited involvement in supervised/organized recreation related to her cognitive impairment and impaired mobility. Goals included resident would participate in activities of interest daily or as scheduled and R34 would verbalize enjoyment or opinion after participation in the activity. Interventions included but were not limited to allowing R34 ample time to respond, assist with mobility to and from activities, provide encouragement to attend, provide reminders in advance of upcoming activities, praise positive behaviors, provide assistance with reading mail, offer social activities, provide overhead announcements daily of prayer at noon meal, post a calendar in room, and respect wishes when activites were offered. When interviewed on 2/27/13, at 12:45 a.m., nursing assistant (NA)-B and NA-A indicated they talk with R34 a lot, as she enjoys talking. NA-B and NA-A described how R34 also enjoyed putting lotion on staff's hands and folding towels. When interviewed again on 2/28/13, at 9:00 a.m. The wellness director (WD)-A stated the facility staff wanted residents to be involved in regular groups but if the residents were not able, attempts were made to do other activities	2 560		

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2 560	Continued From page 5 individually that were not scheduled. WD-A was unable to provide any documentation which indicated R29 and R34 had an individual plan revised for 1:1 activities. Review of the policy titled Care Conferences and Careplan Process last updated 1/20/2010, indicated that "The care conference team is responsible for reviewing each care plan. This includes all needs identified for each resident to ensure interdisciplinary measures possible are included in each plan. The care plan is a joint effort which the Case Manager is responsible for completing." It also indicates "Careplan will be reviewed monthly, quarterly, and PRN." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed and activities staff regarding the importance of developing individualized plans related to activities for the cognitively impaired. The Director of Nursing could randomly audit resident charts to ensure the plans of care were completed appropriately. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 560		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver:	21400		

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21400	Continued From page 6 - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure all residents' clinical records contained complete documentation of Tuberculin skin test (a skin test used to check for tuberculosis infection) for 5 of 8 residents (R5, R62,R49, R77 and R18) reviewed for infection control.	21400		

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21400	Continued From page 7 R5's first Tuberculin skin test (TST) given on 1/11/12, and second step TST injection given 1/25/12, were both documented as negative in the immunization audit report received 2/28/13, however no documentation noted millimeter (mm) measurement of induration was found in the chart. R62's second step TST injection given 7/29/12, had been read as negative in the immunization audit report. No documentation noted mm measurement of induration was found in the chart. R49's first step TST injection given 11/20/12, had been read as negative in the immunization audit report. No documentation noted mm measurement of induration was found in the chart. R77's first step TST injection given 2/21/13, had been read as negative in the immunization audit report. No documentation noted mm measurement of induration was found in the chart. R18's second step TST injection given 12/28/11, had been read as negative in the immunization audit report. No documentation noted mm measurement of induration was found in the chart. During interview on 2/28/13, at 9:44 a.m. Registered Nurse (RN)-A verified she was the infection control nurse and in charge of the tuberculosis screening program. RN-A reviewed R5's chart and acknowledged TST results had been documented as negative. RN-A stated she was unaware of the need to document TST results with a measurement of mm. RN-A stated	21400		

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21400	Continued From page 8 there were no other areas of documentation in the chart to find written measurements for the TST results. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the facility system and also revise their policy to ensure millimeters of induration is documented as directed by the CDC guidelines. TIME PERIOD: Fourteen (14) days	21400		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide individualized activities or interventions for those residents who were cognitively impaired for 2 of 3 residents (R29 and R34) reviewed in the sample for activity needs. Findings include:	21435		

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21435	Continued From page 9 R29 was not observed to participate in activities that were individualized to meet the needs of a resident who was cognitively impaired. R29 had diagnosis of anxiety, Alzheimer disease, unspecified psychosis, depressive disorder, dementia and hallucinations. R29 needed assistance from staff to participate in activities. The quarterly MDS dated 12/27/12, indicated R29 was severely cognitively impaired and never/rarely made decisions regarding tasks of daily life. The MDS identified inattention and disorganized thinking were continuously present and did not fluctuate. Further, the MDS indicated R29 was totally dependent with locomotion on and off the unit, and required one person physical assist. The annual MDS dated 7/12/12, indicated R29 should not be interviewed for daily and activity preferences as resident was rarely/never understood. The staff portion of the MDS for daily and activity preferences was completed by staff an indicated R29 had an interest in listening to music, family, snacking, staying up past 8:00 p.m. and receiving tub baths. During observation on 2/25/13, at approximately 2:30 p.m. R29 sat in front of a mirror at the nurses station. R29 touched/pulled at her her pant legs, socks and shoes. R29 vocalized words to herself and anyone who passed by. Staff stopped periodically to straighten R29's pants, socks and shoes. At 4:17 p.m. R29 continued to sit in front of the mirror, and continued to pull at her pants, socks and shoes. R29 was given medications at 5:06 p.m. and then brought to dinner at 5:37 p.m. At 6:50 p.m. R29 was placed at the mirror again. A music performer was singing in the dining area at the time. R29	21435		

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21435	Continued From page 10	21435		

proceeded to move away from the mirror toward the dinning area and at 7:05 p.m. nursing assistant (NA)-C returned R29 to the mirror from the position in the hall where R29 had moved. At 7:21 p.m. R29 still sat in front of the mirror. R29 was not observed to participate in any activities other than sitting in front of the mirror and touch/pull with her lower pants, socks, and shoes.

During an interview on 2/26/13, at 2:19 p.m., registered nurse (RN)-B stated R29 spent time in front of the mirror and seemed to enjoy it. RN-B stated R29 did not consistently attend other activities, did not do well with crowds and did better with 1:1 interaction.

The care area assessment (CAA) worksheet dated 7/24/12, indicated staff would continue to take R29 to activities such as live music or other activities that she could listen to or watch. The CAA stated other then taking R29 to these activities and providing her with snacks, staff would make sure R29 was able to wander safely and do what she wanted during the day. Time for 1:1 activities was not noted on the activity CAA dated 7/24/12.

Review of the care plan last reviewed 1/21/13, the activity focus, indicated mail was opened and read to R29 per request or determined need, but did not indicate any specific 1:1 activities following the assessment of activity interest. The behavior/mood focus indicated 1:1 attention with simple conversation and hand holding may calm R29 if displayed symptoms of restlessness or agitation but no plan for scheduled 1:1 time was noted.

During interview on 2/28/13, at 8:30 a.m. The wellness director (WD)-A stated interests were

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21435	Continued From page 11 assessed on the MDS and placed in the care plan. WD-A stated staff would try to cue and assist residents to scheduled activities. WD-A stated residents may be re-asked about there interest in participating in an activity because their feelings on participating may change day to day. During a second interview 2/28/13, at 9:00 a.m. WD-A verified no individualized assessment for activities had been completed for R29. R34 was not observed to participate in activities that were individualized to meet the needs of a resident who was cognitively impaired. On 2/25/13, at 7:00 p.m. R34 was observed sitting in her room in the wheelchair with a photo album in her hands, while a singing activity was occurring in the dining room. There were no observations of staff interacting with R34 to show R34 the pictures or inviting R34 to the music activity. On 2/25/13, at 7:20 p.m. R34 was observed sitting in the wheelchair in her room, and stated to writer, "Hello pretty baby." The music activity continued and there was no attempt by staff to interact with R34 or an invitation for R34 to go to the music activity. On 2/26/13, at 2:55 p.m. R34 was observed sitting in the recliner in her room talking to herself. On 2/27/13, at 9:20 a.m. R34 was alone, sitting by the nursing station, in a wheelchair (w/c), and became loud/verbal. R34 was approached by clinical manager (CM)-A, who attempted to redirect. R34 agreed to go with CM-A for a "walk." CM-A took R34 for a "walk" and pushed her in the w/c back to R34's room. After R34 was	21435		

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21435	Continued From page 12 relocated to her room there was no further loud verbalizations overheard in the hall. The quarterly minimum data set (MDS) dated 12/13/12, indicated R34 had difficulty focusing, disorganized thinking, and verbal/physical behavioral symptoms. No notations were made in the section labeled Preferences for Customary Routine and Activities. The activity schedule for 1/13, indicated R34 attended 23 activities to include: spiritual (six times), crafts/hobbies (once), group D (three times), music (twice), physical activity (once), food related (four times), general/special (five times), and media (once). The activity schedule for 2/13, indicated R34 attended eight activities to include: spiritual (two times), music (once), food related (three times), and general/special (twice). When interviewed on 2/27/13. at 12:45 a.m. nursing assistant (NA)-B and NA-A indicated they talked with R34 often. Both nursing assistants indicated R34 enjoyed talking with others. NA-B and NA-A described how R34 also enjoyed putting lotion on staff's hands and folding towels. When interviewed on 2/28/13, at 8:30 a.m. The wellness director (WD)-A indicated on admission, specific questions would be asked of residents regarding interests which were communicated on the care plan. WD-A further described staff attempted to get residents up and transferred to an activity approximately one half an hour prior to the activity. WD-A revealed for residents with cognitive difficulties the staff had tried, "Tactile things," but it was, "Hit or miss" and staff would attempt to talk with residents, but behaviors could be disruptive. WD-A listed other interventions which included going for walks, conversation	21435		

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21435	Continued From page 13 back and forth, coffee and cookies, and a "Rollie bollie" game (where the resident rolled a ball and try to knock down pins). WD-A indicated 1:1 (one to one) interactions were included on the care plans if needed. WD-A did not indicate if R34 would benefit from 1:1 interactions. When interviewed again on 2/28/13, at 9:00 a.m. WD-A stated the facility staff wanted residents to be involved in regular groups but if the residents were not able, attempts were made to do other activities individually that were not scheduled. WD-A was unable to provide any documentation which indicated R34 was individually assessed or had an individual plan developed for activities. SUGGESTED METHOD FOR CORRECTION: The Activity Director could review all of the resident assessment to ensure they are individualized and up to date to meet the needs of each resident. The Director of Nursing and/or designee could monitor to assure activities are provided to meet the individual needs of the residents. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21435		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in	21825		

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21825	Continued From page 14 terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to ensure that 3 of 10 residents (R20, R51, R34) who were taking psychotropic medications were fully informed about the risks and benefits of treatment, and expected outcomes of the treatment and failed to have a system in place to discuss with residents and family the risk vs benefits of psychotropic medications Findings include:	21825		

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	00109	A. BUILDING: _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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21825	Continued From page 15 R20 received psychotropic medications without evidence that risks and benefits were reviewed with R20 or R20's family. R20 received Klonopin (a medication that can be used for anxiety) 0.25 milligrams (mg) every morning and 0.5 mg at bedtime. R20 had an additional physician order that authorized staff to administer additional doses of Klonopin 0.25 mg as needed for anxiety. R20 also received Seroquel (a medication generally used to treat psychosis) 12.5 mg twice a day, which was started on 10/21/12. R20 had diagnoses that included dementia with behavioral disturbance, unspecified psychosis, depressive disorder and anxiety state. An admission minimum data set (MDS) completed on 10/28/12, indicated R20 was severely cognitively impaired and would be unable to make decisions for herself. The MDS further indicated R20 had symptoms of delusions, and specifically was inattentive with disorganized thinking at times. R20 also had behavioral issues and had episodes of being physically/verbally aggressive and at times was resistive with staff performing her personal cares. The admission care area assessment (CAA) completed on 10/28/12, noted "psych medications" were used due to long history of "combative behaviors with resisting cares, spitting;/striking out at those near by." The CAA also indicated R20's dementia had progressed and the ability to comprehend what was being explained or said to was limited. The staff had documented R20 may be striking out related to fear due to not comprehending.	21825		

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21825	Continued From page 16 An interview with registered nurse (RN)-A was completed on 2/27/13, at 12:47 p.m. RN-A reported she was unsure as to who or how informed consent was obtained in regards to the use of psychotropic medication. RN-A reported she thought after the medications were ordered, the nurse, who would work, with the physician would have contacted the family or it would have been discussed in care conferences. RN-A also reported she thought the facility's social worker (SW) or RN care manager addressed the issue but was unsure. A request was made of RN-A to provide documented evidence the family of R20 were aware of the use of psychotropic medication and that risk/benefits were discussed. RN-A was unable to provide any documentation. An interview with the social worker (SW) was completed on 2/28/13, at 8:15 a.m. SW reported she was unsure who met with the resident/family and discussed the use of psychotropic medication, to include the risks versus benefits but assumed nursing staff addressed it. SW indicated although medications were discussed in care conferences, she was unsure if the risk versus benefits of psychotropic medications were reviewed with the resident or family. An interview with the director of nurses (DON) was completed on 2/27/13, at 2:15 p.m. DON reported she expected the informed consent would be completed for psychotropic medications but was unable to describe how it was done. DON reported in the past, they had a very formal process, which changed when the facility changed it's psychiatric provider. R51 received psychotropic medications without evidence that risks versus benefits had been reviewed with R51 or R51's family.	21825		

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21825	Continued From page 17 R51 received Seroquel (a medication generally used to treat psychosis) 37.5 mg daily at bedtime prescribed by the physician with the indication of dementia with behavioral disturbance. Per review of the medical record, it was unclear when the medication was started. R51 was admitted on 3/28/12, with diagnoses that included but were not limited to delusional disorder and dementia with behavioral disturbances. The quarterly minimum data set (MDS) dated 12/13/12, indicated R51 had disorganized thinking, and was severely cognitively impaired with both physical and verbal behavioral symptoms. The Admission Care Area Assessment (CAA) completed 4/9/12, indicated R51 had dementia with short and long term memory deficits. The CAA also indicated R51 had periods of verbal and physical behaviors and refused staff assistance or intervention. Further, the CAA identified, "She does have behavioral episodes with verbal/physical aggression. She is on Seroquel with no obvious adverse effect. Lenth [sic] of use is unclear from record. MD [medical doctor] prn [as needed]. Proceed. " When interviewed on 2/28/13, at 8:10 a.m. RN-A indicated they generally did not get consent when residents transfer in to the on medications. RN-A stated she would call the family with any increase, and the medications were reviewed in care conferences quarterly, but she was not involved in the care conferences and could not state to what extent they were discussed. RN-A was unable to provide any documentation which	21825		

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21825	Continued From page 18 indicated the information was discussed with R51's family. A care conference progress note dated 12/19/12, under medication review stated, "MD [medical doctor] decreased Seroquel dose on recent visit. This has been tolerated without change in mood/behaviors. Bowels regular. Comfortable with scheduled Tylenol." No indication noted regarding the risk versus benefits of the utilization of Seroquel was noted. R34 received psychotropic medications without evidence that risks versus benefits had been reviewed with R34 or R34's family. R34 had diagnoses which included but were not limited to unspecified psychosis, anxiety, and dementia with behavioral disturbances. R34 received risperidone (a medication generally used to treat psychosis) 0.125 mg every night at bedtime. The quarterly MDS dated 12/13/13, indicated R34 was severely cognitively impaired, had difficulty focusing attention, disorganized thinking, and physical/verbal behavioral symptoms. The CAA dated 6/19/12, indicated R34 "has dx of dementia. She is medicated to manage behavioral symptoms." The CAA also indicated, "Will hit at staff and holler during at them during cares" as well as, "is on antipsychotic. She is admitted with hx of use. She has had stays in behavioral units in the past for behavior/medication management. " A care conference progress note dated 12/19/12, did not indicate the risk versus benefits of the use	21825		

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21825	Continued From page 19 of risperidone had been discussed. An interview with the DON was completed on 2/28/13 at 9:15 a.m. and the above findings were verified. An undated policy identified as, "Anti-psychotic Medications" directed staff to obtain a consent for residents admitted on anti-psychotic medications as soon as possible (within 72 hours maximum) for the use of these medications and for resident started on anti-psychotic medications, after their admission, informed consent was to be obtained prior to the starting of these medication. If staff were unable to obtain written consent, they were instructed to obtain telephone consent and to obtain written consent as soon as possible. It also directed the staff to annually review the informed consent with the resident/family. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to assure that and family members and residents are fully informed about the risks and benefits of treatment, and expected outcomes of the treatments. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21825		