CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 731X

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLETED BY TI	HE STAT	TE SURVEY AGENCY	Facility ID: 00681
MEDICARE/MEDICAID PROVIDER NO. (L1) 245440 2.STATE VENDOR OR MEDICAID NO. (L2) 765240200	3. NAME AND ADDRESS OF FACIL (L3) JANESVILLE NURSING HO (L4) 102 EAST NORTH STREET (L5) JANESVILLE, MN	OME	(L6) 56048	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGOR 01 Hospital 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 04/29/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 40 (L18) 13.Total Certified Beds 40 (L17)	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:	m	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A* 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director
18 SNF 18/19 SNF 19 SNF 40 (L37) (L38) (L39)	ICF IID (L42) (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB	LE SHOW LTC CANCELLATION DATE):):		
17. SURVEYOR SIGNATURE Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Holly Kranz, Unit Supervisor	05/15/2018	(L19)	Michaelyn Bruer, Enfo	orcement Specialist 05/15/2018 (L20)
PART II - TO B	E COMPLETED BY HCFA RE	EGIONAL	OFFICE OR SINGLE ST	ATE AGENCY
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH C RIGHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) ::
22. ORIGINAL DATE 23. LTC AGREED	MENT 24. LTC AGREEMI	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING 02/01/1987	G DATE ENDING DATE	Е	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimburseme	** - *** · ****************************
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	(L45)			
28. TERMINATION DATE:	9. INTERMEDIARY/CARRIER NO.		30. REMARKS	
	03001			
31. RO RECEIPT OF CMS-1539 3	2. DETERMINATION OF APPROVAL DA	(L31)		
	2. DETERMINATION OF ALL ROYAL DR	-		07117
(L32)		(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245440

May 15, 2018

Mr. R. Peter Madel III, Administrator Janesville Nursing Home 102 East North Street Janesville, MN 56048

Dear Mr. Madel III:

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 27, 2018 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mother

Health Regulation Division

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 15, 2018

Mr. R. Peter Madel III, Administrator Janesville Nursing Home 102 East North Street Janesville, MN 56048

RE: Project Number S5440028

Dear Mr. Madel III:

On April 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 29, 2018, 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 March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 27, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective April 27, 2018 and therefore remedies outlined in our letter to you dated April 6, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mostalyson

Health Regulation Division Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEI	OICARE/MEDICAID CERTIFICATI	ON AND TRANSMITTAL	ID: 731X
PAR	I - TO BE COMPLETED BY THE	STATE SURVEY AGENCY	Facility ID: 00681
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245440 2.STATE VENDOR OR MEDICAID NO. (L2) 765240200	3. NAME AND ADDRESS OF FACILITY (L3) JANESVILLE NURSING HOMI (L4) 102 EAST NORTH STREET (L5) JANESVILLE, MN	E (L6) 56048	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 03/22/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 P 03 SNF/NF/Distinct 07 X-Ray 11 I	02 (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 40 (L18) 13. Total Certified Beds 40 (L17)	A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNR 5. Life Safety Code * Code: B *	he Following Requirements:
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 40 (L37) (L38) (L39)	F ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE Wendy Dobie, HFE NE-II	Date : 04/20/2018 (1 BE COMPLETED BY HCFA REGIO	Douglas S. Larson, Enfo	orcement Specialist 04/26/2018
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21	20. COMPLIANCE WITH CIVII RIGHTS ACT:	21. 1. Statement of Final	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGRE OF PARTICIPATION BEGINNII 02/01/1987		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety

02-Dissatisfaction W/ Reimbursement

DETERMINATION APPROVAL

03-Risk of Involuntary Termination

04-Other Reason for Withdrawal

30. REMARKS

(L31)

28. TERMINATION DATE:

(L27)

(L24)

25. LTC EXTENSION DATE:

29. INTERMEDIARY/CARRIER NO.

(L25)

(L44)

(L45)

03001

31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions:

B. Rescind Suspension Date:

(L41)

(L28)

(L32) (L33)

FORM CMS-1539 (7-84) (Destroy Prior Editions)

06-Fail to Meet Agreement

07-Provider Status Change

00-Active



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 6, 2018

Mr. R. Peter Madel III, Administrator Janesville Nursing Home 102 East North Street Janesville, MN 56048

RE: Project Number S5440028

Dear Mr. Madel III,

On March 22, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us

Phone: (507) 344-2742 Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 1, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 22, 2018 (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

Janesville Nursing Home April 6, 2018 Page 5

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 September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Janesville Nursing Home April 6, 2018 Page 6

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mostaly Gon

Health Regulation Division

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

PRINTED: 04/17/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245440	B. WING _		03/	/22/2018
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
F 000	Emergency Prepare conducted on Marc during a recertificat compliance with the Preparedness Requ INITIAL COMMENT		F 00	0		
	standard survey wa the Minnesota Depa if your facility was ir requirements of 42	is completed at your facility by artment of Health to determine				
	allegation of compli enrolled in the elect (ePOC), a signatur	on will serve as your facility's ance. Since your facility is tronic Plan of Correction is not required at the bottom the CMS-2567 form.				
F 580	revisit of your facilit validate that substa regulations has bee your verification.	acceptable ePOC an on-site y may be conducted to intial compliance with the en attained in accordance with Injury/Decline/Room, etc.)	F 58	0		4/27/18
	CFR(s): 483.10(g)(§483.10(g)(14) Noti (i) A facility must im consult with the res consistent with his or representative(s) w (A) An accident invo	14)(i)-(iv)(15) ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which I has the potential for requiring	1 30			7/2//10
ABORATOR)	V DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE	TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed 04/16/2018

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245440	B. WING	B. WING		03/:	22/2018
	PROVIDER OR SUPPLIER	<u> </u>		1	TREET ADDRESS, CITY, STATE, ZIP CODE 02 EAST NORTH STREET ANESVILLE, MN 56048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 580	mental, or psychos deterioration in hea status in either life-clinical complication (C) A need to alter a need to discontinitreatment due to accommence a new f (D) A decision to traresident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this section all pertinent informatical pertine	ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or ans); treatment significantly (that is, we an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) and, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. St record and periodically and (mailing and email) and	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245440	B. WING		03/2	22/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE
F 580	by: Based on observat review, the facility fa timely manner of 1 resident (R10) reviewed skin conditions. Findings include: R10's Admission Resident R10 was obesity, unspecified disease. R10's 30-day Minimassessment, dated cognitively intact. R10's care plan, darequired assist of ostanding lift machin weight during transbruising, dated 12/2 prone to bruise east thinner) use. R10's physician ordincluded an order of Rivaroxaban (blood tablet by mouth one During an observed hand near her finger	ntion, interview, and document ailed to notify the physician in an increase in bruising for 1 of viewed for non-pressure ons. ecord, printed on 3/22/18, had diagnoses including dibrain injury and heart num Data Set (MDS) 1/11/18, indicated R10 was ated 3/13/18, indicated R10 ne for transfers with use of a lie, and assist of 2 if bearing fers. A problem area of 27/17, indicated R10 was silly due to anticoagulant (blood ders printed on 3/22/18, lated 12/14/17, for It thinner) 20 mg (milligram)	F 580	We strive to ensure that each res our care receives the best care po To ensure that we are meeting this this area, we have taken the follow steps. We reviewed and revised of policy and procedure related to Cha Resident S Condition or Status 3/28/2018. We re-educated the nistaff to our Change in a Resident Condition Policy and Procedure or in a small group meeting on 4/12/2 Our nursing charting software has modified to provide Resident Stat Change and Incident reports. The reports will be delivered directly to Director of Nursing. The Director of Nursing conduct a ensure that compliance in this area being met. The results f these audits will be reto the QAPI committee at is quarter meeting.	ssible. s goal in ving our lange in on larsing s Status 2018. been lus se	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245440	B. WING _		03	/22/2018
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	her shirt sleeve. During an observathe bruising on R1 viewed. The bruis R10's upper arm in R10 stated she so bruised area. R10's Nurses' Not through 3/20/18 ar 3/2/18, at 2:54 a.m left upper inner arm (cm). Note indicate happened and was discomfort. Action "Continue to obser On 3/3/18, no time read, "Continues with the are slowly reserved." [Late Entry indicate On 3/5/18, document	tion on 3/21/18 at 7:24 a.m., 0's hand and arm was fully ing was noted to extend up note the armpit. At that time, metimes had pain in the es were reviewed from 3/2/18, and revealed the following: a. noted a bruise on resident's m, measuring 4 x 9 centimeters and R10 did not know what is not experiencing any indicated in note was, eve".	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245440	B. WING _		03	/22/2018
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP C 102 EAST NORTH STREET JANESVILLE, MN 56048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	assistance when so observeVerbal cues to resident to push up when stand should assist stand muscles and not reque." On 3/6/18, at 12:58 physician visit note indicate the physiciate bruise. Further review of R 3/7/18 - R10 had a transfers.	candingcontinue to education to staff to provide provide assistance with legs to ding. Educated resident she ling by pushing with leg elying on EZ stand to pull her 8 p.m., R10 was seen by her however, the note did not an was notified or examined 110's progress notes indicated: In inability to bear weight during	F 58	0		
	indicated, "Resider upper arm. Bruise using the EZ stand stand applying pres Resident was taugl 50% [bear at least being transferred wunderstood and hawhen being lifted ualso has fading brucm x 2 cm, and a cm" 3/11/18, at 11:04 precorded indicating purple, had grown 17 cm x 12 cm. On 3/14/18, at 10:3	a.m. a skin assessment for R10 at has dark purple bruise on left has become bigger due to and having the strap of the EZ soure to resident's arm. In the by nursing to 'use her legs at 50% of her own weight] when with the EZ stand'. Resident is been using her legs more producing transfers. Resident isses on right arm measuring 3 couple that are 1 cm x .07				

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F 580	faxed to R10's phy (Occupational The transfers after DON	age 5 sician requesting OT rapy) to assist with safe N consulted with therapy ing leg strengthening.	F 58	30		
	On 3/18/18, at 3:32 indicated R10 had protection of body clutching and holdi "protecting arm" du PRN Acetaminophe	2 a.m. a progress note vocal complaints of pain, movements, posturing, ng a body part. R10 was see to pain at times. Request for en 500 mg tablets (2 iven for pain. Med was noted				
	severe bruising. R to hand. R10 repor 24 hours and, "I us arm during transfel	5 a.m. R10 continued to have 10 had 2-3+ edema (swelling) ted pain more frequent in last e my other hand to help this rs because it hurts." R10 was ency Room) for further sed.				
	arm that originated her forearm to her described as dark out of 10 (10 being Note indicates Phy	p.m. R10's "bruising in left in shoulder has traveled from wrist since yesterday." Wrist is purple, pain is reported as 8 the highest level of pain). sician was updated on status uring rounds on Tuesday				
	on 3/20/18, at 3:03 interventions were notification of the bindicated the EZ st reasoning for the ir continue to monitor	with Registered Nurse (RN) p.m., when asked what put in in place following ruise on 3/2/18, it was and was identified as the njury, measures were to r bruise. RN additionally stated se the EZ stand and had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		E SURVEY MPLETED	
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	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	When ask if the physicident on 3/2/18 a grown larger on 3/1 locate notes or dictabeing informed until During an interview when asked how the with injuries, the DO reported to the chainputs incident into assessment is computed to the chainputs incident. What is report change of evaluations on appliassisted devices be "I would have expected assisted devices be "I would have expected assisted devices be all the right equality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Quality of care is a applies to all treatmost facility residents. Basessment of a rethat residents received accordance with propractice, the comprised plan, and the residents and	start OT for safe transfers. A spician was notified for the and when the bruising had 1/18, RN was unable to ation related to the physician I 3/18/18. If on 03/21/18, at 9:44 a.m. the facility processes incidents and stated incidents were rege nurse, the charge nurse software system, a resident pleted, nature of injury is fan in contacted as well as assured (if appropriate) and an place. DON indicated he and the physician be contacted as the physician be contacted and an an an and the propriateness of equipment and being used the DON indicated, and the charge nurse to the transfer machine and the transfer machine and the uipment to use." The care fundamental principle that the set on the comprehensive sident, the facility must ensure the treatment and care in ofessional standards of the ensive person-centered.	F 684			4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP CO	•	
				102 EAST NORTH STREET		
JANESV	ILLE NURSING HON	ΛE		JANESVILLE, MN 56048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Continued From p	page 7	F 6	84		
	review the facility comprehensive as	ation, interview, and document failed to complete a ssessment to determine the sident (R25) reviewed for n of medications.		It is the goal of the Janesville Home to allow each of its res make their own decisions as care is delivered. To make su happens we have taken the f steps.	idents to to how their ire that this	
	R25's current diagobstructive pulmo R25's Minimum D revealed a Brief Ir	gnosis list included chronic nary disease. rata Set (MDS), dated 2/28/18, nterview for Mental Status score noderate cognitive impairment).		We have reviewed and revise and procedure related to Self Administation of Medications Treatments. We have met v 25 to ascertain what their per are regarding self administrations. It was determined Resident 25 wishes to continuous.	and with Resident sonal wishes tion of ed that	
	2/23/28, included Levalbuterol Tartra inhaler. The dose inhalation every 4	rsician order sheet, dated an order for Xopenex HFA ate 45 microgram (mcg) Aerosol e ordered was (2 puffs) per hours as needed for dyspnea ath). The order indicated:		administration of their inhaler and to keep the inhale We reviewed this resident's cassessment and we conducted medication assessment with	er at bedside. cognitive ed a self	
	self-administer. Review of R25's not have a compre	nedical record revealed he did ehensive assessment to ident's cognitive ability to self		To better allow Resident to conself administer medications, where made the following change. The following treatments were electronic treatment record of 1) Check labels on inhaler one	we have e placed in on 3/20/2018:	
	administration rec that there R25 did administration or f R25 was utilizing f During an observa p.m., R25 was sitt	ation of R25 on 3/19/18 at 6:45 ting in the recliner, watching enex inhaler was sitting on top of		ensure medication has not explasts for one year. 2) Sanitize inhaler once week package insert directions. 3) Nurse to check self admin record kept with inhaler at be monthly. 4) Lock box placed with inhale to ensure safe storage of me Notepad placed with at bedsi	cpired as it cly per distration dside once er at bedside dication.	

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F 684	During an observation inhaler is sitting on the inhaler is sitting. The resident was not buring an interview stated, "When I get stated that he did not recall how inhaler today or yes." During an interview (LPN-A) on 3/20/18 she was aware that causes security for communicate to he the inhaler to himse not use the inhaler. During a interview (DON) on 3/20/18, confirmed that ther R25's ability to self. During interview or DON stated that he confirmed that he	tion on 3/19/18 at 7:30 p.m. the the window ledge of the room. Tion on 3/20/18 at 1:45 p.m, g on top of the bedside table. Tot in the room. You on 3/19/18, at 7:30 p.m., R25, at short of air, I just use it." R25 tot let the nurse know when he how often. Furthermore, he w many times he used the sterday. With licensed practical nurse at 9:49 a.m., LPN-A stated at R25 used the inhaler, "It him." LPN-A stated he did not be every time he administered alf, and revealed that R25 did every day. With the director of nursing at 9:54 a.m., the DON the was not a assessment of administer medication. In 3/20/18, at 11:53 a.m., the shad met with R25, who used the inhaler one to two document entitled, medications and treatments,	F 684	administration recording by Re 5) Resident 25 is seen monthl rounding provider to review eff treatment. The Director of Nursing will concheck audits to ensure complication. The results of these audits will presented to the QAPI commit quarterly meeting.	y by ficacy of induct spot ance.	

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		245440	B. WING		03/	/22/2018	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048			
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F 684	Continued From pa	ge 9	F 684	4			
	resident or in a lock room. The nurse manage resident competent week, considering to information from the capacity to remembe to make a decision to use relevant information. A decision to permit the seven-day interconference. Medications and trepharmacy and place resident's locked discontainers. Noncompliant resident can be update resident can be update resident can be update resident can be update. Seven-day interconference. Medications and trepharmacy and place resident's locked discontainers. Noncompliant resident can be update resident can be update resident can be update. Seven-day interconference. Medications and trepharmacy and place resident's locked discontainers. Noncompliant resident can be update resident can be update. Seven-day interconference. Seven-day interconference. Medications and trepharmacy and place resident's locked discontainers. Noncompliant resident can be update. Seven-day interconference. Seven-day interconference. Medications and trepharmacy and place resident's locked discontainers. Noncompliant resident can be update. Seven-day interconference. Seven-day	t self-administration is made in disciplinary care plan eatments are delivered by the ed with the resident or in the rawer in specially labeled lents are informed by the they may not self- administer tments. The plan. The plan. The plan. The plan is ew, Report Irregular, Act On 1)(2)(4)(5) regimen Review. The plan is each resident at least once a month by a set.	F 750			4/27/18	

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F 756	(i) Irregularities induring that meets the (d) of this section of (ii) Any irregularities during this review is separate, written reattending physicial director and director and director and the irregularity (iii) The attending president's medical irregularity has been action has been to be no change in the physician should director and the resident's medical irregularity has been action has been to the resident's medical irregularity has been action has been to the physician should director the resident's medical irregularity has been to change in the physician should director the resident's medical irregularity in the process and story	clude, but are not limited to, any e criteria set forth in paragraph for an unnecessary drug. It is noted by the pharmacist must be documented on a seport that is sent to the in and the facility's medical for of nursing and lists, at a dent's name, the relevant drug, or the pharmacist identified. Only ician must document in the record that the identified en reviewed and what, if any, ken to address it. If there is to e medication, the attending ocument his or her rationale in	F 75	Due to a sale in our original provider, we had three differe providers in four months. Du period, a couple of things were completed in their entirety. To best possible patient care, we the following steps. 1)DISCUS assessments were on all Residents with current orders for administration of predications.	ent pharmacy ring that re not o deliver the e have taken e completed physician		

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NAME OF	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP C			
JANESV	ILLE NURSING HOM	ΛE		102 EAST NORTH STREET JANESVILLE, MN 56048			
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F 756	psychotic disorder and trouble sleepi indicators exhibited R3's physician's coorders for Seroque milligrams twice distart date of the consultant plant	r. The MDS identified delusions ing as mood and behavior and during the look back period. Inders, dated 3/21/18 included el (an antipsychotic) 12.5 laily for psychosis. The original order was 2/24/17. Redical record revealed no TD been completed since 3/17. Redical record revealed no TD been completed		2)Reviewed and revised policy procedure related to Psychol Initiation. 3) Reviewed policy and defin pharmacy consultant on 3/2 of care placed in pharmacy software to document and a DISCUS assessment is due given to Director of Nursing monthly consultation visit. 4) Facility software setup to and provide documentation when next DISCUS is due for Resident having orders for a of psychotropic medications. The Director of Nursing will to ensure compliance. The results of these audits of the presented to the QAPI compared to the Q	ciency with 22/2018. Plan consultant alert when next e. Report is after each place alerts for completion for each administration s. conduct audits will be		

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F 756	delirium. Review of R20's many monitoring for dyskinesia had be began taking the a During interview or egistered nurse (responsible to conresidents on antipubeen several char (CP) within the last alerted her if some completed, and vescreening. RN-Ascompleted every segin adding this to During interview of stated TD monitors ix months for reshowever, she "had assessments yet, diagnoses were an appropriate indication was a new CP at the R23's quarterly Mit 2/16/18, identified and dementia. The behavioral issues back period. R23's psychiatrist orders for Seroque milligrams three times and behaviored in the property of the results	nedical record did not reveal symptoms of tardive en completed for R3 since she antipsychotic medication. n 3/21/18, at 2:11 p.m. RN)-A stated she was inplete TD monitoring for sychotics, however, there had inges of consultant pharmacist at year, and the CP usually eone needed TD screenings erified R20's record lacked TD stated TD screening should be six months, and she would to her calendar to track. n 3/22/18, at 2:05 p.m. the CP ing should be completed every idents on an antipsychotic, dn't gotten around to looking at I was trying to make sure the occurate and there were tions for use," and stated she	F7	756		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 102 EAST NORTH STREET JANESVILLE, MN 56048		
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F 756	Continued From pa	ge 13	F 75	6		
		edical record revealed no (TD) screenings had been 13/17.				
	not reveal the miss	narmacy consultant notes did ing TD screenings were egularity reports to the facility.				
	active diagnoses of dementia. The MDS asleep, feeling tired and moving or spea	OS, dated 1/26/18, identified finsomnia, depression and Sidentified trouble falling d, poor appetite or over eating aking so slowly that people being exhibited during the				
	orders for Seroque milligrams in the m for psychosis. The Seroquel was 6/28/	ders, dated 3/6/18 included I (an antipsychotic) 12.5 orning and 25 mg at bedtime original start date for the In 17 with a gradual dose lered on 3/6/18 at the dose				
		edical record revealed no TD en completed since 6/28/17.				
	not reveal the miss	narmacy consultant notes did ing TD screenings were egularity reports to the facility.				
F 758	undated, directed to screening for TD ar	hotropic Initiation Checklist, o complete a baseline nd every 6 months thereafter. sychotropic Meds/PRN Use	F 75	8		4/27/18

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	affects brain activiti processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic Based on a compreresident, the facility \$483.45(e)(1) Resident, the facility specific condition a in the clinical record specific condition a in the clinical record specific contraindicated, in a drugs; §483.45(e)(2) Resident specific contraindicated, in a drugs; §483.45(e)(3) Resident specific contraindicated, in a drugs; §483.45(e)(3) Resident specific contraindicated contraindic	tropic Drugs. Archotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following The dents who have not used are not given these drugs ion is necessary to treat a so diagnosed and documented di; The dents who use psychotropic and dose reductions, and the tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 75	8		

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F 758	appropriate for the beyond 14 days, he rationale in the resindicate the duration §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practition the appropriatenes. This REQUIREMED by: Based on observareview, the facility for tardive dyskinesian residents (R3,R20, unnecessary medicantipsychotic. Findings include: R3's quarterly Minimited active diapsychotic disorder. and trouble sleeping indicators exhibited. R3's physician's or orders for Seroque milligrams twice dastart date of the order. Review of R3's mescreenings had been recommended active of R20's significant characteristics.	PRN order to be extended or she should document their dent's medical record and n for the PRN order. orders for anti-psychotic of 14 days and cannot be exattending physician or oner evaluates the resident for soft that medication. NT is not met as evidenced tion, interview and document failed to complete timely (TD) screenings for 4 of 4 (R23 & R15) reviewed for cations who were receiving an an amount of the MDS identified delusions g as mood and behavior during the look back period. ders, dated 3/21/18 included I (an antipsychotic) 12.5 illy for psychosis. The original	F 7	Due to a sale in our original provider, we had three disproviders in four months. period, a couple of things completed in their entirety best possible patient care the following steps. 1)DISCUS assessments on all Residents with currorders for administration medications. 2)Reviewed and revised procedure related to Psyclinitiation. 3) Reviewed policy and depharmacy consultant on of care placed in pharmacy consultant on of care placed in pharmacy consultant on the care placed in pharmacy consultation visit and provide documentation when next DISCUS is dured to pharmacy consultation visit and provide documentation when next DISCUS is dured to pharmacy consultation visit and provide documentation when next DISCUS is dured to pharmacy consultation visit and provide documentation provide documentation of pharmacy consultation visit and provide documentation provide document	fferent pharmacy During that were not y. To deliver the e, we have taken were completed ent physician of psychotropic policy and chotropic eficiency with 3/22/2018. Plan cy consultant d alert when next due. Report is ng after each to place alerts on for completion e for each or administration	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	<u> </u>		10	TREET ADDRESS, CITY, STATE, ZIP CODE D2 EAST NORTH STREET ANESVILLE, MN 56048		
(X4) ID PREFIX TAG			ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	MDS identified no ras well as current of disease and demer R20's care area as psychoactive medic R3 took antipsychothe halls in her geri her peer's rooms, be had short and long-R20's care plan, dashort-tempered and sensitivity to loud not a consultant pharm report, dated 1/30/s scheduled haloperidaily basis for a diadelirium. Review of R20's many monitoring for a dyskinesia had been began taking the arcongistered nurse (R responsible to com residents on antips	mood or behavior indicators, liagnoses of Alzheimer's hitia. sessment (CAA) for cations, dated 2/9/18 identified tic medications, would wander-chair and occasionally enter but was easily redirectable, and term memory loss. Ited 1/18/18 identified she was dirritable with others, with a oises. Ited 1/18/18 identified she was dirritable with others, with a oises. Ited 1/18/18 identified of the was dirritable with others, with a oises. Ited 1/18/18 identified she was dirritable with others, with a oises. Ited 1/18/18 identified of the was receiving dol (an anti-psychotic) on a gnosis of hospice and terminal edical record did not reveal symptoms of tardive on completed for R3 since she on tipsychotic medication. In 3/21/18, at 2:11 p.m. IN)-A stated she was plete TD monitoring for yechotics, however, there had	F 7	58	The Director of Nursing will conduct to ensure compliance. The results of these audits will be presented to the QAPI committee at quarterly meeting.		
	(CP) within the last alerted her if some completed, and ver screening. RN-As completed every size begin adding this to	ges of consultant pharmacist year, and the CP usually one needed TD screenings ified R20's record lacked TD tated TD screening should be a months, and she would other calendar to track. RN-A D's TD screenings had not ery six months.					

		` IDENTIFICATION NUMBER.		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIF 102 EAST NORTH STREET JANESVILLE, MN 56048		00/22/20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 758	stated TD monitoric six months for resich however, she "hade assessments yet, diagnoses were accappropriate indication was a new CP at the stated the facility were to track completion waiting for the CP's the screenings were R23's quarterly Mir 2/16/18, identified a and dementia. The behavioral issues be back period. R23's psychiatrist corders for Seroque milligrams three time original start date for Review of R23's metardive dyskinesia completed since 8/ R15's quarterly MI active diagnoses or dementia. The MD asleep, feeling tired and moving or special services and moving or special services.	in 3/22/18, at 2:05 p.m. the CP ing should be completed every dents on an antipsychotic, in't gotten around to looking at I was trying to make sure the curate and there were ions for use," and stated she ine facility. The CP further rould normally be responsible to of TD screenings, rather than is recommendation to identify the late. Inimum Data Set (MDS), dated active diagnoses of depression in MDS did not identify mood or being exhibited during the look orders, dated 2/21/18 included I (an antipsychotic) 50 ines daily for psychosis. The or the order was 7/7/16.	F 758				
		ders, dated 3/6/18 included I (an antipsychotic) 12.5					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245440	B. WING		03	03/22/2018	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE	
F 758	for psychosis. The Seroquel was 6/28/	nge 18 orning and 25 mg at bedtime original start date for the /17 with a gradual dose lered on 3/6/18 at the dose	F 7:	58			
F 791 SS=D	Review of the Psyc undated, directed to screening for TD an	edical record revealed no TD en completed since 6/28/17. hotropic Initiation Checklist, o complete a baseline nd every 6 months thereafter. y Dental Srvcs in NFs	F 79	91		4/27/18	
00-5	§483.55 Dental Ser The facility must as	rvices ssist residents in obtaining r emergency dental care.					
	outside resource, ir of this part, the follot the needs of each i	ervices (to the extent covered n); and					
	assist the resident- (i) In making appoin	ntments; and transportation to and from the					
		promptly, within 3 days, refer or damaged dentures for					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245440	B. WING		03/22/2018	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 791	dental services. If a 3 days, the facility is what they did to en and drink adequate services and the expled to the delay; §483.55(b)(4) Musicircumstances where dentures is the facicharge a resident if dentures determine policy to be the face §483.55(b)(5) Musicipolicy to be the face policy to be the face	areferral does not occur within must provide documentation of sure the resident could still eat ely while awaiting dental stenuating circumstances that that the loss or damage of lity's responsibility and may not or the loss or damage of ed in accordance with facility ility's responsibility; and the loss or damage of ed in accordance with facility ility's responsibility; and the sasist residents who are participate to apply for dental services as an incurred ander the State plan. Note that dental services were resident (R2) reviewed for the services were resident (R2) reviewed for the services but would like the did not recall having been pointment or the oppportunity be her admission to the facility. In the swere currently sore because aften some Dorito chips.	F 791	In this case we received conflicting information from the resident and the family regarding desire for dental services. It is our goal to always meeds and desires of our resident's provide the best possible care, we litaken the following steps. 1) We reviewed and revised our postand procedure related to Routine/Emergency Dental Service 2) We met with Resident 2 on 3/20/2 and assistance was provided to set dental appointment at that time. Re 2 identified wishes to be have a derappointment to address need for dentures. 3) Nurse and Social Services Direct conducting care conferences were	neir eet the . To have licy s. /2018, up a sident htal	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245440	B. WING	·	03/	22/2018	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO 102 EAST NORTH STREET JANESVILLE, MN 56048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 791	R2's care plan date care approach as, wear dentures per R2's Physician's Or regular diet without separation. No record of dental medical chart. Review of care con 9/21/17, 6/22/17 arevidence that denta discussed or review CARE CONFEREN REVIEW CHECKL documentation date indicated "none ner to title "Recent Derno other notes or c form. During interview on MDS Nurse stated had seen a dentist MDS nurse also stasister-in-law on 2/2 vision appointment 3/21/18, at 1:33 p.r. R2 had not seen a had triggered her c sister-in-law on 2/2 she had contacted ask about dental arabout R2 wanting of	ed 3/13/18, identifies R2's oral "I' am endentulous I do not my choice". I'der dated 6/17/15, indicated a need for mech. (mechanical) I services were located in R2's If serv	F 791	educated to policy and proced documentation requirements, for in-depth discussion relater Resident some of som	and need d to es related to es related to enmunication clearer s with gal guardian ds and enduct spot ensure t findings to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245440	B. WING		03/22/2018		
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION		
F 791	Continued From pa	ge 21	F 7	91			
F 880 SS=F	director of nursing (expectation that res		F 8	80	4/27/18		
	infection prevention designed to provide comfortable environ	stablish and maintain an and control program a safe, sanitary and ament and to help prevent the cansmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention in (IPCP) that must include, at owing elements:					
	reporting, investiga and communicable staff, volunteers, vis providing services u arrangement based	d upon the facility assessment ng to §483.70(e) and following					
	procedures for the but are not limited t (i) A system of surv possible communic	eillance designed to identify able diseases or ey can spread to other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245440	B. WING			03/2	22/2018
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME			102	EET ADDRESS, CITY, STATE, ZIP CODE EAST NORTH STREET NESVILLE, MN 56048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	communicable discreported; (iii) Standard and to be followed to pr (iv)When and how resident; including (A) The type and didepending upon the involved, and (B) A requirement to least restrictive posticity provides are contacted with reside contact with reside contact will transmit (vi)The hand hygie by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual of the facility will contact the facility	nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct ints or their food, if direct if the disease; and the procedures to be followed direct resident contact. Setem for recording incidents of facility's IPCP and the taken by the facility. Indle, store, process, and as to prevent the spread of the review. Induct an annual review of its their program, as necessary. In it is not met as evidenced or and document review, the	F		We have written and put in place a		
	completed to deter	ure a risk assessment was mine where waterborne g Legionella, could spread or		-	Legionella Water Management Pro This program was written in cooper with local water management		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245440	B. WING		03/	22/2018	
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET JANESVILLE, MN 56048				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	grow in the facility's practice had the point the facility. Findings include: On 3/22/18, at 8:30 maintenance direct not developed policy waterborne pathog maintenance direct currently collaborate.	s water sources. This deficient of tential to affect all 30 residents of a.m., the facility's for confirmed the facility had sies and procedures for risks of es including Legionella. The for stated the facility was sing with the city water supplier bing a plan but have not yet	F8	professionals. We have create management team consisting people who will work to identify the water system where bacter and spread and to reduce the Legionnaires Disease. In putting this plan together, we analyzed the flow of water thro building and completed the Leg Environment Assessment Form was developed by the Centers Control and Prevention. We are currently monitoring we temperature at several points i building. We monitor water ter daily in our kitchen as well as we the far end of the water runs. Tregularly monitor our water to a Chlorine levels stay within the deemed safe by the City of Jar. The Water Management Team monitor this area to ensure cor compliance. They will review the gathered by the maintenance of and will report their findings to Committee at its quarterly meet.	of five areas in ia can grow isk of have ughout our gionella n which for Disease ater n our nperature weekly at We will ensure that evels iesville. will atinued he data lepartment the QAPI		

Printed: 03/27/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245440

B. WING

03/20/2018

NAME OF PROVIDER OR SUPPLIER

IANESVILLE NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

102 FAST NORTH STREET

A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on March 20, 2018. At the time of this survey, (Janesville Nursing Home) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Facility is a 1 story building with a partial basement. The facility was constructed in 1965 and was determined to be of Type II (111) construction. An addition was added in 1994 and was determined to be type II (111). Both building types will be classified as one. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 29 certified beds. The requirement at 42 CFR, Subpart 483.70 (b), is MET.	(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
IS ME 1.	K 000	A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on March 20, 2018. At the time of this survey, (Janesville Nursing Home) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Facility is a 1 story building with a partial basement. The facility was constructed in 1965 and was determined to be of Type II (111) construction. An addition was added in 1994 and was determined to be type II (111). Both building types will be classified as one. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The requirement at 42 CFR, Subpart 483.70 (b),			
		IS IVIE 1.	8		

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

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 6, 2018

Mr. R. Peter Madel III, Administrator Janesville Nursing Home 102 East North Street Janesville, MN 56048

Re: State Nursing Home Licensing Orders - Project Number S5440028

Dear Mr. Madel III:

The above facility was surveyed on March 19, 2018 through March 22, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Janesville Nursing Home April 6, 2018 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Holly Kranz, Unit Supervisor, at (507) 344-2742 or holly.kranz@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mostulyson

Health Regulation Division Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		SURVEY LETED	
		00681	B. WING		03/2	2/2049
			l		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S ' NORTH STI	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		LE, MN 560			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 04/16/18

STATE FORM 6899 If continuation sheet 1 of 22 731X11

TITLE

(X6) DATE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILDING.			
		00681	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JANESV	ILLE NURSING HOMI		NORTH STI LE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff the following correction that you	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000			
2 265	Resident Health St. A nursing home mupolicies to guide staphysicians, physicians, physicians, practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which appropriate notificators. A. an accident results in injury and physician interventions.	ust develop and implement aff decisions to consult an assistants, and nurse is known, notify the resident's ac or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an a must be involved in the esse policies. The policies must address at least the attion times for: involving the resident which is has the potential for requiring	2 265			4/27/18

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	B. WING		03/22/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	
JANESVILLE NURSING HOME		NORTH STI		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETE
example, a need to disc of treatment due to adv begin a new form of tre D. a decision to tra resident from the nursir E. expected and ur This MN Requirement by: Based on observation, review, the facility failed a timely manner of an in 1 resident (R10) review related skin conditions. Findings include: R10's Admission Recor indicated R10 was had obesity, unspecified bra disease. R10's 30-day Minimum assessment, dated 1/11 cognitively intact. R10's care plan, dated required assist of one for	either life-threatening omplications; treatment significantly, for continue an existing form verse consequences, or to eatment; ansfer or discharge the ng home; or nexpected resident deaths. is not met as evidenced interview, and document d to notify the physician in increase in bruising for 1 of ved for non-pressure ord, printed on 3/22/18, diagnoses including ain injury and heart a Data Set (MDS) 1/18, indicated R10 was 3/13/18, indicated R10 for transfers with use of a and assist of 2 if bearing and 2 if a contract and 2 if a contra	2 265	We strive to ensure that each resion our care receives the best care por To ensure that we are meeting this this are, we have taken the following steps. We reviewed and revised of policy and procedure related to Change and procedure related to Change in a Resident Condition Policy and Procedure or in a small group meeting on 4/12/2 Our nursing charting software has modified to provide Resident Stat Change and Incident reports. The reports will be delivered directly to of Nursing. The Director of Nursing conduct a ensure that compliance in this are being met.	ssible. s goal in ng our lange in on ursing s Status 2018. been us se Director

Minnesota Department of Health

STATE FORM 6899 731X11 If continuation sheet 3 of 22

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00681	B. WING		03/2	2/2018
	PROVIDER OR SUPPLIER	102 FAST	DRESS, CITY,	STATE, ZIP CODE		
JANLOV	ILLE NONSING HOME	JANESVI	LLE, MN 56	048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	thinner) use.			The results f these audits will be to the QAPI committee at is quar		
	included an order d	thinner) 20 mg (milligram)		meeting.		
	R10 was observed hand near her finge wrist, and forearm. purple in color. Du	ion on 3/20/18 at 2:49 p.m., to have a bruise on her left ers, wrapping around her hand, The bruising appeared dark ring the observation, R10 went farther up her arm under				
	the bruising on R10 viewed. The bruisin R10's upper arm in	ion on 3/21/18 at 7:24 a.m., I's hand and arm was fully ng was noted to extend up to the armpit. At that time, netimes had pain in the				
		s were reviewed from 3/2/18, d revealed the following:				
	left upper inner arm (cm). Note indicated happened and was	noted a bruise on resident's i, measuring 4 x 9 centimeters d R10 did not know what not experiencing any indicated in note was, re".				
		recorded, R10's nurses note th bruises on both upper arms lving."				
	On 3/4/18, 10:43 a. fading."	m. R10's reads, "Bruise slowly				
	[Late Entry indicate	d in on 3/12/18, at 1:07 p.m.]				

Minnesota Department of Health

STATE FORM 6899 731X11 If continuation sheet 4 of 22

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY IPLETED
		00681	B. WING		03/	22/2018
	PROVIDER OR SUPPLIER	102 EAS	DRESS, CITY, S NORTH STF LLE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 265	On 3/5/18, docume nursing (DON) indicand investigation of which read, "On 3 Nurse supervisor. bruise from EZ star utilizes a harness farms to lift them to noted from setting watching resident's sling. Sling slides uraising. Residents assistance when stobserveVerbal cues to resident to push up when standshould assist stand	ge 4 ntation by the director of cated he completed a review freported bruising for R10, 8/2 DON investigated with L (left) arm appears like and [a type of standing lift which astened under the resident's a standing position] sling, as resident up with EZ stand and positioning and positioning of up towards armpits when needs to provide more andingcontinue to education to staff to provide provide assistance with legs to ding. Educated resident she ing by pushing with leg lying on EZ stand to pull her	2 265			
	physician visit note, indicate the physiciath the bruise.	p.m., R10 was seen by her however, the note did not an was notified or examined				
		10's progress notes indicated: n inability to bear weight during				
	indicated, "Residen upper arm. Bruise husing the EZ stand stand applying president was taugh 50% [bear at least being transferred wunderstood and has	m. a skin assessment for R10 t has dark purple bruise on left has become bigger due to and having the strap of the EZ sure to resident's arm. In the bruising to 'use her legs at 50% of her own weight] when with the EZ stand'. Resident is been using her legs more or during transfers. Resident				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00681	B. WING		03/2	22/2018
	PROVIDER OR SUPPLIER	102 EAST	DRESS, CITY, S NORTH STE LLE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	also has fading brucm x 2 cm, and a ccm" 3/11/18, at 11:04 p. recorded indicating purple, had grown to 17 cm x 12 cm. On 3/14/18, at 10:3 follow up to inciden faxed to R10's phys (Occupational Ther transfers after DON department regardion on 3/18/18, at 3:32 indicated R10 had protection of body relutching and holdin "protecting arm" du PRN Acetaminophe tablets/1000 mg) gias effective. On 3/18/18, at 3:35 severe bruising. Reto hand. R10 report 24 hours and, "I use arm during transfer offered ER (Emerge evaluation but refuse on 3/18/18, at 2:24 arm that originated her forearm to her described as dark pout of 10 (10 being Note indicates Physical Processing Pr	ises on right arm measuring 3 ouple that are 1 cm x .07 m. an incident note was left arm bruise was dark bigger in size, and measured 6 a.m. a note was recorded as ton 3/11/18, a report was sician requesting OT apy) to assist with safe I consulted with therapy ng leg strengthening. a.m. a progress note vocal complaints of pain, movements, posturing, ng a body part. R10 was e to pain at times. Request for en 500 mg tablets (2 ven for pain. Med was noted a.m. R10 continued to have 10 had 2-3+ edema (swelling) are my other hand to help this s because it hurts." R10 was ency Room) for further	2 265			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00681	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		NORTH STI			
	0.18.844.537.074		LE, MN 560		011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
	(3/20/18).					
	on 3/20/18, at 3:03 interventions were notification of the b indicated the EZ stareasoning for the incontinue to monitor R10 continued to us recently agreed to s When ask if the phyincident on 3/2/18 a grown larger on 3/1 locate notes or dict being informed until					
	when asked how the with injuries, the DC reported to the chainputs incident into assessment is computed the computed in the co	ron 03/21/18, at 9:44 a.m. be facility processes incidents DN stated incidents were rge nurse, the charge nurse software system, a resident pleted, nature of injury is ian in contacted as well as asured (if appropriate) and an place. DON indicated he ed the physician be contacted nen asked who is responsible condition and make ropriateness of equipment and eing used the DON indicated, cted the charge nurse to the transfer machine and uipment to use." THOD OF CORRECTION: sing or designee could review sary, policies and procedures in notification of changes in				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
			A. BOILDING.		
		00681	B. WING		03/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
JANESV	ILLE NURSING HOME	-	NORTH ST LE, MN 560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 265	Continued From pa	ge 7	2 265		
	audit resident chart changes. The resu with the quality assi ongoing compliance	ese changes and periodically s for timely notification of lts of audits could be reviewed urance committee to ensure e. R CORRECTION: Twenty-one			
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830		4/27/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.			
	by: Based on observati review the facility fa comprehensive ass safety of 1 of 1 resi self-administration Findings include:	sessment to determine the dent (R25) reviewed for of medications.		It is the goal of the Janesville Nursing Home to allow each of its residents to make their own decisions as to how the care is delivered. To make sure that the happens we have taken the following steps. We have reviewed and revised our positions and the statement of the statem	is
	R25's current diagnostructive pulmon	losis list included chronic ary disease.		and procedure related to Self Administation of Medications and	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURV	
, , , , , , , , , , , , , , , , , , , ,	or contraction	BERTIN ISTATISMBER	A. BUILDING	:		
		00681	B. WING		03/22/20	18
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		NORTH ST LE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETE DATE
2 830	Continued From pa	ige 8	2 830			
	revealed a Brief Intof 12. (indicating m Review of the phys	ta Set (MDS), dated 2/28/18, erview for Mental Status score oderate cognitive impairment). ician order sheet, dated n order for Xopenex HFA		Treatments. We have met with F 25 to ascertain what their personal are regarding self administration of medications. It was determined the Resident 25 wishes to continue seadministration of their inhaler and to keep the inhaler at	al wishes of nat elf	
	Levalbuterol Tartrat inhaler. The dose of inhalation every 4 h	te 45 microgram (mcg) Aerosol ordered was (2 puffs) per nours as needed for dyspnea h). The order indicated:		We reviewed this resident's cogni assessment and we conducted a medication assessment with Resident to contin administer medications, we have	itive self dent 25.	
	not have a compred determine the residual administer the mediadministration reconstant there R25 did reconstant the	ication and treatment ord for 2//18 and 3/18 revealed not have a record for or monitoring of the frequency		the following change. The following treatments were platelectronic treatment record on 3/1)Check labels on inhaler once mensure medication has not expire lasts for one year. 2) Sanitize inhaler once weekly perpackage insert directions. 3) Nurse to check self administrative record kept with inhaler at bedsid	aced in 20/2018: conthly to d as it er	
	p.m., R25 was sittir television. A Xopen R25's bedside table During an observat	ion of R25 on 3/19/18 at 6:45 ng in the recliner, watching ex inhaler was sitting on top of e. ion on 3/19/18 at 7:30 p.m. the the window ledge of the room.		monthly. 4) Lock box placed with inhaler at to ensure safe storage of medical Notepad placed with at bedside for administration recording by Reside 5) Resident 25 is seen monthly by rounding provider to review effical	bedside tion. or self lent 25.	
	During an observat the inhaler is sitting The resident was n During an interview stated, "When I get	ion on 3/20/18 at 1:45 p.m, on top of the bedside table.		treatment. The Director of Nursing will conducted audits to ensure compliance. The results of these audits will be presented to the QAPI committee.	uct spot ee.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	00681	B. WING		03/2	2/2018
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME	102 EAST	DRESS, CITY, S NORTH ST LLE, MN 560			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
could not recall how reinhaler today or yested. During an interview wo (LPN-A) on 3/20/18 as she was aware that Recauses security for his communicate to here at the inhaler to himself, not use the inhaler event (DON) on 3/20/18, at confirmed that there were R25's ability to self-action of the facility policy does self-Administered merevised 4/11, indicate Self-administration of must be closely monimedication administration and the resident or in a locked room. The nurse manager of resident competency week, considering the information from the scapacity to remember to make a decision and the resident or make a decision and the competency week and competency	ow often. Furthermore, he many times he used the erday. With licensed practical nurse at 9:49 a.m., LPN-A stated 825 used the inhaler, "It im." LPN-A stated he did not every time he administered, and revealed that R25 did very day. Ith the director of nursing 9:54 a.m., the DON was not a assessment of diminister medication. Was not a assessment of diminister medication. Was not a massessment of diminister medication in the masses and treatments, dimedications and treatments, dimedications and treatments are kept with the diminister for one are resident's ability to receive surrounding environment, information received, ability and give a reason for it, ability mation in making decision,	2 830	quarterly meeting.		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	COMP	SURVEY LETED
		00681	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		NORTH STI LE, MN 560	· -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 830	A decision to permit the seven-day interconference. Medications and trepharmacy and place resident's locked dracontainers. Noncompliant resident medications or treat Update resident can	t self-administration is made in disciplinary care plan eatments are delivered by the ed with the resident or in the awer in specially labeled ents are informed by the they may not self- administer tments.	2 830			
	The administrator, of could review and refor assessment and chooses to administ Nursing staff could the importance of eaccurate and the refor designee, could a on a regular basis to	HOD OF CORRECTION: director of nursing (DON) vise policies and procedures if monitoring when the resident ter his own medications. be educated as necessary on nsure administration is sident is monitored. The DON audit the plan for completion o ensure compliance. R CORRECTION: Twenty-one				
21325	Subpart 1. Routine home must provide resource, routine de needs of each residinclude dental exantillings and crowns, oral surgery, bridge orthodontic procedu	Subp. 1 Providing Routine & ealth Ser e dental services. A nursing e, or obtain from an outside ental services to meet the lent. Routine dental services ninations and cleanings, root canals, periodontal care, s and removable dentures, ures, and adjunctive services r similar dental patients in the	21325			4/27/18

Minneso	<u>ita Department of He</u>	ealth	I			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S	
AIND LEWIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPL	I D
		00681	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
			NORTH ST			
JANESV	ILLE NURSING HOME		LE, MN 56			
(VA) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NI.	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE	DATE
				DEFICIENCY)		
21325	Continued From pa	ge 11	21325			
	community at large	, as limited by third party				
	reimbursement poli					
	Tombursement pon	oles.				
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on interview	and document review, the		In this case we received conflicting		
		ure that dental services were		information from the resident and t		
		resident (R2) reviewed for		family regarding desire for dental s		
	dental care.			It is our goal to always meet the ne		
	Finalinas inalitata			and desires of our resident's. To p		
	Findings include:			the best possible care, we have tall following steps.	ken ine	
	When interviewed (on 3/20/18, at 8:27 a.m. R2		Tollowing steps.		
		ot have dentures but would like		1) We reviewed and revised our po	olicy and	
		e did not recall having been		procedure related to Routine/Emer		
		pointment or the oppportunity		Dental Services.	5 ,	
		ce her admission to the facility.		2) We met with Resident 2 on 3/20	/2018,	
		s were currently sore because		and assistance was provided to se		
	she had recently ea	aten some Dorito chips.		dental appointment at that time. Re		
	50			2 identified wishes to be have a de		
		neet indicated admission to the		appointment to address need for d		
		R2's quarterly MDS dated		 Nurse and Social Services Directions conducting care conferences were 		
	orar ro, indicated fie	er cognition was intact.		educated to policy and procedure,		
	R2's care plan date	ed 3/13/18, identifies R2's oral		documentation requirements, and	need for	
		'I am endentulous I do not		in-depth discussion related to Resi		
	wear dentures per i			needs and wishes related to this ite		
	· ·	-		3/23/2018.		
		der dated 6/17/15, indicated a		4) The Care Conference Commun		
		need for mech. (mechanical)		Form was updated to include clear		
	separation.			documentation of discussions with		
	Nia managari (f. 1) (f. 1)	and a sum to the BO		Residents and family/POA/legal gu		
		services were located in R2's		regarding to Resident's needs and	wishes	
	medical chart.			related to this item.		
	Review of care con	ference meeting notes dated		The Director of Nursing will conduc	et snot	
		id 3/16/17, lacked any		audits at care conferences to ensu		
		al/oral needs had been		compliance.		
		ved The INTERNISH INARY		z z piloti o z		

CARE CONFERENCE AND QUARTERLY

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The Director of Nursing report findings to

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME 102 EAST NORTH STREET JANESVILLE, NN 56048 103/22/2018 REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REVIEW CHECKLIST/DOCUMENTATION documentation dated 9/21/17 and 6/22/17, both indicated mone needed hand written in box next to title "Recent Dentify Nurse stated she was unsure whether R2 had seen a dentist since her admission. The MDS nurse also stated she had contacted R2's sister-in-alw on 2/22/17, to discuss dental and vision appointments. During a later interview on 3/21/18, at 1:33 p.m. the MDS Nurse confirmed R2 had not seen a dentist. When asked what had tinggered her call to the resident's sister-in-alw on 2/22/17, the MDS nurse stated she had contacted R2's sister-in-alw on 2/22/17, the MDS nurse stated she had contacted R2's sister-in-alw on 2/22/17, the MDS nurse stated she had contacted R2's sister-in-alw on 2/22/17, the MDS nurse stated she had contacted sean resident's families to ask about dental and vision needs. When asked about R2' wanting dentures, the MDS nurse saids the had not been aware R2 wanted dentures until the surveyor told her. During interview on 3/21/18, 10:18 a.m. the director of nursing (DON) stated it was an expectation that residents would receive dental services annually or as needed and requested. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for proper dental care and services. Nursing staff could be educated as necessary to the importance of ensure follow up The DON or designee, could adult that the residents are	AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER JANESVILLE NURSING HOME CAN D	AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMP	LETED	
JANESVILLE NURSING HOME CAH ID SUMMARY STATEMENT OF DEFICIENCIES TAGE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL MN 56048 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21325 Continued From page 12 CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			00681	B. WING		03/2	2/2018
Description Description	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21325 Continued From page 12 REVIEW CHECKLIST/DOCUMENTATION documentation dated 9/21/117 and 6/22/17, both indicated "none needed" hand written in box next to title "Recent Dental Appointment". There were no other notes or comments indicated on the form. During interview on 3/20/18, at 10:22 a.m. the MDS (Minimum Data Set) Nurse stated she was unsure whether R2 had seen a dentist since her admission. The MDS nurse also stated she had contacted R2's sister-in-law on 2/22/17, to discuss dental and vision appointments. During a later interview on 3/21/18, at 1:33 p.m. the MDS Nurse confirmed R2 had not seen a dentist. When asked what had triggered her call to the resident's sister-in-law on 2/22/17, the MDS nurse sated she had contacted each resident's families to ask about dental and vision needs. When asked about R2 wanting dentures, the MDS nurse said she had not been aware R2 wanted dentures until the surveyor told her. During interview on 3/21/18, 10:18 a.m. the director of nursing (DON) stated it was an expectation that residents would receive dental services annually or as needed and requested. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for proper dental care and services. Nursing staff could be educated as necessary to the importance of ensure follow up The DON or designee, could adult that the residents are	JANESV	ILLE NURSING HOME	-				
REVIEW CHECKLIST/DOCUMENTATION documentation dated 9/21/17 and 6/22/17, both indicated "none needed" hand written in box next to title "Recent Dental Appointment". There were no other notes or comments indicated on the form. During interview on 3/20/18, at 10:22 a.m. the MDS (Minimum Data Set) Nurse stated she was unsure whether R2 had seen a dentist since her admission. The MDS nurse also stated she had contacted R2's sister-in-law on 2/22/17, to discuss dental and vision appointments. During a later interview on 3/21/18, at 1:33 p.m. the MDS Nurse confirmed R2 had not seen a dentist. When asked what had triggered her call to the resident's siter-in-law on 2/22/17, the MDS nurse stated she had contacted each resident's families to ask about dental and vision needs. When asked about R2 wanting dentures, the MDS nurse said she had not been aware R2 wanted dentures until the surveyor told her. During interview on 3/21/18, 10:18 a.m. the director of nursing (DON) stated it was an expectation that residents would receive dental services annually or as needed and requested. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for proper dental care and services. Nursing staff could be educated as necessary to the importance of ensure follow up The DON or designee, could audit that the residents are	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
documentation dated 9/21/17 and 6/22/17, both indicated "none needed" hand written in box next to title "Recent Dental Appointment". There were no other notes or comments indicated on the form. During interview on 3/20/18, at 10:22 a.m. the MDS (Minimum Data Set) Nurse stated she was unsure whether R2 had seen a dentist since her admission. The MDS nurse also stated she had contacted R2's sister-in-law on 2/22/17, to discuss dental and vision appointments. During a later interview on 3/21/18, at 1:33 p.m. the MDS Nurse confirmed R2 had not seen a dentist. When asked what had triggered her call to the resident's sister-in-law on 2/22/17, the MDS nurse stated she had contacted each resident's families to ask about dental and vision needs. When asked about R2 wanting dentures, the MDS nurse said she had not been aware R2 wanted dentures until the surveyor told her. During interview on 3/21/18, 10:18 a.m. the director of nursing (DON) stated it was an expectation that residents would receive dental services annually or as needed and requested. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for proper dental care and services. Nursing staff could be educated as necessary to the importance of ensure follow up The DON or designee, could audit that the residents are	21325	Continued From pa	nge 12	21325			
offered dental services on a regular basis to ensure compliance.	21325	REVIEW CHECKLI documentation data indicated "none need to title "Recent Denno other notes or coform. During interview on MDS (Minimum Daunsure whether R2 admission. The MD contacted R2's sisted discuss dental and later interview on 3/Nurse confirmed R2 When asked what I resident's sister-instated she had confamilies to ask about MDS nurse said she wanted dentures undirector of nursing (expectation that resistences annually of services annually of services annually of could review and refor proper dental calcould be educated importance of ensure designee, could autoffered dental services annually of services an	IST/DOCUMENTATION ed 9/21/17 and 6/22/17, both eded" hand written in box next stal Appointment". There were comments indicated on the 1 3/20/18, at 10:22 a.m. the sta Set) Nurse stated she was had seen a dentist since her OS nurse also stated she had er-in-law on 2/22/17, to vision appointments. During a //21/18, at 1:33 p.m. the MDS 2 had not seen a dentist. had triggered her call to the law on 2/22/17, the MDS nurse hacted each resident's ut dental and vision needs. R2 wanting dentures, the e had not been aware R2 htil the surveyor told her. 1 3/21/18, 10:18 a.m. the (DON) stated it was an esidents would receive dental ar as needed and requested. THOD OF CORRECTION: director of nursing (DON) evise policies and procedures are and services. Nursing staff as necessary to the are follow up The DON or dit that the residents are lices on a regular basis to	21325		у	

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00681	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
IANESV	ILLE NURSING HOME	102 EAST	NORTH ST	REET		
JANESV	ILLE NURSING HOME	JANESVIL	LE, MN 560	048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 13	21325			
	(21) days					
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			4/27/18
	reviewed at least m currently licensed be This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incavailable through the system. It is not sue B. The pharma irregularities to the land the attending pharmacist. For pure upon means the acreport and the signification of nursing services. C. If the attendity with the pharmacist not provide adequate pharmacist believes being adversely after the matter to the medical direct physician. If the medical direct physician does not must be referred for assessment and as	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. It done in accordance with State Operations Manual, as for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan bject to frequent change. Cist must report any director of nursing services thysician, and these reports in by the time of the next poner, if indicated by the proses of this part, "acted process of this part, "acted process of the process of the inguity of the inguity of life is the resident's quality of life is extended director for review or is not the attending edical director determines that can does not have adequate order and if the attending change the order, the matter is review to the quality surance committee required.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(V2) MULTIDI	E CONSTRUCTION	(V2) DATE (SLIBVEA
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	00681		B. WING		03/22/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DESS CITY (STATE, ZIP CODE		
NAME OF I	-NOVIDEN ON SUFFEIEN		NORTH ST			
JANESV	ILLE NURSING HOME		LE, MN 56			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21530	Continued From pa	ge 14	21530			
		or, the consulting pharmacist er directly to the quality				
		surance committee.				
	This MN Dequireme	ant is not mot as syldensed				
	by:	ent is not met as evidenced				
		on, interview and document		Due to a sale in our original pharm		
		ant pharmacist failed to identify endations related to the lack of		provider, we had three different ph		
		nesia (TD) screenings for 4 of		providers in four months. During t period, a couple of things were no		
		0, R15 & R23) reviewed for		completed in their entirety. To deli		
		ations who were receiving an		best possible patient care, we hav	e taken	
	antipsychotic.			the following steps.		
	Findings include:			1)DISCUS assessments were con on all Residents with current physi		
	R3's quarterly Minir	num Data Set, dated 12/8/17,		orders for administration of psycho		
	identified active dia	gnoses of depression and		medications.	•	
		The MDS identified delusions		2)Reviewed and revised policy and	b	
		g as mood and behavior during the look back period.		procedure related to Psychotropic Initiation.		
	indicators exhibited	during the look back period.		Reviewed policy and deficiency	with	
		ders, dated 3/21/18 included		pharmacy consultant on 3/22/2018	3. Plan	
		(an antipsychotic) 12.5		of care placed in pharmacy consu		
	start date of the ord	ily for psychosis. The original ler was 2/24/17		software to document and alert who DISCUS assessment is due. Repo		
	Start date or the ore	101 Wd3 2/2+/17.		given to Director of Nursing after e		
		dical record revealed no TD		monthly consultation visit.		
	screenings had been completed since 3/17.			4) Facility software setup to place		
	Review of R3's pharmacy consultant notes did			and provide documentation for con when next DISCUS is due for each		
		ng TD screenings were		Resident having orders for admini		
		egularity reports to the facility.		of psychotropic medications.		
				The Director of Nursing will condu	ct audits	
	R20's significant ch	ange in status Minimum Data		to ensure compliance.		
	Set (MDS), dated 2	/04/18 identified she was				
		psychotic medication. The nood or behavior indicators,		The results of these audits will be presented to the QAPI committee	at is	

Minnesota Department of Health

AND DUAN OF CORRECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00681	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		NORTH ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	as well as current of disease and demer R20's care area asses psychoactive medic R3 took antipsychothe halls in her geriher peer's rooms, bhad short and long-R20's care plan, das short-tempered and sensitivity to loud not a consultant pharm report, dated 1/30/1 scheduled haloperidaily basis for a diadelirium. Review of R20's meany monitoring for a dyskinesia had bee began taking the ar During interview on registered nurse (R responsible to compresidents on antipsybeen several change (CP) within the last alerted her if some completed, and verscreening. RN-A siccompleted every size begin adding this to be a several change (CP) and the second completed every size begin adding this to be a several change (CP) and the second completed every size begin adding this to be a several change (CP) within the last alerted her if some completed every size begin adding this to be a several change (CP) within the last alerted her if some completed every size begin adding this to the second control of the second	liagnoses of Alzheimer's nitia. sessment (CAA) for cations, dated 2/9/18 identified tic medications, would wander-chair and occasionally enter but was easily redirectable, and term memory loss. ted 1/18/18 identified she was dirritable with others, with a	21530	quarterly meeting.		
	stated TD monitoring	ng should be completed every lents on an antipsychotic,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00681	B. WING		03/	22/2018
	PROVIDER OR SUPPLIER	102 EAS	DDRESS, CITY, S T NORTH STR ILLE, MN 560	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	however, she "hadr assessments yet, I diagnoses were acc appropriate indicati was a new CP at th	o't gotten around to looking at was trying to make sure the curate and there were ons for use," and stated she	21530			
	2/16/18, identified a and dementia. The	nctive diagnoses of depression MDS did not identify mood or eing exhibited during the look				
	orders for Seroquel milligrams three time	rders, dated 2/21/18 included (an antipsychotic) 50 les daily for psychosis. The or the order was 7/7/16.				
		edical record revealed no TD) screenings had been 13/17.				
	not reveal the missi	armacy consultant notes did ng TD screenings were egularity reports to the facility.				
	active diagnoses of dementia. The MDS asleep, feeling tired and moving or spea	OS, dated 1/26/18, identified insomnia, depression and identified trouble falling poor appetite or over eating aking so slowly that people being exhibited during the				
	orders for Seroquel milligrams in the mo- for psychosis. The	lers, dated 3/6/18 included (an antipsychotic) 12.5 brining and 25 mg at bedtime briginal start date for the 17 with a gradual dose				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00681	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JANESV	ILLE NURSING HOME		NORTH STI LE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 17	21530			
	reduction being ord noted.	ered on 3/6/18 at the dose				
		edical record revealed no TD en completed since 6/28/17.				
	not reveal the missi	armacy consultant notes diding TD screenings were egularity reports to the facility.				
	Review of the Psychotropic Initiation Checklist, undated, directed to complete a baseline screening for TD and every 6 months thereafter.					
	The administrator, of consulting pharmacon policies and proced medication usage. I educated as necession ensure tardive dysk completed timely for antipsychotic medication and labor medication and labor consulting pharmacon process.	CHOD OF CORRECTION: director of nursing (DON) and eist could review and revise ures for proper monitoring of Nursing staff could be sary to the importance of cinesia assessments are er residents receiving cations. The DON or the pharmacist, could audit pratory draw orders for gular basis to ensure				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			4/27/18
	monitor each reside unnecessary drug u	g. A nursing home must ent's drug regimen for usage, based on the nursing I procedures, and the				

Minneso	<u>ta Department of He</u>	alth				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00681	B. WING		03/22/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
141501		102 EAST	NORTH ST	REET		
JANESV	ILLE NURSING HOME	JANESVIL	LE, MN 560	048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE CO	(X5) OMPLETE DATE
21540	Continued From pa	ge 18	21540			
	resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is a the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician physician does not the order and if the change the order, the the qualit (QAA) committee rethe attending physician does not the qualit (QAA) committee rethe attending physician does not physician does not the quality (QAA) committee rethe attending physician does not physician d	port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on observati review, the facility for tardive dyskinesia (residents (R3,R20, unnecessary medica antipsychotic. Findings include: R3's quarterly Minimidentified active dia psychotic disorder, and trouble sleeping indicators exhibited R3's physician's ord	on, interview and document ailed to complete timely TD) screenings for 4 of 4 R23 & R15) reviewed for ations who were receiving an mum Data Set, dated 12/8/17, gnoses of depression and The MDS identified delusions g as mood and behavior during the look back period.		Due to a sale in our original pharm provider, we had three different physocompletes in four months. During a period, a couple of things were no completed in their entirety. To delibest possible patient care, we have the following steps. 1)DISCUS assessments were corron all Residents with current physorders for administration of psychomedications. 2)Reviewed and revised policy and procedure related to Psychotropic Initiation. 3) Reviewed policy and deficiency physmacky consultant on 3/22/2011	narmacy chat t tiver the e taken npleted ician otropic d with	
		(an antipsychotic) 12.5 ily for psychosis. The original		pharmacy consultant on 3/22/2018 of care placed in pharmacy consu		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 19 of 22 731X11

AND DIAM OF CODDECTION INDESTRUCTION AND DEC					(X3) DATE SURVEY COMPLETED	
		00681	B. WING		03/2	2/2018
	PROVIDER OR SUPPLIER	102 EAST	DRESS, CITY, S NORTH STI LLE, MN 560			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	start date of the ord Review of R3's med screenings had been screenings had scurrent of disease and demer screening screening had scurrent of disease and demer screening screening had scurrent of disease and demer screening had screening had screening had short and long-screening had short and long-screening had screening	der was 2/24/17. dical record revealed no TD en completed since 3/17. lange in status Minimum Data /04/18 identified she was psychotic medication. The mood or behavior indicators, liagnoses of Alzheimer's nitia. sessment (CAA) for cations, dated 2/9/18 identified tic medications, would wander chair and occasionally enter but was easily redirectable, and term memory loss. ted 1/18/18 identified she was dirritable with others, with a	21540	software to document and alert who DISCUS assessment is due. Reporting in the provide of Nursing after example of the provide documentation for converse of the provide	ort is each alerts mpletion h stration ct audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00681	B. WING		03/	22/2018
	PROVIDER OR SUPPLIER	102 EAST	DRESS, CITY, ST NORTH STR LLE, MN 5604	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
21540	(CP) within the last alerted her if some completed, and ver screening. RN-A st completed every six begin adding this to verified R3 and R20 been completed ev. During interview on stated TD monitorir six months for resic however, she "hadrassessments yet, I diagnoses were accappropriate indicati was a new CP at the stated the facility with to track completion waiting for the CP's the screenings were R23's quarterly Min 2/16/18, identified a and dementia. The behavioral issues behavioral issues behavioral start date for Review of R23's metardive dyskinesia (completed since 8/s)	year, and the CP usually one needed TD screenings ified R20's record lacked TD stated TD screening should be a months, and she would of her calendar to track. RN-A b's TD screenings had not ery six months. 3/22/18, at 2:05 p.m. the CP and should be completed every lents on an antipsychotic, b't gotten around to looking at was trying to make sure the curate and there were one for use," and stated she e facility. The CP further could normally be responsible of TD screenings, rather than recommendation to identify the late. Immum Data Set (MDS), dated active diagnoses of depression MDS did not identify mood or eing exhibited during the look orders, dated 2/21/18 included (an antipsychotic) 50 are daily for psychosis. The or the order was 7/7/16.	21540			
		insomnia, depression and				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
		00681	B. WING		03/2	2/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JANESVIL	LE NURSING HOME		NORTH STI LE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	asleep, feeling tired and moving or spea could have noticed look back period. R15's physician ord orders for Seroquel milligrams in the motor psychosis. The consulting pharmace policies and proced medication usage. It educated as necessensure tardive dysk completed timely for antipsychotic medication and labe completion on a regonal compliance.	ge 21 Sidentified trouble falling I, poor appetite or over eating aking so slowly that people being exhibited during the lers, dated 3/6/18 included (an antipsychotic) 12.5 braing and 25 mg at bedtime briginal start date for the 17 with a gradual dose ered on 3/6/18 at the dose redical record revealed no TD on completed since 6/28/17. Thotropic Initiation Checklist, to complete a baseline and every 6 months thereafter. THOD OF CORRECTION: Clirector of nursing (DON) and clist could review and revise ures for proper monitoring of Nursing staff could be sary to the importance of inesia assessments are r residents receiving cations. The DON or the pharmacist, could audit bratory draw orders for gular basis to ensure R CORRECTION: Twenty-one	21540	DEFICIENCY)		

6899