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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 731X

PART 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 HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, Unit Supervisor 05/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 05/15/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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
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

DEPARTMENT OF HEALTH

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
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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 731X

PART 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 HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
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 The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Dobie, HFE NE-II 04/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 04/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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:

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

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

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

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

<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

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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on March 19, 20, 21 and 22, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 19th, 20th, 21st and 22nd, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		4/27/18

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

Electronically Signed | 04/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician in a timely manner of an increase in bruising for 1 of 1 resident (R10) reviewed for non-pressure related skin conditions. Findings include: R10's Admission Record, printed on 3/22/18, indicated R10 was had diagnoses including obesity, unspecified brain injury and heart disease. R10's 30-day Minimum Data Set (MDS) assessment, dated 1/11/18, indicated R10 was cognitively intact. R10's care plan, dated 3/13/18, indicated R10 required assist of one for transfers with use of a standing lift machine, and assist of 2 if bearing weight during transfers. A problem area of bruising, dated 12/27/17, indicated R10 was prone to bruise easily due to anticoagulant (blood thinner) use. R10's physician orders printed on 3/22/18, included an order dated 12/14/17, for Rivaroxaban (blood thinner) 20 mg (milligram) tablet by mouth once daily. During an observation on 3/20/18 at 2:49 p.m., R10 was observed to have a bruise on her left hand near her fingers, wrapping around her hand, wrist, and forearm. The bruising appeared dark purple in color. During the observation, R10 stated, the bruising went farther up her arm under	F 580	We strive to ensure that each resident in our care receives the best care possible. To ensure that we are meeting this goal in this area, we have taken the following steps. We reviewed and revised our policy and procedure related to Change in a Resident□s Condition or Status on 3/28/2018. We re-educated the nursing staff to our Change in a Resident□s Condition Policy and Procedure or Status in a small group meeting on 4/12/2018. Our nursing charting software has been modified to provide Resident Status Change and Incident reports. These reports will be delivered directly to Director of Nursing. The Director of Nursing conduct audits to ensure that compliance in this area is being met. The results f these audits will be reported to the QAPI committee at is quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

her shirt sleeve.

During an observation on 3/21/18 at 7:24 a.m., the bruising on R10's hand and arm was fully viewed. The bruising was noted to extend up R10's upper arm into the armpit. At that time, R10 stated she sometimes had pain in the bruised area.

R10's Nurses' Notes were reviewed from 3/2/18, through 3/20/18 and revealed the following:

3/2/18, at 2:54 a.m. noted a bruise on resident's left upper inner arm, measuring 4 x 9 centimeters (cm). Note indicated R10 did not know what happened and was not experiencing any discomfort. Action indicated in note was, "Continue to observe".

On 3/3/18, no time recorded, R10's nurses note read, "Continues with bruises on both upper arms that are slowly resolving."

On 3/4/18, 10:43 a.m. R10's reads, "Bruise slowly fading."

[Late Entry indicated in on 3/12/18, at 1:07 p.m.] On 3/5/18, documentation by the director of nursing (DON) indicated he completed a review and investigation of reported bruising for R10, which read, "...On 3/2 DON investigated with Nurse supervisor. L (left) arm appears like a bruise from EZ stand [a type of standing lift which utilizes a harness fastened under the resident's arms to lift them to a standing position] sling, as noted from setting resident up with EZ stand and watching resident's positioning and positioning of sling. Sling slides up towards armpits when raising. Residents needs to provide more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

assistance when standing....continue to observe.....Verbal education to staff to provide cues to resident to provide assistance with legs to push up when standing. Educated resident she should assist standing by pushing with leg muscles and not relying on EZ stand to pull her up."

On 3/6/18, at 12:58 p.m., R10 was seen by her physician visit note, however, the note did not indicate the physician was notified or examined the bruise.

Further review of R10's progress notes indicated:

3/7/18 - R10 had an inability to bear weight during transfers.

3/11/18, at 10:10 p.m. a skin assessment for R10 indicated, "Resident has dark purple bruise on left upper arm. Bruise has become bigger due to using the EZ stand and having the strap of the EZ stand applying pressure to resident's arm. Resident was taught by nursing to 'use her legs at 50% [bear at least 50% of her own weight] when being transferred with the EZ stand'. Resident understood and has been using her legs more when being lifted up during transfers. Resident also has fading bruises on right arm measuring 3 cm x 2 cm, and a couple that are 1 cm x .07 cm...."

3/11/18, at 11:04 p.m. an incident note was recorded indicating left arm bruise was dark purple, had grown bigger in size, and measured 17 cm x 12 cm.

On 3/14/18, at 10:36 a.m. a note was recorded as follow up to incident on 3/11/18, a report was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

faxed to R10's physician requesting OT (Occupational Therapy) to assist with safe transfers after DON consulted with therapy department regarding leg strengthening.

On 3/18/18, at 3:32 a.m. a progress note indicated R10 had vocal complaints of pain, protection of body movements, posturing, clutching and holding a body part. R10 was "protecting arm" due to pain at times. Request for PRN Acetaminophen 500 mg tablets (2 tablets/1000 mg) given for pain. Med was noted as effective.

On 3/18/18, at 3:35 a.m. R10 continued to have severe bruising. R10 had 2-3+ edema (swelling) to hand. R10 reported pain more frequent in last 24 hours and, "I use my other hand to help this arm during transfers because it hurts." R10 was offered ER (Emergency Room) for further evaluation but refused.

On 3/18/18, at 2:24 p.m. R10's "bruising in left arm that originated in shoulder has traveled from her forearm to her wrist since yesterday." Wrist is described as dark purple, pain is reported as 8 out of 10 (10 being the highest level of pain). Note indicates Physician was updated on status and will see R10 during rounds on Tuesday (3/20/18).

During an interview with Registered Nurse (RN) on 3/20/18, at 3:03 p.m., when asked what interventions were put in in place following notification of the bruise on 3/2/18, it was indicated the EZ stand was identified as the reasoning for the injury, measures were to continue to monitor bruise. RN additionally stated R10 continued to use the EZ stand and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 recently agreed to start OT for safe transfers. When ask if the physician was notified for the incident on 3/2/18 and when the bruising had grown larger on 3/11/18, RN was unable to locate notes or dictation related to the physician being informed until 3/18/18. During an interview on 03/21/18, at 9:44 a.m. when asked how the facility processes incidents with injuries, the DON stated incidents were reported to the charge nurse, the charge nurse inputs incident into software system, a resident assessment is completed, nature of injury is determined, physician in contacted as well as family, injury is measured (if appropriate) and an investigation takes place. DON indicated he would have expected the physician be contacted for this incident. When asked who is responsible to report change of condition and make evaluations on appropriateness of equipment and assisted devices being used the DON indicated, "I would have expected the charge nurse to evaluate the use of the transfer machine and what is the right equipment to use."	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 Based on observation, interview, and document review the facility failed to complete a comprehensive assessment to determine the safety of 1 of 1 resident (R25) reviewed for self-administration of medications. Findings include: R25's current diagnosis list included chronic obstructive pulmonary disease. R25's Minimum Data Set (MDS), dated 2/28/18, revealed a Brief Interview for Mental Status score of 12 (indicating moderate cognitive impairment). Review of the physician order sheet, dated 2/23/28, included an order for Xopenex HFA Levalbuterol Tartrate 45 microgram (mcg) Aerosol inhaler. The dose ordered was (2 puffs) per inhalation every 4 hours as needed for dyspnea (shortness of breath). The order indicated: resident may keep at bedside and self-administer. Review of R25's medical record revealed he did not have a comprehensive assessment to determine the resident's cognitive ability to self administer the medication. Review of the medication and treatment administration record for 2//18 and 3/18 revealed that there R25 did not have a record for administration or for monitoring of the frequency R25 was utilizing the inhaler. During an observation of R25 on 3/19/18 at 6:45 p.m., R25 was sitting in the recliner, watching television. A Xopenex inhaler was sitting on top of R25's bedside table.	F 684	It is the goal of the Janesville Nursing Home to allow each of its residents to make their own decisions as to how their care is delivered. To make sure that this happens we have taken the following steps. We have reviewed and revised our policy and procedure related to Self Administation of Medications and Treatments. We have met with Resident 25 to ascertain what their personal wishes are regarding self administration of medications. It was determined that Resident 25 wishes to continue self administration of their inhaler and to keep the inhaler at bedside. We reviewed this resident's cognitive assessment and we conducted a self medication assessment with Resident 25. To better allow Resident to continue to self administer medications, we have made the following change. The following treatments were placed in electronic treatment record on 3/20/2018: 1)Check labels on inhaler once monthly to ensure medication has not expired as it lasts for one year. 2) Sanitize inhaler once weekly per package insert directions. 3) Nurse to check self administration record kept with inhaler at bedside once monthly. 4) Lock box placed with inhaler at bedside to ensure safe storage of medication. Notepad placed with at bedside for self	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 During an observation on 3/19/18 at 7:30 p.m. the inhaler is sitting on the window ledge of the room. During an observation on 3/20/18 at 1:45 p.m.., the inhaler is sitting on top of the bedside table. The resident was not in the room. During an interview on 3/19/18, at 7:30 p.m., R25, stated, "When I get short of air, I just use it." R25 stated that he did not let the nurse know when he used the inhaler or how often. Furthermore, he could not recall how many times he used the inhaler today or yesterday. During an interview with licensed practical nurse (LPN-A) on 3/20/18 at 9:49 a.m., LPN-A stated she was aware that R25 used the inhaler, "It causes security for him." LPN-A stated he did not communicate to her every time he administered the inhaler to himself, and revealed that R25 did not use the inhaler every day. During a interview with the director of nursing (DON) on 3/20/18, at 9:54 a.m., the DON confirmed that there was not a assessment of R25's ability to self-administer medication. During interview on 3/20/18, at 11:53 a.m,. the DON stated that he had met with R25, who confirmed that he used the inhaler one to two times per day. The faciliyt policy document entitled, Self-Administered medications and treatments, revised 4/11, indicated: Self-administration of medications or treatments must be closely monitored and recorded in the medication administration record (MAR).	F 684	administration recording by Resident 25. 5) Resident 25 is seen monthly by rounding provider to review efficacy of treatment. The Director of Nursing will conduct spot check audits to ensure compliance. The results of these audits will be presented to the QAPI committee at its quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 All medications and treatments are kept with the resident or in a locked drawer in the resident's room. The nurse manager or team leader assesses resident competency to self-administer for one week, considering the resident's ability to receive information from the surrounding environment, capacity to remember information received, ability to make a decision and give a reason for it, ability to use relevant information in making decision, ability to appropriately assess relevant information. A decision to permit self-administration is made in the seven-day interdisciplinary care plan conference. Medications and treatments are delivered by the pharmacy and placed with the resident or in the resident's locked drawer in specially labeled containers. Noncompliant residents are informed by the nurse manager that they may not self- administer medications or treatments. Update resident care plan.	F 684		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 10 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to identify and make recommendations related to the lack of timely tardive dyskinesia (TD) screenings for 4 of 4 residents (R3,R20, R15 & R23) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R3's quarterly Minimum Data Set, dated 12/8/17, identified active diagnoses of depression and	F 756	Due to a sale in our original pharmacy provider, we had three different pharmacy providers in four months. During that period, a couple of things were not completed in their entirety. To deliver the best possible patient care, we have taken the following steps. 1)DISCUS assessments were completed on all Residents with current physician orders for administration of psychotropic medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 11 psychotic disorder. The MDS identified delusions and trouble sleeping as mood and behavior indicators exhibited during the look back period. R3's physician's orders, dated 3/21/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams twice daily for psychosis. The original start date of the order was 2/24/17. Review of R3's medical record revealed no TD screenings had been completed since 3/17. Review of R3's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. R20's significant change in status Minimum Data Set (MDS), dated 2/04/18 identified she was currently on an antipsychotic medication. The MDS identified no mood or behavior indicators, as well as current diagnoses of Alzheimer's disease and dementia. R20's care area assessment (CAA) for psychoactive medications, dated 2/9/18 identified R3 took antipsychotic medications, would wander the halls in her geri-chair and occasionally enter her peer's rooms, but was easily redirectable, and had short and long-term memory loss. R20's care plan, dated 1/18/18 identified she was short-tempered and irritable with others, with a sensitivity to loud noises. A consultant pharmacy drug regimen review report, dated 1/30/18 identified R20 was receiving scheduled haloperidol (an anti-psychotic) on a daily basis for a diagnosis of hospice and terminal	F 756	2)Reviewed and revised policy and procedure related to Psychotropic Initiation. 3) Reviewed policy and deficiency with pharmacy consultant on 3/22/2018. Plan of care placed in pharmacy consultant software to document and alert when next DISCUS assessment is due. Report is given to Director of Nursing after each monthly consultation visit. 4) Facility software setup to place alerts and provide documentation for completion when next DISCUS is due for each Resident having orders for administration of psychotropic medications. The Director of Nursing will conduct audits to ensure compliance. The results of these audits will be presented to the QAPI committee at is quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 12	F 756		

delirium.

Review of R20's medical record did not reveal any monitoring for symptoms of tardive dyskinesia had been completed for R3 since she began taking the antipsychotic medication.

During interview on 3/21/18, at 2:11 p.m. registered nurse (RN)-A stated she was responsible to complete TD monitoring for residents on antipsychotics, however, there had been several changes of consultant pharmacist (CP) within the last year, and the CP usually alerted her if someone needed TD screenings completed, and verified R20's record lacked TD screening. RN-A stated TD screening should be completed every six months, and she would begin adding this to her calendar to track.

During interview on 3/22/18, at 2:05 p.m. the CP stated TD monitoring should be completed every six months for residents on an antipsychotic, however, she "hadn't gotten around to looking at assessments yet, I was trying to make sure the diagnoses were accurate and there were appropriate indications for use," and stated she was a new CP at the facility.

R23's quarterly Minimum Data Set (MDS), dated 2/16/18, identified active diagnoses of depression and dementia. The MDS did not identify mood or behavioral issues being exhibited during the look back period.

R23's psychiatrist orders, dated 2/21/18 included orders for Seroquel (an antipsychotic) 50 milligrams three times daily for psychosis. The original start date for the order was 7/7/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 13 Review of R23's medical record revealed no tardive dyskinesia (TD) screenings had been completed since 8/13/17. Review of R23's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. R15's quarterly MDS, dated 1/26/18, identified active diagnoses of insomnia, depression and dementia. The MDS identified trouble falling asleep, feeling tired, poor appetite or over eating and moving or speaking so slowly that people could have noticed being exhibited during the look back period. R15's physician orders, dated 3/6/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams in the morning and 25 mg at bedtime for psychosis. The original start date for the Seroquel was 6/28/17 with a gradual dose reduction being ordered on 3/6/18 at the dose noted. Review of R15's medical record revealed no TD screenings had been completed since 6/28/17. Review of R23's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. Review of the Psychotropic Initiation Checklist, undated, directed to complete a baseline screening for TD and every 6 months thereafter.	F 756		
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758 SS=E	Continued From page 14 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 15 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings for 4 of 4 residents (R3,R20, R23 & R15) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R3's quarterly Minimum Data Set, dated 12/8/17, identified active diagnoses of depression and psychotic disorder. The MDS identified delusions and trouble sleeping as mood and behavior indicators exhibited during the look back period. R3's physician's orders, dated 3/21/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams twice daily for psychosis. The original start date of the order was 2/24/17. Review of R3's medical record revealed no TD screenings had been completed since 3/17. R20's significant change in status Minimum Data Set (MDS), dated 2/04/18 identified she was currently on an antipsychotic medication. The	F 758	Due to a sale in our original pharmacy provider, we had three different pharmacy providers in four months. During that period, a couple of things were not completed in their entirety. To deliver the best possible patient care, we have taken the following steps. 1)DISCUS assessments were completed on all Residents with current physician orders for administration of psychotropic medications. 2)Reviewed and revised policy and procedure related to Psychotropic Initiation. 3) Reviewed policy and deficiency with pharmacy consultant on 3/22/2018. Plan of care placed in pharmacy consultant software to document and alert when next DISCUS assessment is due. Report is given to Director of Nursing after each monthly consultation visit. 4) Facility software setup to place alerts and provide documentation for completion when next DISCUS is due for each Resident having orders for administration of psychotropic medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 16 MDS identified no mood or behavior indicators, as well as current diagnoses of Alzheimer's disease and dementia. R20's care area assessment (CAA) for psychoactive medications, dated 2/9/18 identified R3 took antipsychotic medications, would wander the halls in her geri-chair and occasionally enter her peer's rooms, but was easily redirectable, and had short and long-term memory loss. R20's care plan, dated 1/18/18 identified she was short-tempered and irritable with others, with a sensitivity to loud noises. A consultant pharmacy drug regimen review report, dated 1/30/18 identified R20 was receiving scheduled haloperidol (an anti-psychotic) on a daily basis for a diagnosis of hospice and terminal delirium. Review of R20's medical record did not reveal any monitoring for symptoms of tardive dyskinesia had been completed for R3 since she began taking the antipsychotic medication. During interview on 3/21/18, at 2:11 p.m. registered nurse (RN)-A stated she was responsible to complete TD monitoring for residents on antipsychotics, however, there had been several changes of consultant pharmacist (CP) within the last year, and the CP usually alerted her if someone needed TD screenings completed, and verified R20's record lacked TD screening. RN-A stated TD screening should be completed every six months, and she would begin adding this to her calendar to track. RN-A verified R3 and R20's TD screenings had not been completed every six months.	F 758	The Director of Nursing will conduct audits to ensure compliance. The results of these audits will be presented to the QAPI committee at is quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 17	F 758		

During interview on 3/22/18, at 2:05 p.m. the CP stated TD monitoring should be completed every six months for residents on an antipsychotic, however, she "hadn't gotten around to looking at assessments yet, I was trying to make sure the diagnoses were accurate and there were appropriate indications for use," and stated she was a new CP at the facility. The CP further stated the facility would normally be responsible to track completion of TD screenings, rather than waiting for the CP's recommendation to identify the screenings were late.
R23's quarterly Minimum Data Set (MDS), dated 2/16/18, identified active diagnoses of depression and dementia. The MDS did not identify mood or behavioral issues being exhibited during the look back period.

R23's psychiatrist orders, dated 2/21/18 included orders for Seroquel (an antipsychotic) 50 milligrams three times daily for psychosis. The original start date for the order was 7/7/16.

Review of R23's medical record revealed no tardive dyskinesia (TD) screenings had been completed since 8/13/17.

R15's quarterly MDS, dated 1/26/18, identified active diagnoses of insomnia, depression and dementia. The MDS identified trouble falling asleep, feeling tired, poor appetite or over eating and moving or speaking so slowly that people could have noticed being exhibited during the look back period.

R15's physician orders, dated 3/6/18 included orders for Seroquel (an antipsychotic) 12.5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 18 milligrams in the morning and 25 mg at bedtime for psychosis. The original start date for the Seroquel was 6/28/17 with a gradual dose reduction being ordered on 3/6/18 at the dose noted. Review of R15's medical record revealed no TD screenings had been completed since 6/28/17. Review of the Psychotropic Initiation Checklist, undated, directed to complete a baseline screening for TD and every 6 months thereafter.	F 758		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for	F 791		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 19 dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that dental services were provided for 1 of 1 resident (R2) reviewed for dental care. Findings include: When interviewed on 3/20/18, at 8:27 a.m. R2 indicated she did not have dentures but would like them. R2 stated she did not recall having been offered a dental appointment or the oppportunity to get dentures since her admission to the facility. R2 stated her gums were currently sore because she had recently eaten some Dorito chips. R2's current facesheet indicated admission to the facility on 9/12/11. R2's quarterly Minimum Data Set (MDS) dated 3/9/18, indicated her cognition was intact.	F 791	In this case we received conflicting information from the resident and their family regarding desire for dental services. It is our goal to always meet the needs and desires of our resident's. To provide the best possible care, we have taken the following steps. 1) We reviewed and revised our policy and procedure related to Routine/Emergency Dental Services. 2) We met with Resident 2 on 3/20/2018, and assistance was provided to setup a dental appointment at that time. Resident 2 identified wishes to be have a dental appointment to address need for dentures. 3) Nurse and Social Services Director conducting care conferences were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 20 R2's care plan dated 3/13/18, identifies R2's oral care approach as, "I am endentulous I do not wear dentures per my choice". R2's Physician's Order dated 6/17/15, indicated a regular diet without need for mech. (mechanical) separation. No record of dental services were located in R2's medical chart. Review of care conference meeting notes dated 9/21/17, 6/22/17 and 3/16/17, lacked any evidence that dental/oral needs had been discussed or reviewed. The INTERDISPLINARY CARE CONFERENCE AND QUARTERLY 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 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.	F 791	educated to policy and procedure, documentation requirements, and need for in-depth discussion related to Resident□s needs and wishes related to this item on 3/23/2018. 4) The Care Conference Communication Form was updated to include clearer documentation of discussions with Residents and family/POA/legal guardian regarding to Resident□s needs and wishes related to this item. The Director of Nursing will conduct spot audits at care conferences to ensure compliance. The Director of Nursing report findings to the QAPI committee at its quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 21 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.	F 791		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a risk assessment was completed to determine where waterborne pathogens including Legionella, could spread or	F 880	We have written and put in place a Legionella Water Management Program. This program was written in cooperation with local water management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 grow in the facility's water sources. This deficient practice had the potential to affect all 30 residents in the facility. Findings include: On 3/22/18, at 8:30 a.m., the facility's maintenance director confirmed the facility had not developed policies and procedures for risks of waterborne pathoges including Legionella. The maintenance director stated the facility was currently collaborating with the city water supplier to assist in developing a plan but have not yet implemented such.	F 880	professionals. We have created a water management team consisting of five people who will work to identify areas in the water system where bacteria can grow and spread and to reduce the risk of Legionnaires Disease. In putting this plan together, we have analyzed the flow of water throughout our building and completed the Legionella Environment Assessment Form which was developed by the Centers for Disease Control and Prevention. We are currently monitoring water temperature at several points in our building. We monitor water temperature daily in our kitchen as well as weekly at the far end of the water runs. We will regularly monitor our water to ensure that Chlorine levels stay within the levels deemed safe by the City of Janesville. The Water Management Team will monitor this area to ensure continued compliance. They will review the data gathered by the maintenance department and will report their findings to the QAPI Committee at its quarterly meetings.	

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

F5440027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET** **JANESVILLE, MN 56048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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.	K 000		

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

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

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 03/19/17 through 03/22/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for	2 265		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 2 example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician in a timely manner of an increase in bruising for 1 of 1 resident (R10) reviewed for non-pressure related skin conditions. Findings include: R10's Admission Record, printed on 3/22/18, indicated R10 was had diagnoses including obesity, unspecified brain injury and heart disease. R10's 30-day Minimum Data Set (MDS) assessment, dated 1/11/18, indicated R10 was cognitively intact. R10's care plan, dated 3/13/18, indicated R10 required assist of one for transfers with use of a standing lift machine, and assist of 2 if bearing weight during transfers. A problem area of bruising, dated 12/27/17, indicated R10 was prone to bruise easily due to anticoagulant (blood	2 265	We strive to ensure that each resident in our care receives the best care possible. To ensure that we are meeting this goal in this are, we have taken the following steps. We reviewed and revised our policy and procedure related to Change in a Resident□s Condition or Status on 3/28/2018. We re-educated the nursing staff to our Change in a Resident□s Condition Policy and Procedure or Status in a small group meeting on 4/12/2018. Our nursing charting software has been modified to provide Resident Status Change and Incident reports. These reports will be delivered directly to Director of Nursing. The Director of Nursing conduct audits to ensure that compliance in this area is being met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 thinner) use. R10's physician orders printed on 3/22/18, included an order dated 12/14/17, for Rivaroxaban (blood thinner) 20 mg (milligram) tablet by mouth once daily. During an observation on 3/20/18 at 2:49 p.m., R10 was observed to have a bruise on her left hand near her fingers, wrapping around her hand, wrist, and forearm. The bruising appeared dark purple in color. During the observation, R10 stated, the bruising went farther up her arm under her shirt sleeve. During an observation on 3/21/18 at 7:24 a.m., the bruising on R10's hand and arm was fully viewed. The bruising was noted to extend up R10's upper arm into the armpit. At that time, R10 stated she sometimes had pain in the bruised area. R10's Nurses' Notes were reviewed from 3/2/18, through 3/20/18 and revealed the following: 3/2/18, at 2:54 a.m. noted a bruise on resident's left upper inner arm, measuring 4 x 9 centimeters (cm). Note indicated R10 did not know what happened and was not experiencing any discomfort. Action indicated in note was, "Continue to observe". On 3/3/18, no time recorded, R10's nurses note read, "Continues with bruises on both upper arms that are slowly resolving." On 3/4/18, 10:43 a.m. R10's reads, "Bruise slowly fading." [Late Entry indicated in on 3/12/18, at 1:07 p.m.]	2 265	The results f these audits will be reported to the QAPI committee at is quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 On 3/5/18, documentation by the director of nursing (DON) indicated he completed a review and investigation of reported bruising for R10, which read, "...On 3/2 DON investigated with Nurse supervisor. L (left) arm appears like a bruise from EZ stand [a type of standing lift which utilizes a harness fastened under the resident's arms to lift them to a standing position] sling, as noted from setting resident up with EZ stand and watching resident's positioning and positioning of sling. Sling slides up towards armpits when raising. Residents needs to provide more assistance when standing....continue to observe.....Verbal education to staff to provide cues to resident to provide assistance with legs to push up when standing. Educated resident she should assist standing by pushing with leg muscles and not relying on EZ stand to pull her up." On 3/6/18, at 12:58 p.m., R10 was seen by her physician visit note, however, the note did not indicate the physician was notified or examined the bruise. Further review of R10's progress notes indicated: 3/7/18 - R10 had an inability to bear weight during transfers. 3/11/18, at 10:10 p.m. a skin assessment for R10 indicated, "Resident has dark purple bruise on left upper arm. Bruise has become bigger due to using the EZ stand and having the strap of the EZ stand applying pressure to resident's arm. Resident was taught by nursing to 'use her legs at 50% [bear at least 50% of her own weight] when being transferred with the EZ stand'. Resident understood and has been using her legs more when being lifted up during transfers. Resident	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5	2 265		

also has fading bruises on right arm measuring 3 cm x 2 cm, and a couple that are 1 cm x .07 cm...."

3/11/18, at 11:04 p.m. an incident note was recorded indicating left arm bruise was dark purple, had grown bigger in size, and measured 17 cm x 12 cm.

On 3/14/18, at 10:36 a.m. a note was recorded as follow up to incident on 3/11/18, a report was faxed to R10's physician requesting OT (Occupational Therapy) to assist with safe transfers after DON consulted with therapy department regarding leg strengthening.

On 3/18/18, at 3:32 a.m. a progress note indicated R10 had vocal complaints of pain, protection of body movements, posturing, clutching and holding a body part. R10 was "protecting arm" due to pain at times. Request for PRN Acetaminophen 500 mg tablets (2 tablets/1000 mg) given for pain. Med was noted as effective.

On 3/18/18, at 3:35 a.m. R10 continued to have severe bruising. R10 had 2-3+ edema (swelling) to hand. R10 reported pain more frequent in last 24 hours and, "I use my other hand to help this arm during transfers because it hurts." R10 was offered ER (Emergency Room) for further evaluation but refused.

On 3/18/18, at 2:24 p.m. R10's "bruising in left arm that originated in shoulder has traveled from her forearm to her wrist since yesterday." Wrist is described as dark purple, pain is reported as 8 out of 10 (10 being the highest level of pain). Note indicates Physician was updated on status and will see R10 during rounds on Tuesday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 (3/20/18). During an interview with Registered Nurse (RN) on 3/20/18, at 3:03 p.m., when asked what interventions were put in in place following notification of the bruise on 3/2/18, it was indicated the EZ stand was identified as the reasoning for the injury, measures were to continue to monitor bruise. RN additionally stated R10 continued to use the EZ stand and had recently agreed to start OT for safe transfers. When ask if the physician was notified for the incident on 3/2/18 and when the bruising had grown larger on 3/11/18, RN was unable to locate notes or dictation related to the physician being informed until 3/18/18. During an interview on 03/21/18, at 9:44 a.m. when asked how the facility processes incidents with injuries, the DON stated incidents were reported to the charge nurse, the charge nurse inputs incident into software system, a resident assessment is completed, nature of injury is determined, physician in contacted as well as family, injury is measured (if appropriate) and an investigation takes place. DON indicated he would have expected the physician be contacted for this incident. When asked who is responsible to report change of condition and make evaluations on appropriateness of equipment and assisted devices being used the DON indicated, "I would have expected the charge nurse to evaluate the use of the transfer machine and what is the right equipment to use." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise if necessary, policies and procedures related to physician notification of changes in status. The director of nursing or designee could	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 educate staff on these changes and periodically audit resident charts for timely notification of changes. The results of audits could be reviewed with the quality assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a comprehensive assessment to determine the safety of 1 of 1 resident (R25) reviewed for self-administration of medications. Findings include: R25's current diagnosis list included chronic obstructive pulmonary disease.	2 830	It is the goal of the Janesville Nursing Home to allow each of its residents to make their own decisions as to how their care is delivered. To make sure that this happens we have taken the following steps. We have reviewed and revised our policy and procedure related to Self Administation of Medications and	4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 R25's Minimum Data Set (MDS), dated 2/28/18, revealed a Brief Interview for Mental Status score of 12. (indicating moderate cognitive impairment). Review of the physician order sheet, dated 2/23/28, included an order for Xopenex HFA Levalbuterol Tartrate 45 microgram (mcg) Aerosol inhaler. The dose ordered was (2 puffs) per inhalation every 4 hours as needed for dyspnea (shortness of breath). The order indicated: resident may keep at bedside and self-administer. Review of R25's medical record revealed he did not have a comprehensive assessment to determine the resident's cognitive ability to self administer the medication. Review of the medication and treatment administration record for 2//18 and 3/18 revealed that there R25 did not have a record for administration or for monitoring of the frequency R25 was utilizing the inhaler. During an observation of R25 on 3/19/18 at 6:45 p.m., R25 was sitting in the recliner, watching television. A Xopenex inhaler was sitting on top of R25's bedside table. During an observation on 3/19/18 at 7:30 p.m. the inhaler is sitting on the window ledge of the room. During an observation on 3/20/18 at 1:45 p.m.., the inhaler is sitting on top of the bedside table. The resident was not in the room. During an interview on 3/19/18, at 7:30 p.m., R25, stated, "When I get short of air, I just use it." R25 stated that he did not let the nurse know when he	2 830	Treatments. We have met with Resident 25 to ascertain what their personal wishes are regarding self administration of medications. It was determined that Resident 25 wishes to continue self administration of their inhaler and to keep the inhaler at bedside. We reviewed this resident's cognitive assessment and we conducted a self medication assessment with Resident 25. To better allow Resident to continue to self administer medications, we have made the following change. The following treatments were placed in electronic treatment record on 3/20/2018: 1)Check labels on inhaler once monthly to ensure medication has not expired as it lasts for one year. 2) Sanitize inhaler once weekly per package insert directions. 3) Nurse to check self administration record kept with inhaler at bedside once monthly. 4) Lock box placed with inhaler at bedside to ensure safe storage of medication. Notepad placed with at bedside for self administration recording by Resident 25. 5) Resident 25 is seen monthly by rounding provider to review efficacy of treatment. The Director of Nursing will conduct spot check audits to ensure compliance. The results of these audits will be presented to the QAPI committee at its	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 used the inhaler or how often. Furthermore, he could not recall how many times he used the inhaler today or yesterday. During an interview with licensed practical nurse (LPN-A) on 3/20/18 at 9:49 a.m., LPN-A stated she was aware that R25 used the inhaler, "It causes security for him." LPN-A stated he did not communicate to her every time he administered the inhaler to himself, and revealed that R25 did not use the inhaler every day. During a interview with the director of nursing (DON) on 3/20/18, at 9:54 a.m., the DON confirmed that there was not a assessment of R25's ability to self-administer medication. During interview on 3/20/18, at 11:53 a.m,. the DON stated that he had met with R25, who confirmed that he used the inhaler one to two times per day. The faciliyt policy document entitled, Self-Administered medications and treatments, revised 4/11, indicated: Self-administration of medications or treatments must be closely monitored and recorded in the medication administration record (MAR). All medications and treatments are kept with the resident or in a locked drawer in the resident's room. The nurse manager or team leader assesses resident competency to self-administer for one week, considering the resident's ability to receive information from the surrounding environment, capacity to remember information received, ability to make a decision and give a reason for it, ability to use relevant information in making decision, ability to appropriately assess relevant information.	2 830	quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 A decision to permit self-administration is made in the seven-day interdisciplinary care plan conference. Medications and treatments are delivered by the pharmacy and placed with the resident or in the resident's locked drawer in specially labeled containers. Noncompliant residents are informed by the nurse manager that they may not self- administer medications or treatments. Update resident care plan. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review and revise policies and procedures for assessment and monitoring when the resident chooses to administer his own medications. Nursing staff could be educated as necessary on the importance of ensure administration is accurate and the resident is monitored. The DON or designee, could audit the plan for completion on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the	21325		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 11 community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that dental services were provided for 1 of 1 resident (R2) reviewed for dental care. Findings include: When interviewed on 3/20/18, at 8:27 a.m. R2 indicated she did not have dentures but would like them. R2 stated she did not recall having been offered a dental appointment or the oppportunity to get dentures since her admission to the facility. R2 stated her gums were currently sore because she had recently eaten some Dorito chips. R2's current facesheet indicated admission to the facility on 9/12/11. R2's quarterly MDS dated 3/9/18, indicated her cognition was intact. R2's care plan dated 3/13/18, identifies R2's oral care approach as, "I am endentulous I do not wear dentures per my choice". R2's Physician's Order dated 6/17/15, indicated a regular diet without need for mech. (mechanical) separation. No record of dental services were located in R2's medical chart. Review of care conference meeting notes dated 9/21/17, 6/22/17 and 3/16/17, lacked any evidence that dental/oral needs had been discussed or reviewed. The INTERDISPLINARY CARE CONFERENCE AND QUARTERLY	21325	In this case we received conflicting information from the resident and their family regarding desire for dental services. It is our goal to always meet the needs and desires of our resident's. To provide the best possible care, we have taken the following steps. 1) We reviewed and revised our policy and procedure related to Routine/Emergency Dental Services. 2) We met with Resident 2 on 3/20/2018, and assistance was provided to setup a dental appointment at that time. Resident 2 identified wishes to be have a dental appointment to address need for dentures. 3) Nurse and Social Services Director conducting care conferences were educated to policy and procedure, documentation requirements, and need for in-depth discussion related to Resident's needs and wishes related to this item on 3/23/2018. 4) The Care Conference Communication Form was updated to include clearer documentation of discussions with Residents and family/POA/legal guardian regarding to Resident's needs and wishes related to this item. The Director of Nursing will conduct spot audits at care conferences to ensure compliance. The Director of Nursing report findings to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 12 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 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 offered dental services on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21325	the QAPI committee at its quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 13 (21) days	21325		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is	21530		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 14 the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to identify and make recommendations related to the lack of timely tardive dyskinesia (TD) screenings for 4 of 4 residents (R3,R20, R15 & R23) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R3's quarterly Minimum Data Set, dated 12/8/17, identified active diagnoses of depression and psychotic disorder. The MDS identified delusions and trouble sleeping as mood and behavior indicators exhibited during the look back period. R3's physician's orders, dated 3/21/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams twice daily for psychosis. The original start date of the order was 2/24/17. Review of R3's medical record revealed no TD screenings had been completed since 3/17. Review of R3's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. R20's significant change in status Minimum Data Set (MDS), dated 2/04/18 identified she was currently on an antipsychotic medication. The MDS identified no mood or behavior indicators,	21530	Due to a sale in our original pharmacy provider, we had three different pharmacy providers in four months. During that period, a couple of things were not completed in their entirety. To deliver the best possible patient care, we have taken the following steps. 1)DISCUS assessments were completed on all Residents with current physician orders for administration of psychotropic medications. 2)Reviewed and revised policy and procedure related to Psychotropic Initiation. 3) Reviewed policy and deficiency with pharmacy consultant on 3/22/2018. Plan of care placed in pharmacy consultant software to document and alert when next DISCUS assessment is due. Report is given to Director of Nursing after each monthly consultation visit. 4) Facility software setup to place alerts and provide documentation for completion when next DISCUS is due for each Resident having orders for administration of psychotropic medications. The Director of Nursing will conduct audits to ensure compliance. The results of these audits will be presented to the QAPI committee at is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 15 as well as current diagnoses of Alzheimer's disease and dementia. R20's care area assessment (CAA) for psychoactive medications, dated 2/9/18 identified R3 took antipsychotic medications, would wander the halls in her geri-chair and occasionally enter her peer's rooms, but was easily redirectable, and had short and long-term memory loss. R20's care plan, dated 1/18/18 identified she was short-tempered and irritable with others, with a sensitivity to loud noises. A consultant pharmacy drug regimen review report, dated 1/30/18 identified R20 was receiving scheduled haloperidol (an anti-psychotic) on a daily basis for a diagnosis of hospice and terminal delirium. Review of R20's medical record did not reveal any monitoring for symptoms of tardive dyskinesia had been completed for R3 since she began taking the antipsychotic medication. During interview on 3/21/18, at 2:11 p.m. registered nurse (RN)-A stated she was responsible to complete TD monitoring for residents on antipsychotics, however, there had been several changes of consultant pharmacist (CP) within the last year, and the CP usually alerted her if someone needed TD screenings completed, and verified R20's record lacked TD screening. RN-A stated TD screening should be completed every six months, and she would begin adding this to her calendar to track. During interview on 3/22/18, at 2:05 p.m. the CP stated TD monitoring should be completed every six months for residents on an antipsychotic,	21530	quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 16	21530		

however, she "hadn't gotten around to looking at assessments yet, I was trying to make sure the diagnoses were accurate and there were appropriate indications for use," and stated she was a new CP at the facility.

R23's quarterly Minimum Data Set (MDS), dated 2/16/18, identified active diagnoses of depression and dementia. The MDS did not identify mood or behavioral issues being exhibited during the look back period.

R23's psychiatrist orders, dated 2/21/18 included orders for Seroquel (an antipsychotic) 50 milligrams three times daily for psychosis. The original start date for the order was 7/7/16.

Review of R23's medical record revealed no tardive dyskinesia (TD) screenings had been completed since 8/13/17.

Review of R23's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility.

R15's quarterly MDS, dated 1/26/18, identified active diagnoses of insomnia, depression and dementia. The MDS identified trouble falling asleep, feeling tired, poor appetite or over eating and moving or speaking so slowly that people could have noticed being exhibited during the look back period.

R15's physician orders, dated 3/6/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams in the morning and 25 mg at bedtime for psychosis. The original start date for the Seroquel was 6/28/17 with a gradual dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 17 reduction being ordered on 3/6/18 at the dose noted. Review of R15's medical record revealed no TD screenings had been completed since 6/28/17. Review of R23's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. Review of the Psychotropic Initiation Checklist, undated, directed to complete a baseline screening for TD and every 6 months thereafter. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of ensure tardive dyskinesia assessments are completed timely for residents receiving antipsychotic medications. The DON or designee, along with the pharmacist, could audit medication and laboratory draw orders for completion on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the	21540		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 18 pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings for 4 of 4 residents (R3,R20, R23 & R15) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R3's quarterly Minimum Data Set, dated 12/8/17, identified active diagnoses of depression and psychotic disorder. The MDS identified delusions and trouble sleeping as mood and behavior indicators exhibited during the look back period. R3's physician's orders, dated 3/21/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams twice daily for psychosis. The original	21540	Due to a sale in our original pharmacy provider, we had three different pharmacy providers in four months. During that period, a couple of things were not completed in their entirety. To deliver the best possible patient care, we have taken the following steps. 1)DISCUS assessments were completed on all Residents with current physician orders for administration of psychotropic medications. 2)Reviewed and revised policy and procedure related to Psychotropic Initiation. 3) Reviewed policy and deficiency with pharmacy consultant on 3/22/2018. Plan of care placed in pharmacy consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 19 start date of the order was 2/24/17. Review of R3's medical record revealed no TD screenings had been completed since 3/17. R20's significant change in status Minimum Data Set (MDS), dated 2/04/18 identified she was currently on an antipsychotic medication. The MDS identified no mood or behavior indicators, as well as current diagnoses of Alzheimer's disease and dementia. R20's care area assessment (CAA) for psychoactive medications, dated 2/9/18 identified R3 took antipsychotic medications, would wander the halls in her geri-chair and occasionally enter her peer's rooms, but was easily redirectable, and had short and long-term memory loss. R20's care plan, dated 1/18/18 identified she was short-tempered and irritable with others, with a sensitivity to loud noises. A consultant pharmacy drug regimen review report, dated 1/30/18 identified R20 was receiving scheduled haloperidol (an anti-psychotic) on a daily basis for a diagnosis of hospice and terminal delirium. Review of R20's medical record did not reveal any monitoring for symptoms of tardive dyskinesia had been completed for R3 since she began taking the antipsychotic medication. During interview on 3/21/18, at 2:11 p.m. registered nurse (RN)-A stated she was responsible to complete TD monitoring for residents on antipsychotics, however, there had been several changes of consultant pharmacist	21540	software to document and alert when next DISCUS assessment is due. Report is given to Director of Nursing after each monthly consultation visit. 4) Facility software setup to place alerts and provide documentation for completion when next DISCUS is due for each Resident having orders for administration of psychotropic medications. The Director of Nursing will conduct audits to ensure compliance. The results of these audits will be presented to the QAPI committee at is quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 20	21540		

(CP) within the last year, and the CP usually alerted her if someone needed TD screenings completed, and verified R20's record lacked TD screening. RN-A stated TD screening should be completed every six months, and she would begin adding this to her calendar to track. RN-A verified R3 and R20's TD screenings had not been completed every six months.

During interview on 3/22/18, at 2:05 p.m. the CP stated TD monitoring should be completed every six months for residents on an antipsychotic, however, she "hadn't gotten around to looking at assessments yet, I was trying to make sure the diagnoses were accurate and there were appropriate indications for use," and stated she was a new CP at the facility. The CP further stated the facility would normally be responsible to track completion of TD screenings, rather than waiting for the CP's recommendation to identify the screenings were late.

R23's quarterly Minimum Data Set (MDS), dated 2/16/18, identified active diagnoses of depression and dementia. The MDS did not identify mood or behavioral issues being exhibited during the look back period.

R23's psychiatrist orders, dated 2/21/18 included orders for Seroquel (an antipsychotic) 50 milligrams three times daily for psychosis. The original start date for the order was 7/7/16.

Review of R23's medical record revealed no tardive dyskinesia (TD) screenings had been completed since 8/13/17.

R15's quarterly MDS, dated 1/26/18, identified active diagnoses of insomnia, depression and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 21 dementia. The MDS identified trouble falling asleep, feeling tired, poor appetite or over eating and moving or speaking so slowly that people could have noticed being exhibited during the look back period. R15's physician orders, dated 3/6/18 included orders for Seroquel (an antipsychotic) 12.5 milligrams in the morning and 25 mg at bedtime for psychosis. The original start date for the Seroquel was 6/28/17 with a gradual dose reduction being ordered on 3/6/18 at the dose noted. Review of R15's medical record revealed no TD screenings had been completed since 6/28/17. Review of the Psychotropic Initiation Checklist, undated, directed to complete a baseline screening for TD and every 6 months thereafter. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of ensure tardive dyskinesia assessments are completed timely for residents receiving antipsychotic medications. The DON or designee, along with the pharmacist, could audit medication and laboratory draw orders for completion on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21540		