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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 784E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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 **08/24/2018** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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 08/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/28/2018 (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
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245548
August 27, 2018

Tuff Memorial Home
Attn: Administrator
505 East 4th Street
Hills, MN 56138

Dear Administrator:

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 July 31, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 27, 2018

Tuff Memorial Home
Attn: Administrator
505 East 4th Street
Hills, MN 56138

RE: Project Number S5548027

Dear Administrator:

On July 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 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 August 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective July 31, 2018 and therefore remedies outlined in our letter to you dated July 9, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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: 784E

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Facility ID: 00576

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2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

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(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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 **06/28/2018** (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

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To (b) :

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___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
	50			
(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 07/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kami Fiske-Downing 09/06/2018 (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 :
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22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 9, 2018

Mrs. Eli Ripley, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: Project Number S5548027

Dear Mrs. Ripley:

On June 28, 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 attached 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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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 August 7, 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 August 7, 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 September 28, 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 December 28, 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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	245548	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/25/18 thru 6/28/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their policies and	E 026	Tuff Memorial Home has implemented a policy in regards if a state of emergency	7/17/18

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

Electronically Signed | 07/18/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 026	Continued From page 1 procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 43 residents currently residing in the facility. Findings include: On 6/27/18, at 2:40p.m. the emergency preparedness policies and procedure manual dated 7/2017, was reviewed with the administrator and the maintenance director. The administrator confirmed the lack of a policy and procedure which identified the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. Both indicated they were unaware of this requirement.	E 026	declared by the Secretary. Staff education will be provided at the next all staff in-service on this issue. Tuff Memorial Home will be in compliance on 7/17/2018. The Administrator will monitor compliance on this correction.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 039		7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 039	Continued From page 2 facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as	E 039		

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	245548	A. BUILDING _____ B. WING _____	06/28/2018

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E 039	Continued From page 3 needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conducted exercises to test their emergency plan at least annually, including participation in a full scale and table top exercise. This had the potential to affect all 43 clients currently residing in the facility. Findings include: During interview with the administrator and maintenance director on 6/27/18, at 2:40 p.m. confirmed the facility had developed a training plan for emergency procedures, but had not yet conducted any table top or full scale exercises.	E 039	Tuff Memorial Home will contact local fire dept., County Ambulance, and County Emergency Management to conduct an annual table top exercise. Tuff Memorial Home has contacted The County Emergency Management Administrator and left a message regarding the table top exercise. Once Tuff Memorial Home hears from him we will get a definitive date set for the exercise to be in compliance with the regulation. Tuff Memorial Home will be in compliance by 8/15/2018 The Administrator and Maintenance Supervisor will monitor compliance on this correction.	
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as you allegation of compliance upon the Department's acceptance. Becuase you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submissioni of the POC will be used as verification of compliance. Upon receipt of an acceptable electornic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verifications.	F 000		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		7/16/18

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F 689 SS=D	Continued From page 4 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess falls to determine possible causative factors in order to develop resident centered interventions to minimize the risk of further falls for 1 of 2 residents (R34) reviewed with a history of falls. Additionally, the facility failed to ensure provide an environment free of accident hazards for 3 of 3 residents (R8) (R34) amd (R37) with severe cognitive impairment who had Super Sani-Cloth germicidal disposable wipes left within reach. Findings include: R34's diagnosis taken from the Medical Diagnosis sheet updated on 1/4/18 included dementia, auditory hallucinations, corneal dystrophy, athrosclerotic heart disease, ostoeporosis, anciaty disorter, Type 2 diabetis, psychosis, and postural kyphosis. A Morse Fall Scale completed 5/29/18, revealed a that R34 was a high risk for falls. Review of the annual care area assessment	F 689	Tuff Memorial Home has removed sani-cloth germicidal disposable wipes from all resident rooms. Staff members will bring them in if they need to use them in the room but the supply will be kept outside of the room. Tuff Memorial Home does complete the morse fall scale on all residents to help identify risk of falls. In addition to this, Tuff Memorial Home will start a PIP team that will meet monthly to help come up with ideas and solutions to prevent residents falls and ensure safety. Tuff Memorial Home will also bring up falls at the daily stand-up meetings, if applicable. This will give an even more inter-disciplinary approach to fall analysis. Tuff Memorial home will be in Compliance on 7/31/2018. The Director of Nursing will monitor compliance with this correction.	

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F 689	Continued From page 5	F 689		

dated 3/15/18, revealed R34 had 4 falls since the last MDS assessment, and that she had unsteady balance requiring staff assist.

R34's care plan, last updated on 5/30/18, revealed R34 had severe cognitive impairment, and was extensive assist of one to completed cares. The care plan identified a high risk for falls related to gait and balance problems, safety needs, and vision and hearing problems. Intervientions included night light, raised edge mattress, appropriate footwear, fall mat alarm, bathroom door alarm, bedroom door open, for monitoring, gripper strips on floor, clear path, and anticipate needs.

Review of the progress notes from January 2018 to June 2018, indicated R34 had continued self transfering attempts when in her room.

Review of fall incident reports from January 2018 to August 2018, revealed the following falls without a causal analysis completed to determinine further interventions:

-5/1/18 found sitting on the floor, attempted to self transfer from the bed, wanting to go to the bathroom 4 am.

-4/8/18 at 11:45 p.m., found on floor in room, she was getting up to go to the bathroom. The fall was unwitnessed and heard by the recorder. Found sitting on the floor with her back facing the bed and only had her brief on. The floor mat was not attached at the time of the fall, aggitated and refused vitals and the mechanical lift. R34 was assisted to stand with 2 staff and ambulated to the bathroom with her walker, she was incontinent of stool.

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F 689	Continued From page 6 -3/20/18 at midnight, during a transfer R34 attempted to sit on the edge of the bed and slid down the mattress, sat on floor. The fall was unwitnessed, staff were in the room, turned away from her, and attaching the alarmed barrier on the bathroom door. Two staff assisted her to a standing position and with her waler assisted her to walk to the bathroom. -3/12 at 11:40 a.m., resident was on the toilet, R34 reached for shoe and slid to the floor. When staff went to check on her they witnessed the fall. The walker was between the staff and the resident and the staff were unable to reach her in time to prevent fall. -2/27/18 at 12:25 a.m., R34 observed sitting on floor at foot of bed holding onto foot board. Before staff could get Hoyer lift, resident scooted on bottom into the bathroom. 2 staff assisted her to stand , to toilet stool. Resident did make it to toilet in time-continent of bladder. Observe left elbow 1cm abrasion red area possibility of bruising. -1/21/18 12:15a.m., found resident on floor trying to go to the bathroom. -1/18/18 6:45a.m., heard resident's floor mat alarm sounding and resident hollering "Help me I slipped." Entered resident's room and found resident sitting on buttocks with back resting against bed frame towards head of bed. Resident agitated and looking for her medication. 2 staff assisted resident to recliner via hoyer lift. Resident physically and verbally abusive towards staff. During a interview with the director of nursing	F 689		

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F 689	Continued From page 7	F 689		

(DON) on 6/27/18 at 1:30 p.m. the DON reveaked that the facility does not have a interdisciplinary reveiw after each fall. The facility had recognized that the falls have increased, and the new admissions to the nursing home are having more frequent falls. The DON revealed that going forward she would like to develop a falls program for program improvement.

A policy was requested regarding falls, and assessment/analysis to prevent further falls. The DON revealed that the facility did not have a policy.

Sani-Wipes

R8's annual Minimum Data Set (MDS) dated 9/26/17 revealed R8 had a diagnosis of dementia, with moderate cognitive loss and required one assist with cares.

During a observation on 6/27/18 at 8 a.m., of cares for R8, a small 3 drawer chest stored in the resident bathroom, next to the sink, 3 feet high. On top of the chest was a container of Super-Sani Cloth germicidal disposable wipes. On 6/28/18 at 8:38 a.m., the container remained on the chest in the resident bathroom within reach of the R8.

R34's quarterly MDS dated 5/29/18, revealed that R34 had a diagnosis of dementia with severe cognitive loss and required one assist with cares.

R34's care plan last updated 5/30/18 revealed she was a high risk for falls secondary to impaired thinking, judgement and impulsive behavior.

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F 689	Continued From page 8 During a observation on 6/26/18 at 2:31 p.m., of cares for R34. a small 3 drawer chest was stored in the resident bathrrom, next to the sink. 3 feet high. On top of the chest was a container of Super Sani Cloth germicidal disposable wipes. The top of the cover had a 3 inch label that said to keep out of reach of children. R37's quarterly Minimum Data Set (MDS) dated 6/5/18, indicated R37 to have a BIMS (Brief Interview Mental Status) score of 5 indicating severe cognitive deficit. MDS further indicated R37 required extensive assistance for activities of daily living and had a catheter. Review of R37 care plan dated 6/13/18, indicated to monitor for safety, R37 takes medications that can cause increased impaired thinking/judgement for his behaviors, anxiety and depression. Review of R37's medical record indicated R37 had diagnosis of dementia with lewy bodies, dementia with behaviors, anxiety, depression and REM (Rapid eye movement) sleep behavior disorder. On 6/27/18, at 8:19 a.m., R37 was observed wheeling self independently out of the dining room. On 6/27/18, at 10:23 a.m., R37 was observed wheeling self independently in hallway next to his room. On 6/28/18, at 8:17 a.m., R37 was observed laying in his bed awake as R37 indicated he had a good breakfast and just laid down.	F 689		

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F 689	Continued From page 9 On 6/28/18, at 11:44 a.m., a container of Super Sani-Cloth germicidal disposable wipes were observed to be on bedside table next to R37 bed as he slept labeled "not for use on skin" During interview on 6/28/18, at 11:46 a.m., nursing assistant (NA)-C indicated the germicidal wipes are there to clean the floor if R37 catheter leaks. NA-C further indicated R37 had never reached for the germicidal wipes as far as NA-C knew of and indicated had only seen R37 take a glass of water from table in past. During interview on 6/28/18, at 11:54 a.m., director of nursing (DON) indicated there should not be any germicidal wipes in resident rooms. DON further verified that R37 is able to move independently once in wheelchair and indicated she would remove germicidal wipes immediately. Material Safety Data Sheet dated 11/30/09, for Super Sani-Cloth Germicidal Disposable Wipes was reviewed and indicated harmful if absorbed through skin. Material safety data sheet also indicated danger keep out of reach of children, not for use on skin, not a baby wipe, use on hard surfaces only.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		7/17/18

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F 755	Continued From page 10 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic diversion for 3 of 3 residents reviewed for medication pass (R21, R27 & R30) who received narcotic medications. Findings include: R21's admission record, dated 6/28/18, identified R21 had Parkinson's disease, dementia, anxiety disorder, and was under palliative (comfort) care. R21 received Diazepam (an anti-anxiety	F 755	Tuff Memorial Home will take away all of the keys from the nurses and the only people with the key to the narcotic box will be the Director of Nursing and Pharmacist Consultant. This will help prevent any tampering with the narcotics. Staff education was provided to appropriate staff that narcotics will be signed out at the time they were administered. Disciplinary action will be taken if recording of narcotics is not properly administered and recorded.	

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F 755	Continued From page 11 medication) 1 milligram (mg) three times per day. R27's admission record, dated 6/28/18, identified R27 had anxiety disorder, low back pain, arteriosclerotic heart disease, repeated falls, and gastro-esophageal reflux disease. R27 received oxycodone (a narcotic medication used to treat pain) 30 mg two times per day R30's admission record, dated 6/28/18, identified R30 had Alzheimer's disease, delusional disorders, anxiety, drug induced dyskinesia, and macular degeneration. R30 received Norco (a narcotic analgesic pain medication) 5/325 mg one tablet four times per day. During a tour of the medication room and observation of the narcotic monitoring systems on 6/28/18 at 9:58 a.m., the medication cart was reviewed with the registered nurse (RN-B). The cart was locked with a physical key, and the bottom drawer contained a permanently affixed lock box which contained narcotics and other controlled medications. A narcotic count was completed and found to be incorrect on 3 medication cards. RN-B stated staff were to sign out the medications in a narcotic control log when removed from the medication cart and confirmed that the medications were not signed out in the narcotic control log as they should have been during her medication pass. During a interview with RN-C on 6/28/18 at 10:12 a.m., the observation was reviewed and a policy regarding narcotic administration was requested. RN-C verified that it was her expectation that narcotics were signed out immediately in the narcotic book when they are removed from the narcotic medication double locked box.	F 755	When the narcotics are discontinued, the Director of Nursing will do a count with the charge nurse on duty before putting it into the narcotics box to ensure accuracy. The Director of Nursing and Pharmacist Consultant will do a final count and destruction of the narcotics once a month. Tuff Memorial Home will be in compliance by 7/17/18 The Director of Nursing will monitor compliance of this correction.	

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F 755	Continued From page 12 During a interview with the director of nursing (DON) on 6/28/18 at 10:29 a.m., the DON stated her expectation is that every narcotic medication was signed for immediately when removed from the double locked narcotic box. The DON stated, "I can't imagine why she [RN-B] wouldn't." Review the facility policy entitled Medication administration policy of the Tuff Memorial Home, revised 6/18/13 indicated: It is the policy of the Tuff Memorial home to have a set policy on the administration of medication to insure that each resident receives the right medication ordered for them in the right dose, route and time. Procedure; 5. Controlled drug record is the narcotic book for all class II and III, which records the prescription number expiration date, name, and dose and the count remaining. This book is kept with thee cart. Each trained med aide and or charge nurse will sign this record. Medication aides are able to pass controlled medications if they are properly trained to recognize side effects of controlled medications and will report any abnormalities to the charge nurse.	F 755		
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.	F 880		7/17/18

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F 880	Continued From page 13 §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; (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	F 880		

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F 880	Continued From page 14 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 develop and implement a program to reduce the risk of a Legionella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of pneumonia). This had the potential to affect all 43 residents who resided in the facility. Findings include: Review of the Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings from Centers for Disease Control and Prevention and Water System Flow Diagram dated 6/5/17, indicated there were no protocol for how the facility would monitor for Legionella or what corrective action would need to be taken. When interviewed on 6/27/18, at 11:43 a.m. the administrator stated the facility water	F 880	Tuff Memorial Home has contacted Ecolab in an effort to get the correct policy as well as material to be in compliance with state regulations. Nalco Water, who is an affiliate of Ecolab, is going to complete an assessment to get us the testing strips and other tools that Tuff Memorial Home will need to be in compliance with this regulation. Tuff Memorial Home will be in compliance by 7/27/2018. The Maintenance Supervisor will monitor compliance on this correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 management program is "work in progress". There was no policy related to Legionella provided during the survey.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2018**

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Tuff Memorial Home was found to be not 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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K 000	Continued From page 2 corridors which is monitored for automatic fire department notification. There are two-hour fire walls equipped with labeled 90-minute fire door assemblies, separating the buildings of Type II(111) construction from the additions of Type V(000) construction. The facility has a capacity of 48 beds and had a census of 43 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 919 SS=E	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 06/27/2018, several boxes were observed	K 919	Tuff Memorial Home has applied a marker 36" away from electrical panels. Along with this, there will be a sign to notify staff not to place anything within this boundary. Monthly checks will be done by the maintenance department to make sure no boxes or other items are within this boundary. Tuff Memorial Home is in compliance on 6/27/2018. The Maintenance Supervisor will monitor	7/11/18

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K 919	Continued From page 3 stored directly in front of electrical panels in the N4 Storage Room. 36" clearance needs to be maintained. This deficient practice was verified by the Facility Maintenance Director.	K 919	compliance with this correction.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 13, 2018

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5548027

Dear Administrator:

The above facility was surveyed on June 25, 2018 through June 28, 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
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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	00576	A. BUILDING: _____ B. WING _____	06/28/2018

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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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		

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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 6/25/18-6/28/18, 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. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 comprehensively reassess falls to determine possible causative factors in order to develop resident centered interventions to minimize the risk of further falls for 1 of 2 residents (R34) reviewed with a history of falls. Additionally, the facility failed to ensure provide an environment free of accident hazards for 3 of 3 residents (R8) (R34) amd (R37) with severe cognitive impairment who had Super Sani-Cloth germicidal disposable wipes left within reach.	2 830	Tuff Memorial Home has removed sani-cloth germicidal disposable wipes from all resident rooms. Staff members will bring them in if they need to use them in the room but the supply will be kept outside of the room. Tuff Memorial Home does complete the morse fall scale on all residents to help identify risk of falls. In addition to this, Tuff Memorial Home will start a PIP team that will meet monthly to help come up with ideas and solutions to prevent residents falls and ensure safety. Tuff Memorial	7/16/18

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2 830	Continued From page 3 Findings include: R34's diagnosis taken from the Medical Diagnosis sheet updated on 1/4/18 included dementia, auditory hallucinations, corneal dystrophy, athrosclerotic heart disease, ostoeporosis, anciaty disorter, Type 2 diabetis, psychosis, and postural kyphosis. A Morse Fall Scale completed 5/29/18, revealed a that R34 was a high risk for falls. Review of the annual care area assessment dated 3/15/18, revealed R34 had 4 falls since the last MDS assessment, and that she had unsteady balance requiring staff assist. R34's care plan, last updated on 5/30/18, revealed R34 had severe cognitive impairment, and was extensive assist of one to completed cares. The care plan identified a high risk for falls related to gait and balance problems, safety needs, and vision and hearing problems. Intervientions included night light, raised edge mattress, appropriate footwear, fall mat alarm, bathroom door alarm, bedroom door open, for monitoring, gripper strips on floor, clear path, and anticipate needs. Review of the progress notes from January 2018 to June 2018, indicated R34 had continued self transfering attempts when in her room. Review of fall incident reports from January 2018 to August 2018, revealed the following falls without a causal analysis completed to determinine further interventions: -5/1/18 found sitting on the floor, attempted to self transfer from the bed, wanting to go to the	2 830	Home will also bring up falls at the daily stand-up meetings, if applicable. This will give an even more inter-disciplinary approach to fall analysis. Tuff Memorial home will be in Compliance on 7/31/2018. The Director of Nursing will monitor compliance with this correction.	

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2 830	Continued From page 4 bathroom 4 am. -4/8/18 at 11:45 p.m., found on floor in room, she was getting up to go to the bathroom. The fall was unwitnessed and heard by the recorder. Found sitting on the floor with her back facing the bed and only had her brief on. The floor mat was not attached at the time of the fall, aggitated and refused vitals and the mechanical lift. R34 was assisted to stand with 2 staff and ambulated to the bathroom with her walker, she was incontinent of stool. -3/20/18 at midnight, during a transfer R34 attempted to sit on the edge of the bed and slid down the mattress, sat on floor. The fall was unwitnessed, staff were in the room, turned away from her, and attaching the alarmed barrier on the bathroom door. Two staff assisted her to a standing position and with her waler assisted her to walk to the bathroom. -3/12 at 11:40 a.m., resident was on the toilet, R34 reached for shoe and slid to the floor. When staff went to check on her they witnessed the fall. The walker was between the staff and the resident and the staff were unable to reach her in time to prevent fall. -2/27/18 at 12:25 a.m., R34 observed sitting on floor at foot of bed holding onto foot board. Before staff could get Hoyer lift, resident scooted on bottom into the bathroom. 2 staff assisted her to stand , to toilet stool. Resident did make it to toilet in time-continent of bladder. Observe left elbow 1cm abrasion red area possibility of bruising. -1/21/18 12:15a.m., found resident on floor trying to go to the bathroom.	2 830		

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2 830	Continued From page 5 -1/18/18 6:45a.m., heard resident's floor mat alarm sounding and resident hollering "Help me I slipped." Entered resident's room and found resident sitting on buttocks with back resting against bed frame towards head of bed. Resident agitated and looking for her medication. 2 staff assisted resident to recliner via hoyer lift. Resident physically and verbally abusive towards staff. During a interview with the director of nursing (DON) on 6/27/18 at 1:30 p.m. the DON reveaked that the facility does not have a interdisciplinary reveiw after each fall. The facility had recognized that the falls have increased, and the new admissions to the nursing home are having more frequent falls. The DON revealed that going forward she would like to develop a falls program for program improvement. A policy was requested regarding falls, and assessment/analysis to prevent further falls. The DON revealed that the facility did not have a policy. Sani-Wipes R8's annual Minimum Data Set (MDS) dated 9/26/17 revealed R8 had a diagnosis of dementia, with moderate cognitive loss and required one assist with cares. During a observation on 6/27/18 at 8 a.m., of cares for R8, a small 3 drawer chest stored in the resident bathroom, next to the sink, 3 feet high. On top of the chest was a container of Super-Sani Cloth germicidal disposable wipes. On 6/28/18 at 8:38 a.m., the container remained on the chest in the resident bathroom within reach of the R8.	2 830		

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2 830	Continued From page 6 R34's quarterly MDS dated 5/29/18, revealed that R34 had a diagnosis of dementia with severe cognitive loss and required one assist with cares. R34's care plan last updated 5/30/18 revealed she was a high risk for falls secondary to impaired thinking, judgement and impulsive behavior. During a observation on 6/26/18 at 2:31 p.m., of cares for R34. a small 3 drawer chest was stored in the resident bathrrom, next to the sink. 3 feet high. On top of the chest was a container of Super Sani Cloth germicidal disposable wipes. The top of the cover had a 3 inch label that said to keep out of reach of children. R37's quarterly Minimum Data Set (MDS) dated 6/5/18, indicated R37 to have a BIMS (Brief Interview Mental Status) score of 5 indicating severe cognitive deficit. MDS further indicated R37 required extensive assistance for activities of daily living and had a catheter. Review of R37 care plan dated 6/13/18, indicated to monitor for safety, R37 takes medications that can cause increased impaired thinking/judgement for his behaviors, anxiety and depression. Review of R37's medical record indicated R37 had diagnosis of dementia with lewy bodies, dementia with behaviors, anxiety, depression and REM (Rapid eye movement) sleep behavior disorder. On 6/27/18, at 8:19 a.m., R37 was observed wheeling self independently out of the dining room.	2 830		

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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2 830	Continued From page 7 On 6/27/18, at 10:23 a.m., R37 was observed wheeling self independently in hallway next to his room. On 6/28/18, at 8:17 a.m., R37 was observed laying in his bed awake as R37 indicated he had a good breakfast and just laid down. On 6/28/18, at 11:44 a.m., a container of Super Sani-Cloth germicidal disposable wipes were observed to be on bedside table next to R37 bed as he slept labeled "not for use on skin" During interview on 6/28/18, at 11:46 a.m., nursing assistant (NA)-C indicated the germicidal wipes are there to clean the floor if R37 catheter leaks. NA-C further indicated R37 had never reached for the germicidal wipes as far as NA-C knew of and indicated had only seen R37 take a glass of water from table in past. During interview on 6/28/18, at 11:54 a.m., director of nursing (DON) indicated there should not be any germicidal wipes in resident rooms. DON further verified that R37 is able to move independently once in wheelchair and indicated she would remove germicidal wipes immediately. Material Safety Data Sheet dated 11/30/09, for Super Sani-Cloth Germicidal Disposable Wipes was reviewed and indicated harmful if absorbed through skin. Material safety data sheet also indicated danger keep out of reach of children, not for use on skin, not a baby wipe, use on hard surfaces only. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	06/28/2018

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2 830	Continued From page 8 procedures to ensure all residents have a fall analysis and implementation of a plan to prevent the resident from falling. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. .	2 830		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hot water temperatures did not exceed 115 degrees Farenheit at the tap in 4 of 4 resident rooms (W31, W35, E26 & E16) observed for physical environment. Findings include: On 6/25/18, at 6:30 p.m., the bathroom water	21710	Tuff Memorial Home is in the process of getting quotes a mixing valve for the water heater to ensure water temperatures are within regulations. This will mix cold water with the hot water to help control the water temperature going out to resident rooms. Tuff Memorial Home has received a quote from Comfort zones and is waiting on one from DRG before purchasing one.	7/17/18

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21710	Continued From page 9 temperature in room W31 was observed to be 118.6 degrees Fahrenheit. On 6/25/18, at 6:36 p.m., the bathroom water temperature in room W35 was observed to be 118 degrees Fahrenheit. On 6/25/18, at 6:40 p.m., the bathroom water temperature in room E26 was observed to be 116.8 degrees Fahrenheit. On 6/25/18, at 7:19 p.m., the bathroom water temperature in room E16 was observed to be 117.7 degrees Fahrenheit. On 6/28/18, at 10:11 a.m., a tour was completed with the maintenance supervisor who tested the bathroom water temperature in room E16 which was observed to be 117.2 degrees Fahrenheit, room E26 was observed to be 117.7 degrees Fahrenheit, room W35 was observed to be 118 degrees Fahrenheit, and room W31 was observed to be 117.8 degrees Fahrenheit. During interview on 6/27/18, at 1:10 p.m., maintenance supervisor indicated he checks random bathroom temperatures once a week however, keeps no records of these temperatures. The maintenance supervisor further indicated facility installed a new water heater about a month ago and the lowest the temperature it was able to be set was 120 degrees Fahrenheit. The facility policy entitled Preventative Maintenance, undated, indicated there would be weekly water temperature checks for a) rooms 105-115 degrees Fahrenheit b) laundry 140 degrees Fahrenheit and c) dishwasher 160-180 degrees Fahrenheit.	21710	Tuff Memorial Home will be in compliance by 8/15/2018. The Maintenance Supervisor will monitor compliance with this correction.	

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21710	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The facility maintenance supervisor or designee could audit hot water temperatures in resident bathrooms to ensure they are at or below 115 degrees Farenheit periodically, and revise facility policies and procedures for monitoring hot water temperatures. The maintenance supervisor or designee would educate all affected staff on the changes to policy and procedure, and forward results of audits to the quality assurance committee for follow up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		