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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7F27

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245491**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **08/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 10/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(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
08/12/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5491

Augustana Mercy Care Center was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on July 2, 2015 and the Federal Monitoring Survey (FMS) completed on July 16, 2015. On August 11, 2015, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on October 7, 2015, the Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the August 11, 2015 standard survey and the July 16, 2015 FMS, effective August 14, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V office the following action related to the remedy imposed in CMS letter of July 30, 2015.

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions(DPNA), effective October 2, 2015, be rescinded.

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP, beginning October 2, 2015

Refer to the CMS-2567b for both health and life safety code FMS.

Effective August 14, 2015, the facility is certified for 72 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245491

October 13, 2015

Mr. Steven Mork, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, Minnesota 55767

Dear Mr. Mork:

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 August 14, 2015 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 13, 2015

Mr. Steven Mork, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, Minnesota 55767

RE: Project Number S5491024, F5491025

Dear Mr. Mork:

On July 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 2, 2015. 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 July 16, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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 July 30, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, October 2, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of July 30, 2105, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

On August 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 7, 2015 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 July 2, 2015 and a Federal Monitoring Survey (FMS) completed on July 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015 and FMS completed July 16, 2105, effective August 14, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of July 30, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, October 2, 2015 be rescinded (42 CFR 488.417(b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In the CMS letter of July 30, 2015, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 14, 2105, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245491	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	**08/07/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**08/01/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**08/01/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**08/01/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	10/13/2015	28035	08/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/2/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245491	A. Building B. Wing **01 - MAIN BUILDING 01**	10/7/2015

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/07/2015**	ID Prefix	Correction Completed **08/03/2015**	ID Prefix	Correction Completed **08/07/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0022		Reg. # **NFPA 101** LSC K0025	
ID Prefix	Correction Completed **08/07/2015**	ID Prefix	Correction Completed **07/16/2015**	ID Prefix	Correction Completed **08/07/2015**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **07/16/2015**	ID Prefix	Correction Completed **08/14/2015**	ID Prefix	Correction Completed **08/05/2015**
Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0143	
ID Prefix	Correction Completed **07/30/2015**	ID Prefix	Correction Completed **08/14/2015**	ID Prefix	Correction Completed **08/14/2015**
Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147		Reg. # **NFPA 101** LSC K0154	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/13/2015	245491	10/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/16/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7F27

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245491**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **07/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(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 :
Cynthia Stramel, HFE NEII 08/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/11/2015 (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
07/01/1987
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1751

July 16, 2015

Mr. Steven Mork, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, Minnesota 55767

RE: Project Number S5491024

Dear Mr. Mork:

On July 2, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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 a "F" tag), i.e., the plan of correction should be directed to:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

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 11, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 11, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

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

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility social worker failed to provide medically related social services for 1 of 1 discharged residents (R93) who was dealing with mental health issues, family complications, and financial stresses. Findings include: R93's quarterly Minimum data set (MDS) dated 1/29/15, indicated the resident had no cognitive	F 250	Augustana Mercy works to provide medically-related social services to help residents maintain the highest practicable physical, mental, and psychosocial well being of each resident. Augustana Care does work to assist residents with Medical Assistance applications and provides that assistance both locally and through our corporate office staff in Minneapolis. This work is	8/7/15

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

Electronically Signed | 07/23/2015

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F 250	Continued From page 1 impairment, required extensive assistance with all activities of daily living (ADLs), and had feelings of feeling down and hopeless, and had little interest in doing things. During interview on 7/1/15, at 12:41 p.m., Social Services (SS)-A stated R93 was in a Medicaid, or medical assistance (MA) pending status, she had recently moved to the state and into the home of one of her daughters, and her husband had been in the hospital. SS-A stated she thinks the MA process was started in the hospital, but when she spoke to R93's daughter about it, SS-A was told the family was using an agency to help with the paperwork, however, SS-A was not able to provide the name or phone number of the agency assisting R93's family with the MA paperwork. SS-A stated MA paperwork was not, "her expertise" and she would call the facility's corporate office in Minneapolis to work with families or call the county to assist with MA paperwork if a resident needed assistance. SS-A stated R93 and her husband were considering divorce in order to make qualifying for MA easier, and family dynamics were difficult. SS-A stated she did not assist the resident or her family with the medical assistance application process, nor did the SS-A remember any specific work she had done on behalf of R93 dealing with the financial and emotional changes she was going through. During interview on 7/1/15, at 1:00 p.m. with the facility's director of nursing (DON), administrator, and corporate consultant, the administrator stated a county social worker assisted R93 with the medical assistance paperwork. The facility had corporate accounts receivable staff communicating with R93's husband, and family	F 250	coordinated with county staff. Since the example noted was done on a closed chart all improvement efforts were directed towards current residents in need of psychosocial and medical assistance as identified by the IDT. All residents identified by IDT will be assessed for needed medically-related social services to assist in maintaining the highest practicable physical, mental, and psychosocial well being. AMHCC has educated its Social Worker on the needs and requirements to assure that residents are provided medically-related social services to assist residents to maintain the highest practicable physical, mental, and psychosocial well being. On going an audit of 10 charts will be done monthly by the consulting Social Services leader in Augustana Care. The findings in these audits will be shared with the administrator and the licensed social service worker at the care center to assure that all social service needs are being delivered. The results of these audits and follow-up work will be shared with the Quality Assurance Performance Improvement Committee until it is determined that the needed medically needed social services are being delivered appropriately. The administrator will monitor.	

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F 250	Continued From page 2 told the facility they had applied for medical assistance, however, the administrator stated there was not much the facility felt they could assist R93 with due to the complicated family and financial situations. During a telephone interview on 7/2/15, at 12:37 p.m., County Social Worker (CSW)-A stated a vulnerable adult report had been received as R93 was fearful of eviction from the facility. According to CSW-A, R93's family was unable to assist with the medical assistance application due to personal concerns that each were struggling with, complications due to an out-of-state property, and the family's inability to understand that R93's social security income was to go directly to the facility. According to CSW-A, the facility administrator and DON had previously expressed to her that it was not the job of the facility social worker to assist with MA applications. CSW-A stated that he met with R93 before her discharge from the facility and she was, "Terrified of being kicked out." During the course of R93's admission there were 4 social service notes, dated 11/12/14, 1/23/15, 1/26/15, and 4/9/15, however, none of them were related to assistance with the medical assistance application, supporting R93 with her diagnoses, husband's health, or other family complexities.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		8/1/15

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F 309	Continued From page 3 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess, monitor, and provide ongoing pain management for 1 of 3 residents (R109) reviewed for pain. Findings include: R109 admission Minimum Data Set (MDS) dated 5/3/15, indicated R109 had a BIMS (brief interview for mental status) score of 12, which indicated the resident was cognitively intact, had diagnoses including chronic pain, post-traumatic stress disorder, depression, traumatic brain injury, and the resident was identified as having pain within the previous 5 days of the assessment. During interview on 6/30/15, at 10:17 a.m. R109 stated he had chronic pain to the back and chest area, and the pain would sometimes radiate from his back to the front left side. R109 stated he was currently having pain, but was unable to rate the pain, stating at times it gets, "Pretty bad." R109's Physician order dated 5/3/15, indicated acetaminophen 650 milligrams (mg) every 4 hours as needed for pain. During observation on 7/1/15, at 12:52 p.m., R109 was observed in his room eating lunch. He stated he was having pain, and when asked if he needed a nurse he stated, "Nobody here gives a shit if I hurt, or if I'm short of breath, or if I want to	F 309	It is the policy of Augustana Mercy Health Care Center to identify and treat pain in all of our residents. Per facility policy nursing staff monitor for pain during cares and complete formal assessments on admission, quarterly and with significant change. During the survey process the facility was never asked to provide our policy on pain management. Resident R109 was interviewed during survey and reported pain to his left side to the DON, resident was unable to rate pain on a pain scale but reported pain as medium. Following his reports of pain he was offered an ice pack per facility standing orders which he declined. He was then offered Tylenol which he took and reported relief from. Upon interview with NAR who was caring for the resident she reported that the resident had no complaints of pain that morning. Upon review of medical record it was noted that the resident had been on qshift pain monitoring and had only reported pain two times at a level of 4 &5 over the past month. The facility NP was updated regarding his complaints of pain and was noted to order a CT scan of his abdomen. Results indicated some Colitis but no evidence of perforation. As follow up to the CT scan the resident was seen by a colorectal surgeon. No new orders were obtained from this visit and the surgeon	

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F 309	Continued From page 4 see a doctor." During a follow up interview on 7/2/15, at 10:10 a.m. R109 was seated on his bed and stated he was not having any pain at that time, but if he were to bend over and put his shoes on, the pain would start again. R109's Nursing progress note dated 5/1/15, indicated the residents initial pain assessment identified chronic pain rated 8 out of 10, which got increasingly worse the past several years. The writer indicated she would ask the nurse practioner (NP) to schedule a pain medication. R109 care plan dated 5/15/15, indicated the resident had alteration in comfort related to fibrometosis, chronic pain, epilepsy, and convulsions. The interventions included observe for symptoms of pain, grimacing, anxiety, moaning and decreased function. The care plan instructed to medicate with analgesics and observe for medication effectiveness, to notify the physician if the pain medication was not effective, and the resident does not always verbalize pain as it occurs. A Physician Visit form signed on 5/5/15, by registered nurse (RN)-C, and signed on 6/4/15 , by the practioner indicated the resident and power of attorney (POA) expressed concerns related to chronic pain to the neck and lower back, and a scheduled pain medication was requested. A fax communication form dated 5/7/15, to the physician indicated the resident was complaining of pain to the left side of his chest and torso and rated the pain 8 out of 10. The resident stated	F 309	stated that the resident had resolving colitis and c-difficile infection which would cause cramping to his abdomen at times. Upon review of his medical record the resident is noted to take Naproxen BID during interview the resident reported that this was effective in managing his back pain which he had had for many years. The resident is noted to have a dx of TBI which includes short term memory impairment; this makes it difficult for him to accurately report pain and to remember treatments and or tests that have been completed in the past. Nursing staff will continue to monitor the pain of R109 every shift and complete pain interviews per policy and procedure, all reports of un-relieved pain will be forwarded to the resident¿s medical care provider. All nursing staff have been educated on reporting all resident complaints of pain, offering pain relieving interventions and updating the physician or nurse practitioner as needed. In addition to address that this may occur in other residents all facility LN staff will be educated on use of the PAINAD scale as a way to assess for pain in residents with dementia or other conditions which make it difficult for a resident to accurately report pain. LN staff will also complete a baseline pain interview on all residents by 7/30/15 to ensure that no residents are experiencing un-reported or un-treated pain. The RN staff will then complete random pain interviews of ten residents per week x4 weeks, ten residents per month x2months, results of the random audits will be reviewed by facility Quality	

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F 309	Continued From page 5 the pain had been occurring 4 or 5 days, but staff had not been aware of it. Tylenol had been given, but was not effective. An order was received at that time for Ibuprofen, 600 mg three times a day as needed. A nursing progress note dated 5/11/15, indicated the residents pain concerns had been discussed the the power of attorney (POA). The POA indicated the resident did not want to discuss pain with anyone but a doctor, and the note indicated, "The writer assured (POA) that pain would be addressed with MD or NP tomorrow." The note indicated R109's Pain had been observed and was radiating to the front of the torso, and continued to ache. A physician order dated 5/14/15, was to discontinue Ibuprofen, and a new order was received for Naproxen 500 mg twice daily. R109 physician Admission History and Physical dated 6/4/15, indicated the resident was reporting "...Some left sided abdominal pain intermittent for several days." The assessment noted, "Mild tenderness in his left lower quadrant without rebound or guarding." Review of the resident medication treatment record (MAR) for June 2015, indicated R109 received as needed acetaminophen for pain three times in the month on 6/4, 6/19, and 6/25. The 14-day treatment record indicated the resident was having "0" pain during all shifts during the 14 period, including 6/19, and 6/24. During a telephone interview on 7/2/15 at 9:30 a.m., POA stated the resident had chronic back pain for years, but the pain seemed to be	F 309	assurance performance improvement committee. The DON will monitor for compliance. All corrections will be made by 7/30/15.	

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F 309	Continued From page 6 changing, and was moving to the front of his body. POA stated R109 was not able to get comfortable, and the POA had discussed with staff that the resident did not like to complain. POA stated she called RN-C two times last week related to the residents complaints of pain and shortness of breath. There was no documentation in R109's nursing progress notes related to the phone call from the POA regarding the concerns of R109's pain management. During interview on 7/2/15, at 10:30 a.m. RN-C pm stated she did not recall speaking to R109's POA during the previous week, and stated the physician had ordered labs on 6/4/15, however, there had been no follow up orders related to the results or a change in pain management medication for R109. During interview on 7/2/15, at 10:33 a.m. the director of nursing (DON), RN-C, and surveyor entered R109's room. The resident stated he was having "medium pain" from his left side radiating to the front of his chest. The DON asked R109 if he was receiving relief from the current pain medications, and R109 stated he was not aware he was receiving any pain medications. The DON stated she would ask the NP to visit R109 today to review the pain management which was in place for R109. Although R109 and POA had notified staff of the unrelieved pain the resident was having, the facility did not monitor or follow up to ensure the pain regimen was effective for the resident. A policy for pain management was requested but not provided.	F 309		

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F 371	Continued From page 7	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure food preparation equipment was properly cleaned to prevent potential food-borne illness for 66 of 68 residents who received food from the facility kitchen. Findings include: During a tour of the kitchen on 6/29/15, at 12:45 p.m. with the dietary supervisor (DS), the heavy duty blender was found to have an accumulation of a yellowish creamy colored food debris under the blade. The DS verified there was food debris under the blade and it had been cleaned, was stored, and was ready for use. The meat slicer was observed to have easily removable greasy debris on the meat table and the edge guide, and there was also debris on the meat table that was not easily removable. DS stated the debris was removable and the meat slicer had been cleaned, was stored, and was ready for use. The DS stated the blender and meat slicer are both	F 371	Augustana Mercy contracts with Mercy Hospital to assure that all food services are delivered in a safe and sanitary manner. A copy of the Health Department F-371 deficiency was posted for all staff to review on 7/21/15. All staff were required to read and sign off on the posting by 8/1/15. The proper procedures for cleaning both the blender and the meat slicer were posted for all staff to review on 7/21/15. All staff were required to read and sign off on the posted education by 8/1/15. An in-service on proper cleaning of kitchen equipment will be conducted at the next monthly Dietary dept meeting. Change in Procedures: Before using the blender or the meat slicer the dietary aide will inspect the equipment visually to assure that the equipment has been cleaned. The aide will date and initial on a flow sheet that they have inspected the equipment before use. After use and after cleaning and sanitizing, the dietary	8/1/15

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F 371	Continued From page 8 cleaned after each use, and stated staff needed to clean them better to prevent potential food bourne illness. During a follow up tour of the kitchen on 7/1/15, at 1:45 p.m., the blender and the meat slicer were found to be clean and free of debris. The kitchen cleaning schedule was requested and was not provided. The facility policy and procedure titled Food Preparation/Sanitation dated 1/27/12, directed all food grinders, choppers, mixers, meat slicer's, are to be cleaned, sanitized, air dried, and reassembled after each use.	F 371	aide will record time of cleaning and initial that they have cleaned the equipment. The kitchen manager (CDM) is responsible for daily monitoring of compliance with equipment cleaning practices and techniques. Daily, the CDM will physically inspect the meat slicer and blender and document on a flow sheet posted by the slicer and the blender that the equipment has been inspected and meets cleanliness standards. The slicer and the blender will be disassembled in the inspection process to make sure no hidden food items or grease remains. If any piece of equipment is found to be out of compliance, the equipment will be pulled out of service until it can be properly cleaned. The CDM will identify the last person to clean that equipment and will re-coach that individual on the proper cleaning of the equipment. The kitchen manager will conduct monthly audits of all kitchen equipment to assure that compliance with sanitation standards continues. Results of each audit will be posted in the Dietary Department as well as discussed at each monthly department meeting. Audits will be completed and results provided at QAPI meetings until such time that the committee determines that the regulation has been met and acceptable outcomes sustained. The Dietary Manager will monitor for compliance first monthly audit before August 1, 2015	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		8/1/15

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F 431	Continued From page 9 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper temperature control in 1 of 2 medication storage	F 431	It is the policy of Augustana Mercy Health Care Center to store all medications as recommended by the manufacturer to	

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AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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F 431	Continued From page 10 refrigerators. This had the potential to effect 68 of 68 residents who resided in the facility, as well as any new admits. Findings include: During observation of the facility's medication storage areas with registered nurse (RN)-B on 7/1/15, at approximately 2:30 p.m., the West nursing station medication refrigerator was noted to have medication containers frozen onto the tray on which they stood. The bottom of the tray was filled with a thin sheet of ice, approximately 1/4" thick. RN-B stated the thermometer in the West medication refrigerator currently read 34-35 degrees Fahrenheit, and she stated she would inform maintenance and the Director of Nursing with the information of the medication containers frozen to the tray. The medications that were in the West refrigerator at this time were: Resident/Medication/Recommended storage/source of information R65- Cimzia: 36-46 degress noted on the container. R51- Lantus: 36-46 degress/ do not freeze noted on container. R36- Lantus: 2 both opened / do not freeze noted on container. R17, R5, and R56- Lantus: 36-46 / do not freeze noted on container. R3- Novolog Injection: (3) opened: Store NovoLog® in the refrigerator between 36°F and 46°F (2°C and 8°C) until first use, Do not freeze according to manufacturer's recommendation. R73- Liraglutide: Open / Refrigerate, do not freeze noted on container.	F 431	ensure safety of all prescribed medications administered to residents. On 7/1/15 when it was found that the medication fridge was at the incorrect temperature all medications in the fridge were disposed of and re-ordered from the pharmacy. None of the affected medications were administered to residents. The facility had an electrical outage that day and it is speculated that this event caused a fluctuation in temps within the refrigerator. The refrigerator was taken out of service and monitored x3 days. It was found that the temperature was stable over that time period and the refrigerator was put back into use. Facility policy and procedure was updated to include monitoring of temperatures on the medication fridge twice per day for one month to ensure temperatures are within recommended ranges for storage of medications. All licensed nursing staff were educated on the updated policy and procedure. The RCC's will complete random audits of the medication refrigerators weekly x4 weeks and monthly x2 months with the results to be reviewed by the facility Quality assurance performance improvement committee. The DON will monitor for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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F 431	Continued From page 11 R89- Latanoprost Opthalmic: Unopened: Store in fridge (36-46) according to Merwin LTC Pharmacy. R14- Ketorolac: Store at room temperature away from moisture and heat according to manufacturer's recommendations. R42- Novolog solution / Store NovoLog® in the refrigerator-between 36°F and 46°F (2°C and 8°C)-until first use. Do not freeze according to manufacturer ' s recommendation R67- Clindamycin 90 mg, IV: Store at room temperature away from moisture and heat. Protect the injectable medicine from high heat according to container instructions. For facility use: E-Kit / Novolin R: Store new (unopened) vials in the refrigerator, between 36 and 46 degrees F (2 and 8 degrees C). Do not freeze. Do not use Novolin R if it has been frozen according to manufacturer's recommendation Mantoux tests (2) stock Influenza vaccines: 3 boxes with 5 in each. During interview on 7/2/15 at approximately 10:00 p.m. the Director of Nursing (DON) stated the facility policy indicated the medication refrigerators should be within a 36-46 degree temperature range, however, the facility temperature recording sheet directs staff the refrigerator should be between 33-46 degrees Fahrenheit. The DON stated she would re-order all medications that were stored in the refrigerator in case they were compromised. All temperatures recorded for the month of May 2015, and June 2015, were all recorded as "40".	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/02/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	**710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767**

(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	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Augustana Mercy Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Augustana Mercy Care Center is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building.

The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity 72 beds and had a census of 70 at the time of the survey.

At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.

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.