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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8EJI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**
2.STATE VENDOR OR MEDICAID NO.
(L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL- MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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 **11/17/2014** (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)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(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 :
Kathryn Serie, Unit Supervisor 11/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/18/2014 (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
11/01/1991
(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
11/12/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245594

November 18, 2014

Ms. Terrie Frank, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

Dear Ms. Frank:

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 October 30, 2014 the above facility is certified for or recommended for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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, Program Specialist
Licensing and Certification Program

Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 18, 2014

Ms. Terrie Frank, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

RE: Project Number S5594025

Dear Ms. Frank:

On October 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 3, 2014. 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 November 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 30, 2014 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 October 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 3, 2014, effective October 30, 2014 and therefore remedies outlined in our letter to you dated October 15, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fike-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245594	A. Building B. Wing	11/17/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/30/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/30/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/30/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/30/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/30/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	11/18/2014	03048	11/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/3/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245594	01 - MAIN BUILDING 01	10/30/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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 Reg. # NFPA 101 LSC K0062	10/30/2014	ID Prefix Reg. # NFPA 101 LSC K0144	10/30/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	11/18/2014	34764	10/30/2014
CMS RO				

Followup to Survey Completed on: 10/1/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8EJI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**
2.STATE VENDOR OR MEDICAID NO.
(L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL- MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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 **10/03/2014** (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)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(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 :
Jodi Johnson, HFE NE II 10/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/10/2014 (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
11/01/1991
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0042

October 15, 2014

Ms. Terrie Frank, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5594025

Dear Ms. Frank:

The above facility was surveyed on September 29, 2014 through October 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Office: (507) 476-4233
Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	See attached Plan of Correction approved KMS 10/27/14 RECEIVED OCT 27 2014 Minnesota Department of Health Marshall	10/30/14

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

Terrie Frank Terrie Frank Administrator 10/22/2014

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
	245594	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 279	Continued From page 1 by: Based on observation, interview and document review the facility failed to develop a plan of care for 1 of 1 resident (R 23) reviewed who had an ongoing skin rash located on the chest area. Findings include: On 9/29/14, at 7:50 p.m., during the initial interview, R23 stated he had a rash on his chest (below breast areas) and subsequently, lifted his shirt to display a reddened, scaly area which extended across his chest. There were visible reddened marks across the chest area and R23 stated he had been scratching the area as it "itched" but it did not "hurt". R23 also indicated that staff applied topical cream to the area. R23's care plan, with a revision date of 7/23/2014, identified R23 at low risk for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to immobility, oxygen tubing; fatigue and urinary incontinence. The care plan lacked reference to non-pressure related skin issues including rashes or interventions to manage them. Document review revealed a medical doctor (MD) notification dated 9/17/14, which identified R23 with the following: "red and raw [area] underneath bilateral breasts" and nursing interventions which had been attempted (Nystatin and gold bond powder). Upon notification, the MD responded with an order dated 9/17/14, for Silvadine cream two times daily (BID). Review of the September 2014 treatment record identified the physician ordered Silvadene cream to apply under bilateral breasts BID until healed had been initiated on 9/18/14. Documentation related to	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 279	Continued From page 2 this skin condition was not evident in the medical record nor was there evidence the skin condition had been monitored.. During an interview on 10/02/2014, at 12:15 P.M. registered nurse (RN)- A, verified the chest skin rash was intially identified on 9/17/14 and the physician was notified with a request for an evaluation of the skin condition. RN-A further verified that R23, "had ongoing skin issues on various areas of his body since he was admitted". RN-A confirmed the care plan lacked any identification of this ongoing skin issue nor were any treatment records available that identified the area had been monitored. On 10/2/14, at 2:20 p.m. the director of nursing (DON), was interviewed and stated she would expect the skin condition to be identified as part of the care plan, especially since the resident had received ongoing treatments.. Facility procedure titled: Weekly Wound Documentation Progress Sheet was reviewed and the following was noted: Bullet #1-To be completed on any skin concern that is not a pressure ulcer, arterial wound, venous wo und, or neuropathic wound; Bullet #7-To be completed upon discovery of a skin condition and then at least weekly thereafter; and Bullet#8- Once the area is healed, the other skin conditions form is to be filed into resident medical record.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	See attached Plan of correction	10/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 309	Continued From page 3 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 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify, investigate, and/or monitor 2 of 3 residents (R12 & R23) reviewed for non-pressure related skin issues which included bruising and a skin rash. Findings include: During an observation/interview on 9/30/14, at 1:17 p.m. R12 was observed with a quarter size purple bruise on the top aspect of her right wrist. R12 stated she did not know how the bruise was obtained and further stated that staff had also questioned her about it. Review of the significant change minimum data set (MDS) assessment dated 8/15/14 revealed a brief interview for mental status (BIMS) score of 13 indicating R12 as cognitively intact. The assessment further indicated R12 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. When interviewed on 10/2/2014, at 3:30 p.m. registered nurse (RN)-A stated that when a bruise is identified on a resident it is investigated, measured, and monitored until healed. Documentation related to the bruise is recorded on the treatment record. RN-A further stated that	F 309		

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	245594	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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F 309	Continued From page 4 skin is visualized weekly on bath day by the nursing assistant who assisted with bathing and also by the licensed nurse. R12's treatment record was reviewed and did not include monitoring of any known bruises; and this was confirmed by RN-A. RN-A and RN-B confirmed that R12 had a bath earlier on 10/2/14. RN-B further confirmed that she had performed R12's skin assessment and no bruising had been identified. RN-A confirmed the presence of a quarter size bruise to the top aspect of R12's right wrist. RN-A further confirmed this bruise should have been identified, investigated, and monitored until healed with documented evidence in the treatment book. RN-B then entered R12's room, observed the bruise to the resident's right wrist, and confirmed she had not identified the bruise when completing R12 skin assessment earlier in the day. RN-B questioned R12 whether she knew how long she'd had the bruise. R12 responded, "for awhile". R12 further indicated the bruise looked good now as it had been much worse, as evidenced by a darker purple color and a swollen appearance. RN-B confirmed that R12's bruise should have been identified, investigated and monitored until healed with documented evidence in the treatment record. No further documentation was available to review related to the identified bruise. After staff were alerted to the observable bruise, a Witnessed or Unwitnessed Injury Incident Report dated 10/2/14 was documented at 4:15 p.m. and identified the bruise to R12's right forearm to measure 3 centimeters (cm) x (by) 2 cm in size.	F 309		

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F 309	Continued From page 5 On 9/29/14, at 7:50 p.m., during the initial interview, R23 stated he had a rash on his chest (below breast areas) and subsequently, lifted his shirt to display a reddened, scaly area which extended across his chest. There were visible reddened marks across the chest area and R23 stated he had been scratching the area as it "itched" but it did not "hurt". R23 also indicated that staff applied topical cream to the area. R23's care plan, with a revision date of 7/23/2014, identified R23 at low risk for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to immobility, oxygen tubing; fatigue and urinary incontinence. The care plan lacked reference to non-pressure related skin issues including rashes nor were interventions identified.. Document review revealed a medical doctor (MD) notification dated 9/17/14, which identified R23 with the following: "red and raw [area] underneath bilateral breasts" and nursing interventions which had been attempted (Nystatin and gold bond powder). Upon notification, the MD responded with an order dated 9/17/14, for Silvadene cream two times daily (BID). Review of the September 2014 treatment record identified the physician ordered Silvadene cream to apply under bilateral breasts BID until healed had been initiated on 9/18/14. Documentation related to this skin condition was not evident in the medical record nor was there evidence the skin condition had been monitored. During an interview on 10/02/2014, at 12:15 P.M. registered nurse (RN)- A, verified the chest skin rash was initially identified on 9/17/14 and the physician was notified with a request for an	F 309		

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F 309	Continued From page 6 evaluation of the skin condition. RN-A further verified that R23, "had ongoing skin issues on various areas of his body since he was admitted". RN-A confirmed the care plan lacked any identification of this ongoing skin issue nor were any treatment records available that identified the area had been monitored. RN- A indicated documentation should have been available related to R23's skin issues. RN-A also reviewed the progress note documentation and verified no notations regarding R23's rash nor it's progression were evident. During interview on 10/02/2014, at 2:19 p.m.-B verified the treatment sheet listed Silvadene cream under bilateral breasts until healed. RN-B then confirmed there was no ongoing monitoring of the condition and documentation was lacking to indicate whether the treatment had improved the skin rash. RN-B further stated that she would have expected this information to be recorded in the nursing progress documentation. On 10/2/14, at 2:20 p.m. the director of nursing (DON), was interviewed and stated she would expect the skin condition to be identified as part of the care plan, especially since the resident had received ongoing treatments. The DON further stated, that if staff had monitored the condition, entries would have been documented on the treatment record. She further stated, "if nothing is on the record it wasn't done". Facility procedure titled: Weekly Wound Documentation Progress Sheet was reviewed and the following was noted: Bullet #1-To be completed on any skin concern that is not a pressure ulcer, arterial wound, venous wound, or neuropathic wound;	F 309		

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F 309	Continued From page 7 Bullet #7-To be completed upon discovery of a skin condition and then at least weekly thereafter; and Bullet#8- Once the area is healed, the other skin conditions form is to be filed into resident medical record.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 329	Please see attached Plan of correction RECEIVED OCT 27 2014 Minnesota Department of Health Marshall	10/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 8 facility failed to ensure that 1 of 5 residents (R42) reviewed for unnecessary medications had defined parameters for the use of Acetaminophen (Tylenol) with a dose not to exceed the maximum recommended daily dose. Findings include: R42 was admitted to the facility 7/25/14 with the diagnoses of multiple myeloma, chronic pain and mild cognitive impairment. Review of the September 2014 medication administration record (MAR) indicated that Tylenol (Acetaminophen) arthritis strength 650 milligram (mg) tablets 1-2 were to be administered twice daily (total potential dose in 24 hrs= 2600 mg). Medication administration times were scheduled AM (morning) and HS (hour of sleep) and the number of tablets that were given for the AM medication administration was documented but the MAR did not indicate the number of tablets that were administered at HS. Documentation on the MAR also indicated a prescription for Tylenol tablets 1000 mg twice a day as needed (PRN) for pain. Although R42 had not utilized the PRN prescription in September, the potential daily dose totaled 2000 mg. However, there were no parameters for use identified on the physician order and/or on the MAR to determine how many tablets to administer to remain within in the safe daily dose of Acetaminophen (Tylenol). The current physician orders for Acetaminophen dose per 24 hrs was 4600 mg which exceeds the daily recommended limits of 4000 mg. When interviewed on 10/2/14, at 10:15 a.m. the pharmacist consultant verified the number of tablets of Tylenol arthritis administered to R42 should be identified on the MAR. He further	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 9 verified that safe daily dosing parameters of acetaminophen should be indicated on the MAR. When interviewed on 10/1/14, at 12:00 p.m. the director of nursing (DON) indicated that she would expect staff documentation which identified the amount of medication administered when the medication order identified a range of 1-2 tablets. It was also verified there were no safe daily dosing parameters for acetaminophen on the MAR and it should have indicated that administration not exceed 4000 mg daily.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the pharmacist consultant failed to ensure that 1 of 5 residents (R42) reviewed for unnecessary medications had defined parameters for the use of Acetaminophen (Tylenol) with a daily dose not to exceed the maximum recommended daily dose. Findings include:	F 428	Please see attached plan of correction RECEIVED OCT 27 2014 Minnesota Department of Health Marshall	10/30/14

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F 428	Continued From page 10 R42 was admitted to the facility 7/25/14 with the diagnoses of multiple myeloma, chronic pain and mild cognitive impairment. Review of the September 2014 medication administration record (MAR) indicated that Tylenol (Acetaminophen) arthritis strength 650 milligram (mg) tablets 1-2 were to be administered twice daily (total potential dose in 24 hrs= 2600 mg). Medication administration times were scheduled AM (morning) and HS (hour of sleep) and the number of tablets that were given for the AM medication administration was documented but the MAR did not indicate the number of tablets that were administered at HS. Documentation on the MAR also indicated a prescription for Tylenol tablets 1000 mg twice a day as needed (PRN) for pain. Although R42 had not utilized the PRN prescription in September, the potential daily dose totaled 2000 mg. However, there were no parameters for use identified on the physician order and/or on the MAR to determine how many tablets to administer to remain within in the safe daily dose of Acetaminophen (Tylenol). The current physician orders for Acetaminophen dose per 24 hrs was 4600 mg which exceeds the daily recommended limits of 4000 mg. When interviewed on 10/2/14, at 10:15 a.m. the pharmacist consultant verified the number of tablets of Tylenol arthritis administered to R42 should be identified on the MAR. He further verified the daily parameters of acetaminophen should be indicated on the MAR. The monthly drug therapy review was completed by the pharmacist consultant on 9/9/14 and there were no noted irregularities. When interviewed on 10/1/14, at 12:00 p.m. the	F 428		

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F 428	Continued From page 11 director of nursing (DON) indicated that she would expect staff documentation would identify the amount of medication administered when the medication order identified a range of 1-2 tablets. It was also verified there were no safe daily dosing parameters for acetaminophen on the MAR and it should have indicated that administration not exceed 4000 mg daily.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	Please see attached plan of correction RECEIVED OCT 27 2014 Minnesota Department of Health Marshall	10/30/14

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F 431	Continued From page 12 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 maintain the security of medications on 1 of 2 medication administration carts (west-central). Findings include: During observation on 10/01/14, at 10:02 a.m. trained medication aide (TMA)-C was observed placing medication cards into drawer one of the medication cart for the center/west unit. TMA-C pushed the locking mechanism to secure the medication cart and verified the cart drawers were supposed to be locked. Even though the cart was in the locked position, drawer one was observed to be partially open and drawer four was also not locked. TMA-C stated the lock on the cart was not functioning properly. TMA-C further verified that a request had been filled out approximately "a week or so ago" notifying the director of nursing (DON) of the malfunctioning lock on the cart. It was noted that both drawers (1 & 4) had individual punch cards that contained resident prescription medications. The medications were stored in the medication cart for residents who reside on the either the west and/or center wings. During an interview on 10/1/14, at 10:57 a.m. the DON verified the medication cart was to be	F 431		

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F 431	Continued From page 13 locked when not in use and she was aware the locking mechanism was not functioning properly. The DON further stated the administrator had been notified of the improperly locking medication cart and she was waiting for approval to purchase a new medication cart. It was observed on 10/01/14, at 12:22 p.m. the west/central medication cart was located in front of the nursing station and no nursing staff were in the immediate area. During this time frame a resident was observed to be seated next to the nursing station while a housekeeper cleaned in the area. At 12:30 p.m., the DON, registered nurse(RN)-A and TMA-C returned to the nursing station and verified this cart was able to be opened while in the locked position and that no nursing staff were in the immediate area. Review of the policy titled, Administering Medications dated 2001 and revised 2007; the policy interpretation and implementation; item 9 stated: "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by."	F 431		

Morgan Memorial Foundation, Inc.
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Morgan, MN 56266
Telephone 507-249-3143
Fax 507-249-2310
Facility ID: 00542

Plan of Correction
Minnesota DHS Survey 09/29/2014 to 10/02/2014
Project Number: S5594025

F279 (Scope/Severity = D)
483.20(d), 483.20(k)(1) Develop comprehensive care plans

Based on observation, interview and documentation review the facility failed to develop a comprehensive plan of care for 1 of 1 residents (R23) reviewed non-pressure related skin issues.

When non-pressure related skin issues are found, the licensed nursing staff will update the care plan to include these non-pressure related skin issues and include appropriate interventions for all identified care needs. All staff will be educated on new protocols at the in-service scheduled on October 30, 2014. Then on a quarterly basis, the director of nursing or designee will monitor nursing staff compliance by auditing care plans for non-pressure related skin issues. Correction completion date will be October 30, 2014.

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Plan of Correction
Minnesota DHS Survey 09/29/2014 to 10/02/2014
Project Number: S5594025

F309 (Scope/Severity = D)
483.25 Provide care/services for highest well being

Based on observation, interview and documentation review, the facility failed to identify, investigate and monitor bruising for 1 of 3 residents (R12) and failed to monitor a rash for 1 of 3 residents (R23) reviewed for non-pressure related skin issues.

When non-pressure related skin issues or new skin abnormalities are discovered, licensed staff will be notified immediately and the licensed nursing staff will document and monitor these on a regular basis for comparison until healed. On October 30, 2014, nursing staff will be educated on how to document and monitor skin abnormalities or non-pressure related skin issues. Then on a quarterly basis, the director of nursing or designee will monitor nursing staff compliance by auditing incident report and care plans for skin abnormalities and non-pressure related skin issues to ensure compliance. Correction completion date will be October 30, 2014.

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Plan of Correction
Minnesota DHS Survey 09/29/2014 to 10/02/2014
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F329 (Scope/Severity = D)
483.25(l) Drug regimen is free from unnecessary drugs

Resident 42 was found to be prescribed both Tylenol and Arthritis Tylenol by the physician. This dosage had the potential to exceed the maximum dosage recommendations of 4000 mg within a 24-hour period.

The charge nurse will review all resident records for similar pain medications. In the event that there have been similar medications ordered by the physician, the charge nurse will send clarification orders to the prescribing physician asking to address and clarify these medication orders. All medications that contain Tylenol will state on the medication administration record not to exceed 4,000 mg in a 24-hour period. The director of nursing or designee will audit medication records monthly to ensure that Tylenol orders read, not to exceed 4,000 mg and to ensure that residents do not have two orders for medications that contain Tylenol. If two medications with Tylenol are prescribed, specific parameters will be obtained from the primary physician. All licensed nurses and trained medication aides will receive education and training on reviewing pain medications when two or more pain medications are ordered by the physician. Individualized education and training will be completed by October 30, 2014. Then on a quarterly basis these audit results will be discussed at our quarterly Quality Assurance and Assessment meeting. Completion date is October 30, 2014.

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Plan of Correction
Minnesota DHS Survey 09/29/2014 to 10/02/2014
Project Number: S5594025

F428 (Scope/Severity = D)
483.60 (c) Drug regiment review, report irregular, act on

Based on interview and documentation review the pharmacist consultant failed to ensure that 1 of 5 residents reviewed for unnecessary medications had defined parameters for the use of Tylenol with a daily dose not to exceed the maximum recommended daily dose.

The charge nurse and pharmacy consultant will review all resident records for similar pain medications. In the event that there are similar medications ordered by the physician, the pharmacy consultant will notify the charge nurse who will send clarification orders to the prescribing physician asking to address and clarify these medication orders. All medications that contain Tylenol will state on the medication administration record (MAR) not to exceed 4,000 mg in a 24-hour period. The director of nursing or designee will audit medication records monthly to ensure that Tylenol orders read, not to exceed 4,000 mg and to ensure that residents do not have two orders for medications that contain Tylenol. If two medications with Tylenol are prescribed, specific parameters will be obtained from the primary physician. All licensed nurses and trained medication aides will receive education and training on reviewing pain medications when two or more pain medications are ordered by the physician on October 30, 2014. Individualized education will also be provided on October 27, 2014 at Quality Assurance and Assessment meeting with the Pharmacy Consultant and Medical Director. Then on a quarterly basis these audit results will be discussed at our quarterly Quality Assurance and Assessment meeting. Completion date is October 30, 2014.

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Plan of Correction
Minnesota DHS Survey 09/29/2014 to 10/02/2014
Project Number: S5594025

F431 (Scope/Severity = E)
483.60(b), (d), (e) Drug records label/store drugs and Biologicals

Based on observation, interview and document review, the facility failed to maintain the security of medications on 1 of 2 medication administration carts. At the time of the survey, the cart which was identified to have drawers that were not secure was removed from service and temporarily replaced with a different lockable medication cart. A new medication cart was ordered on October 1, 2014 and received on October 10, 2014 and put into service. In the event that there are any future problems with securing medications, the cart will be immediately removed from service and repaired or replaced if necessary to ensure the security and safety of our residents. Education will be provided at the October 30, 2014 in-service on the importance of reporting and removing defective equipment from use.

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	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/01/2014**

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GIL- MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 1, 2014. At the time of this survey, Gil-Mor Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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	K 000	POC ok 10-29-14 FB RECEIVED OCT 27 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 11-12-14

Exit: 10-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrie Frank Terrie Frank	Administrator	10/22/2014

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
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Gil-Mor Manor was constructed as follows: The original building was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1989 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.	K 000		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000	K 062	Please see attached plan of correction	10/14/14

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K 062	Continued From page 2 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1 and 2-2.2. This deficient practice could affect all 35 out 35 residents. Findings include: On facility tour between 11:15 am and 1:15 pm on 10/01/2014, observation revealed that the following were found: 1. Kitchen- Dishwashing area, the fire sprinkler heads located in this area were corroded.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This STANDARD is not met as evidenced by: Based upon a staff interview and review of	K 144	Please see attached plan of correction	10-2-14 ~~9/29/14~~

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K 144	Continued From page 3 available records, the facility did not properly document weekly inspections for the emergency generator. In a fire or other emergency, this deficient practice could adversely affect 35 of 35 residents, staff and visitors. FINDINGS INCLUDE: On 10/01/2014 at 11:15 AM, during a staff interview and review of available records, no documentation could be provided verifying the required weekly inspection of the emergency generator had been performed between 01/10/14-02-02/2014 and 08-26-2014-09-28-2014. This deficient practice was not in accordance with NFPA 110 (1999), Chapter 6, Section 6-4.2 and NFPA 99 (1999), Chapter 3, Section 3-4.4.1.1.	K 144		

Morgan Memorial Foundation, Incorporated
d.b.a. Gil-Mor Manor and Gil-Mor Haven
96 Third Street East
Morgan, MN 56266
Telephone 507-249-3143
Fax 507-249-2310

October 6, 2014

Plan of Correction

Minnesota Fire Marshal Survey completed on 10/01/2014

K62 (SS = E)

During the survey, it was observed that two (2) sprinkler heads were corroded in the dishwashing room and needed to be replaced. On 10/03/2014, Terrie Frank, Administrator called and spoke with Jeff at Summit Fire Protection regarding replacing the sprinkler heads identified at the time of the Fire Marshall inspection. On 10/08/2014, Jeff came out to evaluate the area and sprinkler heads that needed to be replaced and set the service call date for 10/14/2014. Summit Fire Protection arrived on-site on 10/14/2014 and replaced the corroded sprinkler heads identified during the Fire Marshal inspection. Corrective action was completed on 10/14/2014.

K144 (SS = F)

Based on record review and interview, the facility failed to perform weekly generator inspections during the time frames of 01/10/2014 to 02/02/2014 and 08/26/2014 to 09/28/2014. Weekly generator inspections will be placed on a routine schedule and the Maintenance Technician will perform and document Gil-Mor Manor's weekly generator inspections and document in the Life Safety Code Documentation book. Then on a quarterly basis at the QA&A Meeting, the Maintenance Technician will bring the Life Safety Code Documentation book to be reviewed to ensure that all components of the weekly generator inspection has been performed and documented properly.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0042

October 15, 2014

Ms. Terrie Frank, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5594025

Dear Ms. Frank:

The above facility was surveyed on September 29, 2014 through October 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Office: (507) 476-4233
Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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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: On September 29th and 30th, and October 1st and 2nd, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan	2 560		

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2 560	Continued From page 2 required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for 1 of 1 resident (R 23) reviewed who had an ongoing skin rash located on the chest area. Findings include: On 9/29/14, at 7:50 p.m., during the initial interview, R23 stated he had a rash on his chest (below breast areas) and subsequently, lifted his shirt to display a reddened, scaly area which extended across his chest. There were visible reddened marks across the chest area and R23 stated he had been scratching the area as it "itched" but it did not "hurt". R23 also indicated that staff applied topical cream to the area. R23's care plan, with a revision date of 7/23/2014, identified R23 at low risk for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to immobility, oxygen tubing; fatigue and urinary incontinence. The care plan lacked reference to non-pressure related skin issues including rashes or interventions to manage them. Document review revealed a medical doctor (MD) notification dated 9/17/14, which identified R23 with the following: "red and raw [area] underneath bilateral breasts" and nursing interventions which had been attempted (Nystatin and gold bond powder). Upon notification, the MD responded with an order dated 9/17/14, for Silvadine cream two times daily (BID). Review of the September 2014 treatment record identified	2 560		

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2 560	Continued From page 3 the physician ordered Silvadene cream to apply under bilateral breasts BID until healed had been initiated on 9/18/14. Documentation related to this skin condition was not evident in the medical record nor was there evidence the skin condition had been monitored.. During an interview on 10/02/2014, at 12:15 P.M. registered nurse (RN)- A, verified the chest skin rash was intially identified on 9/17/14 and the physician was notified with a request for an evaluation of the skin condition. RN-A further verified that R23, "had ongoing skin issues on various areas of his body since he was admitted". RN-A confirmed the care plan lacked any identification of this ongoing skin issue nor were any treatment records available that identified the area had been monitored. On 10/2/14, at 2:20 p.m. the director of nursing (DON), was interviewed and stated she would expect the skin condition to be identified as part of the care plan, especially since the resident had received ongoing treatments.. Facility procedure titled: Weekly Wound Documentation Progress Sheet was reviewed and the following was noted: Bullet #1-To be completed on any skin concern that is not a pressure ulcer, arterial wound, venous wo und, or neuropathic wound; Bullet #7-To be completed upon discovery of a skin condition and then at least weekly thereafter; and Bullet#8- Once the area is healed, the other skin conditions form is to be filed into resident medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service licensed	2 560		

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2 560	Continued From page 4 staff to develop a care plan to include appropriate interventions for all identified care needs. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
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 identify, investigate, and/or monitor 1 of 1 resident (R12) reviewed for non-pressure related skin issue which included bruising. Findings include: During an observation/interview on 9/30/14, at 1:17 p.m. R12 was observed with a quarter size purple bruise on the top aspect of her right wrist.	2 830		

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2 830	Continued From page 5 R12 stated she did not know how the bruise was obtained and further stated that staff had also questioned her about it. Review of the significant change minimum data set (MDS) assessment dated 8/15/14 revealed a brief interview for mental status (BIMS) score of 13 indicating R12 as cognitively intact. The assessment further indicated R12 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. When interviewed on 10/2/2014, at 3:30 p.m. registered nurse (RN)-A stated that when a bruise is identified on a resident it is investigated, measured, and monitored until healed. Documentation related to the bruise is recorded on the treatment record. RN-A further stated that skin is visualized weekly on bath day by the nursing assistant who assisted with bathing and also by the licensed nurse. R12's treatment record was reviewed and did not include monitoring of any known bruises; and this was confirmed by RN-A. RN-A and RN-B confirmed that R12 had a bath earlier on 10/2/14. RN-B further confirmed that she had performed R12's skin assessment and no bruising had been identified. RN-A confirmed the presence of a quarter size bruise to the top aspect of R12's right wrist. RN-A further confirmed this bruise should have been identified, investigated, and monitored until healed with documented evidence in the treatment book. RN-B then entered R12's room, observed the bruise to the resident's right wrist, and confirmed she had not identified the bruise when completing R12 skin assessment earlier in the day. RN-B questioned R12 whether she knew how long she'd had the bruise. R12	2 830		

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2 830	Continued From page 6 responded, "for awhile". R12 further indicated the bruise looked good now as it had been much worse, as evidenced by a darker purple color and a swollen appearance. RN-B confirmed that R12's bruise should have been identified, investigated and monitored until healed with documented evidence in the treatment record. No further documentation was available to review related to the identified bruise. After staff were alerted to the observable bruise, a Witnessed or Unwitnessed Injury Incident Report dated 10/2/14 was documented at 4:15 p.m. and identified the bruise to R12's right forearm to measure 3 centimeters (cm) x (by) 2 cm in size. SUGGESTED METHOD OF CORRECTION: The DON or designee could re-educate staff to document new skin abnormalities and monitor these on a regular basis for comparison. The designee could perform audits to ensure compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection	21390		

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21390	Continued From page 7 prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to have an infection control program that assured each employee 8 of 11 reviewed had received a tuberculin skin test (TST) which had the potential to affect 34 of 34 residents residing in the facility. Findings include: During review of employee TST records the following documentation was noted: 1. Certified nursing assistant (NAR)-D was hired on 7/2/14 and failed to have any evidence in her immunization record to identify a TST had been conducted. 2. Dietary aide (DA)-A, hired 5/22/14, was administered the first step of the two step TST on 5/19/14. DA-A's immunization record revealed the	21390		

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21390	Continued From page 8 results of the first step TST were negative when checked on 5/21/14. DA-A had a second step tuberculin skin test conducted on 7/30/14 and the TB Blood Test document was not completed to indicate the results of the step two tuberculin skin test. 3. Social services (SS)-A, hired 7/21/14, was noted to have a tuberculin skin test from a previous employer dated 11/8/12. SS-A's immunization record had a note in it indicating SS-A had declined a tuberculin skin test upon hire. 4. Maintenance employee-A, hired 9/11/14, immunization record failed to reveal any evidence of a tuberculin skin test.. 5. Laundry aide (LA)-A, hired 9/8/14, immunization record failed to reveal any evidence of a tuberculin skin test. 6. Dietary aide (DA)-B, hired 6/13/14, immunization record failed to reveal any evidence of a tuberculin skin test. 7. NAR-E , hired 9/12/14, immunization record failed to reveal any evidence of a tuberculin skin test being conducted. 8. NAR-F , hired 8/12/14, immunization record failed to reveal any evidence of a TST being conducted. During interview with the director of nursing (DON) on 2/10/14, at 2:19 p.m. who served as the facility infection control professional, she stated she was unsure why the tuberculin skin test records were incomplete. The DON stated the facility policy required all staff and residents a two-step tuberculin skin test upon admission/hire. The DON also stated the facility procedure for tuberculin skin test administration was for each staff person, upon hire, to get their initial Mantoux reading on the first day of work. The DON stated staff may have contact with residents before first TST was read. The facility's process for	21390		

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21390	Continued From page 9 conducting TST explained by the DON was for staff to receive their first TST on the first day of work then have the TB Test form left at the nurses station for the nursing staff to read within 72 hours and conduct a second step 2-3 weeks later. The DON verified the system was not functioning as intended. All findings were verified for the missed or partially missed TST's were verified by the DON. The DON also verified if a staff member would refuse to have the TST conducted they would have to find an alternative method to verify they were free of Tuberculosis (i.e. chest x-ray). The facility policy for Tuberculosis Screening for Employees, dated 2013, identified the following standard: 1. New employees who present a written report of a negative two-step Tuberculin Skin Test (TST) within the previous 12 months will not need their TB screen repeated and the employee screening tool will be completed. 2. Previous documental negative TST result less than 12 months before employment, single TST needed for baseline testing; this will be the second step. 3. New employees with a known, documented positive skin test will not receive a repeat TST but will undergo a chest x-ray (CXR) if they do not have a documented negative chest x-ray after a positive TST. 4. Individuals with documented positive TST and negative CXR will be assessed for signs and symptoms of active TB disease and counseled to report such symptoms to the infection control staff immediately.	21390		

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21390	Continued From page 10 5. TST should be postponed if employee has an acute viral illness to avoid the possibility of a falsely negative test. 6. New employees will not be allowed to work until the TST or CXR results are known 7. Employees who will be receiving the two-step TST may begin work after the first step results are negative. 8. Second step TST can have a time frame suggested of 1-3 weeks, but not greater than 365 days. 9. TST results will be documented in each employee's medical record. a. Skin test results will be documented in millimeters of induration rather than stating result is "positive" or "negative". b. The tuberculin manufacturer and lot number will be recorded. c. A record of all positive TST's is readily available to facilitate annual and as needed assessment for TB disease in the employee. The facility failed to follow their own policy to ensure all new employees are screened for TB and that employees do not begin to provide services for residents until their first step TST has been read. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) could designate one staff to be in charge of ensuring 2-step tuberculin skin test are completed for employees upon hire. The DON could complete random audits to ensure continued compliance.	21390		

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21390	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required	21530		

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21530	Continued From page 12 by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the pharmacist consultant failed to ensure that 1 of 5 residents (R42) reviewed for unnecessary medications had defined parameters for the use of Acetaminophen (Tylenol) with a daily dose not to exceed the maximum recommended daily dose. Findings include: R42 was admitted to the facility 7/25/14 with the diagnoses of multiple myeloma, chronic pain and mild cognitive impairment. Review of the September 2014 medication administration record (MAR) indicated that Tylenol (Acetaminophen) arthritis strength 650 milligram (mg) tablets 1-2 were to be administered twice daily (total potential dose in 24 hrs= 2600 mg). Medication administration times were scheduled AM (morning) and HS (hour of sleep) and the number of tablets that were given for the AM medication administration was documented but the MAR did not indicate the number of tablets that were administered at HS. Documentation on the MAR also indicated a prescription for Tylenol tablets 1000 mg twice a day as needed (PRN) for pain. Although R42 had not utilized the PRN prescription in September, the potential daily dose totaled 2000 mg. However, there were no parameters for use identified on the physician order and/or on the MAR to determine how many tablets to administer to remain within in the safe	21530		

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21530	Continued From page 13 daily dose of Acetaminophen (Tylenol). The current physician orders for Acetaminophen dose per 24 hrs was 4600 mg which exceeds the daily recommended limits of 4000 mg. When interviewed on 10/2/14, at 10:15 a.m. the pharmacist consultant verified the number of tablets of Tylenol arthritis administered to R42 should be identified on the MAR. He further verified the daily parameters of acetaminophen should be indicated on the MAR. The monthly drug therapy review was completed by the pharmacist consultant on 9/9/14 and there were no noted irregularities. When interviewed on 10/1/14, at 12:00 p.m. the director of nursing (DON) indicated that she would expect staff documentation would identify the amount of medication administered when the medication order identified a range of 1-2 tablets. It was also verified there were no safe daily dosing parameters for acetaminophen on the MAR and it should have indicated that administration not exceed 4000 mg daily. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, and the consultant pharmacist (CP) could develop, review and/or revise policies and procedures to ensure medication orders are reviewed for the potential for overdose with mulitiple drug orders and include a notation of dosage limits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 14 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure that 1 of 5 residents (R42) reviewed for unnecessary medications had defined parameters for the use of Acetaminophen (Tylenol) with a dose not to exceed the safe maximum daily dose.. Findings include: R42 was admitted to the facility 7/25/14 with the diagnoses of multiple myeloma, chronic pain and mild cognitive impairment. Review of the	21535		

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21535	Continued From page 15 September 2014 medication administration record (MAR) indicated that Tylenol (Acetaminophen) arthritis strength 650 milligram (mg) tablets 1-2 were to be administered twice daily (total potential dose in 24 hrs= 2600 mg). Medication administration times were scheduled AM (morning) and HS (hour of sleep) and the number of tablets that were given for the AM medication administration was documented but the MAR did not indicate the number of tablets that were administered at HS. Documentation on the MAR also indicated a prescription for Tylenol tablets 1000 mg twice a day as needed (PRN) for pain. Although R42 had not utilized the PRN prescription in September, the potential daily dose totaled 2000 mg. However, there were no parameters for use identified on the physician order and/or on the MAR to determine how many tablets to administer to remain within in the safe daily dose of Acetaminophen (Tylenol). The current physician orders for Acetaminophen dose per 24 hrs was 4600 mg which exceeds the daily recommended limits of 4000 mg. When interviewed on 10/2/14, at 10:15 a.m. the pharmacist consultant verified the number of tablets of Tylenol arthritis administered to R42 should be identified on the MAR. He further verified that safe daily dosing parameters of acetaminophen should be indicated on the MAR. When interviewed on 10/1/14, at 12:00 p.m. the director of nursing (DON) indicated that she would expect staff documentation which identified the amount of medication administered when the medication order identified a range of 1-2 tablets. It was also verified there were no safe daily dosing parameters for acetaminophen on the MAR and it should have indicated that administration not exceed 4000 mg daily.	21535		

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21535	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies/procedures for unnecessary medications, educate staff, and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the security of medications on 1 of 2 medication administration carts (west-central). Findings include: During observation on 10/01/14, at 10:02 a.m. trained medication aide (TMA)-C was observed placing medication cards into drawer one of the medication cart for the center/west unit. TMA-C pushed the locking mechanism to secure the medication cart and verified the cart drawers were supposed to be locked. Even though the cart was in the locked position, drawer one was observed to be partially open and drawer four was also not locked. TMA-C stated the lock on the cart was not functioning properly. TMA-C	21610		

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21610	Continued From page 17	21610		

further verified that a request had been filled out approximately "a week or so ago" notifying the director of nursing (DON) of the malfunctioning lock on the cart. It was noted that both drawers (1 & 4) had individual punch cards that contained resident prescription medications. The medications were stored in the medication cart for residents who reside on the either the west and/or center wings.

During an interview on 10/1/14, at 10:57 a.m. the DON verified the medication cart was to be locked when not in use and she was aware the locking mechanism was not functioning properly. The DON further stated the administrator had been notified of the improperly locking medication cart and she was waiting for approval to purchase a new medication cart.

It was observed on 10/01/14, at 12:22 p.m. the west/central medication cart was located in front of the nursing station and no nursing staff were in the immediate area. During this time frame a resident was observed to be seated next to the nursing station while a housekeeper cleaned in the area. At 12:30 p.m., the DON, registered nurse(RN)-A and TMA-C returned to the nursing station and verified this cart was able to be opened while in the locked position and that no nursing staff were in the immediate area.

Review of the policy titled, Administering Medications dated 2001 and revised 2007; the policy interpretation and implementation; item 9 stated: "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others

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21610	Continued From page 18 passing by." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could re-educate staff on proper storage of the medication cart and periodically audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		