DEPARTMENT OF HEALTH A						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 8EJI
I. MEDICARE/MEDICAID PROVIDER (L1) 245594 2.STATE VENDOR OR MEDICAID NO. (L2) 220043100		3. NAME AND AL (L3) GIL- MOR 1 (L4) 96 THIRD S (L5) MORGAN, 1	DRESS OF FAC MANOR TREET EAST	CILITY	TE SURVEY AGENCY (L6) 56266	Facility ID: 00542 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 11/17/2014 (L34) 8. ACCREDITATION STATUS:(L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02_ (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	35 (L18) 35 (L17)	Complianc 1. A B. Not in Con	nce With equirements e Based On: cceptable POC ppliance with Prog	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
15. Total Contribut Deas	33 (==+)	Requirem	ents and/or Appli	ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN	1				15. FACILITY MEETS	
18 SNF 18/19 SNF 35	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Kathryn Serie, Unit Sup</u>	ervisor	1	1/17/2014	(L19)	K <u>amala Fiske-Downing, I</u>	Enforcement Specialist 11/18/2014 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	COFFICE OR SINGLE S	TATE AGENCY
 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE 2	3. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 11/01/1991	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	oo run to meet rigitement
25. LTC EXTENSION DATE: 2		VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>OTHER</u>
	A. Suspension	n of Admissions:	(L44)		04-Ouler Reason for windrawar	07-Provider Status Change 00-Active
(L27)	B. Rescind S	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	11/12/2014		(L33)	DETERMINATION APPE	ROVAL



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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Gil- Mor Manor November 18, 2014 Page 2

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

cc: Licensing and Certification File



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,

Kumala Piske Downing

Gil- Mor Manor November 18, 2014 Page 2 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

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 245594	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/17/2014
Name	e 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	Correction Completed 10/30/2014	ID Prefix	F0309	Correction Completed 10/30/2014	ID Prefix	F0329	Correction Completed 10/30/2014
	483.20(d), 483.20(k)(1)	-		483.25			483.25(I)	
ID Prefix	F0428 483.60(c)	Correction Completed 10/30/2014	ID Prefix	F0431 483.60(b), (d), (e)	Correction Completed 10/30/2014	Dog #		
	403.00(0)	-	LSC	403.00(D), (U), (E)		LSC		
ID Prefix Reg. # LSC			Reg. #			Reg. #		
Reg. #								
Reg. #			Reg. #			Deg #		
Reviewed I	By Reviewed	i By	Date:	Signature of	Surveyor:		Da	te:
State Agen	cy KS/KF	² D	11/18/20	014	03	3048		11/17/2014
Reviewed I CMS RO	By Reviewed	i By	Date:	Signature of	Surveyor:		Da	te:
Followup t	o Survey Completed of 10/3/2014	n:		Check for any U Uncorrected E	ncorrected Defic Deficiencies (CM		the Feelling	ES NO

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 245594	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 10/30/2014	ID Prefix		Correction Completed 10/30/2014	ID Prefix		Correction Completed
0	NFPA 101		U U	NFPA 101	-	Reg. #		
LSC	K0062		LSC	K0144		LSC _		
		Correction			Correction			Correction
		Completed			Completed			Completed
		-			-			
Reg. #			Reg. #		-	Reg. #		
			LOC					
		Correction			Correction			Correction
		Completed	ID Drofin		Completed	ID Drofin		Completed
ID Prefix		-			-			
Reg. #			Reg. #		-	Reg. #		
		Correction			Correction			Correction
		Completed	ID Drofin		Completed	ID Drofin		Completed
		-			-			
Reg. #			Reg. #		-	Reg. #		
		Correction			Correction			Correction
ID Drofiv		Completed	D Drofiv		Completed	ID Brofiv		Completed
		-			-			
Reg. #			Reg. #		-	Reg. #		
Reviewed B	By Reviewed	Ву	Date:	Signature of Su	rveyor:		Date:	
State Agen	cy PS/KFI	D	11/18/2	014	34	764		10/30/2014
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Su	rveyor:		Date:	
	o Survey Completed or	۱·		Ohaali far area U				
i onowup i	10/1/2014			Check for any Unco Uncorrected Defi				NO
							. 20	

DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MED	DICARE & MEDICAID SERVICES		
	ARE/MEDICAID CERTIFICATION		ID: 8EJI		
PART I -	TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00542		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245594	3. NAME AND ADDRESS OF FACILITY (L3) GIL- MOR MANOR		4. TYPE OF ACTION: $\underline{2}(L8)$		
2.STATE VENDOR OR MEDICAID NO.	(14) 96 THIRD STREET EAST		1. Initial2. Recertification3. Termination4. CHOW		
(L2) 220043100	(L5) MORGAN, MN	(L6) 56266	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)	01 Hospital 05 HHA 09 ESRD	RD 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 10/03/2014 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:(L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/II		12/31		
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	A. In Compliance With	And/Or Approved Waivers Of	The Following Requirements:		
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds 35 (L18)	1. Acceptable POC	 3. 24 Hour RN 4. 7-Day RN (Rural SN 	7. Medical Director F)8. Patient Room Size		
		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds 35 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers	: * Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
35 (L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION DATE):				
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
Jodi Johnson, HFE NE II	10/29/2014 (L19)	K <u>amala Fiske-Downing. I</u>	ng. Enforcement Specialist 11/10/2014 (L20)		
PART II - TO BE (COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL		ncial Solvency (HCFA-2572)		
 Facility is Eligible to Participate 	RIGHTS ACT:	 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible					
(L21)					
22. ORIGINAL DATE 23. LTC AGREEN	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNING	DATE ENDING DATE	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY		
11/01/1991		01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety		
(L24) (L41)	(L25)	03-Risk of Involuntary Terminatio	n		
25. LTC EXTENSION DATE: 27. ALTERNATIV	VE SANCTIONS 1 of Admissions:	04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change		
-	(L44)		00-Active		
(L27) B. Rescind Su	spension Date:				
	(L45)				
28. TERMINATION DATE:29	. INTERMEDIARY/CARRIER NO.	30. REMARKS			
	03001				
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DATE	•			
(L32)	(L33)	DETERMINATION APPE	ROVAL		



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

Gil- Mor Manor October 15, 2014 Page 2 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,

Kumalu 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 Gil- Mor Manor October 15, 2014 Page 3

PHETA PEOLATORY OF DEVIDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE F 000 INITIAL COMMENTS F 000	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391	
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS. GTY, STATE, ZP CODE GIL- MOR MANOR STREET ADDRESS. GTY, STATE, ZP CODE OWE DEFENDENT STATEMENT OF DEFICIENCES STREET ADDRESS. GTY, STATE, ZP CODE TAG SUMMARY STATEMENT OF DEFICIENCES FOOD INITIAL COMMENTS F COD FOOD The facility splan of correction (POC) will serve as your validgation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility must use the result of the assessment to develop, review and revise the resident's comprehensive plan of care. F 279 Adadity must develop a comprehensive care. The facility must develop a comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the							
GIL- MOR MANOR 96 THIRD STREET EAST MORGAN, MN 56266 PMUD PTERTX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTERING INFORMATION) PAGE TAG PREFX (EACH DEFICIENCY AND STATE MENT ON ACULU BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTERING INFORMATION) PREFX TAG PREFX (EACH DEFICIENCY MUST BY EACH AND			245594	B. WING		10/03/2014	
PARTING REACT DEFICIENCY NULTING INFORMATION PARTING PAGE RECELLATION YOR LISCIDENTIFYING INFORMATION PAGE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS			<u> </u>	96	THIRD STREET EAST		
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. F279 F279 H33.20(d), 483.20(k)(1) DEVELOP SS=D F279 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F279 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. F279 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). Mit and the comprehensive streatment and psychosocial well and psychosocial mediate that are identified in the resident's 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). Mit and the comprehensive streatment and psychosocial well are not provided due to the resident's exercise of rights under §483.25, including the righ	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION	
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 279 483.20(k)(1) DEVELOP F 279 483.20(k)(1) DEVELOP F 279 Jee cottached 16/30/M SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F 279 Jee cottached 16/30/M The facility must develop a comprehensive care plan for each resident that includes measurable objectives and mental and psychosocial medical, nursing, and mental and psychosocial medical, nursing, and mental, and psychosocial well-being as required under § 483.10, including the right to refuse treatment under § 483.10, including the right to refuse treatment TITLE 000 IMTE	F 000	INITIAL COMMEN	TS	F 000			
revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 483.20(0), 483.20(k)(1) DEVELOP SS=D 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 §483.20; including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced were to the result or PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE WERE TORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE (V0) DATE (V0) DATE		as your allegation of Department's acce bottom of the first p	of compliance upon the ptance. Your signature at the page of the CMS-2567 form will				
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		revisit of your facili validate that substa regulations has be your verification. 483.20(d), 483.20(ty may be conducted to antial compliance with the en attained in accordance with k)(1) DEVELOP	F 279	Lee attached flan of Correc	10/30/14	
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 SORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		to develop, review	the results of the assessment and revise the resident's an of care. \mathcal{A}	pproved	•		
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 BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		plan for each resid objectives and time medical, nursing, a needs that are ide	and mental and psychosocial	10/27/1			
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		The care plan must to be furnished to highest practicable psychosocial well- §483.25; and any be required under due to the resident §483.10, including	attain or maintain the resident's e physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment		OCT 2 7 2014 Ranestoa Department of Her		
BORATORY DIRECTORS OR PROVIDENSOFFLER REPRESENTATIVE S GUINTOIL	2 4 W.						
$\mathcal{A}\mathcal{A}\mathcal{A}\mathcal{A}$	BORATOR	y director's or prov Frank	. 12 (7	â	administrato		

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.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	COWFLETED
		245594	B. WING		10/03/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST	
GIL- MO	RMANOR			MORGAN, MN 56266	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 279	review the facility fa for 1 of 1 resident (ongoing skin rash I Findings include: On 9/29/14, at 7:50 interview, R23 stat (below breast area shirt to display a re extended across h reddened marks ac stated he had beer "itched" but it did n that staff applied to R23's care plan, w 7/23/2014, identifie or interference with skin caused by pro immobility, oxygen incontinence. The non-pressure relat or interventions to Document review I notification dated S with the following: underneath bilater interventions which and gold bond pow responded with an Silvadine cream tw the September 20 the physician orde under bilateral bre	tion, interview and document ailed to develop a plan of care (R 23) reviewed who had an ocated on the chest area. D p.m., during the initial ed he had a rash on his chest s) and subsequently, lifted his eddened, scaly area which is chest. There were visible cross the chest area and R23 n scratching the area as it ot "hurt". R23 also indicated opical cream to the area. ith a revision date of ed R23 at low risk for ulceration n structural integrity of layers of blonged pressure related to tubing; fatigue and urinary care plan lacked reference to ed skin issues including rashes		RECEIVED OCI 27201 Minestoa Department of H Marchall	H salth
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:8EJI11		Facility ID: 00542 If cont	inuation sheet Page 2 of 14

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	13 FUR MEDIUARE	A MEDICAID SERVICES			<u> JIND NO.</u>	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245594	B. WING		10/	03/2014
NAME OF I	PROVIDER OR SUPPLIER		F	STREET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MO	R MANOR			96 THIRD STREET EAST MORGAN, MN 56266		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG			COMPLÉTION DATE
F 279 F 309 SS=D	record nor was the had been monitore During an interview registered nurse (F rash was intially ide physician was notif evaluation of the sl verified that R23, "I various areas of his RN-A confirmed th identification of this any treatment reco area had been mon On 10/2/14, at 2:2 (DON), was intervi- expect the skin cor of the care plan, es received ongoing t Facility procedure Documentation Pro and the following w Bullet #1-To be cor that is not a press venous wo und, or Bullet #7-To be cor skin condition and thereafter; and Bullet#8- Once the conditions form is record. 483.25 PROVIDE HIGHEST WELL E	was not evident in the medical re evidence the skin condition d r on 10/02/2014, at 12:15 P.M. RN)- A, verified the chest skin entified on 9/17/14 and the fied with a request for an kin condition. RN-A further had ongoing skin issues on s body since he was admitted". e care plan lacked any s ongoing skin issue nor were rds available that identified the nitored. 0 p.m. the director of nursing ewed and stated she would ndition to be identified as part specially since the resident had reatments titled: Weekly Wound ogress Sheet was reviewed vas noted: mpleted on any skin concern ure ulcer, arterial wound, neuropathic wound; mpleted upon discovery of a then at least weekly area is healed, the other skin to be filed into resident medical CARE/SERVICES FOR		279 RECENDOCT 27 DCT 27 Manestoa Departmen Marchall 309 Sue artached Plan of correct	2014 ht of Health	10/30/14
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:8EJI11		Facility ID: 00542	uation shee	et Page 3 of 14

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245594	B. WING			10/0	03/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MOI	RMANOR				6 THIRD STREET EAST IORGAN, MN 56266		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	or maintain the hig mental, and psycho accordance with th and plan of care.	ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment	F	309			
	by: Based on observa review the facility f and/or monitor 2 o reviewed for non-p	NT is not met as evidenced tion, interview, and document ailed to identify, investigate, f 3 residents (R12 & R23) ressure related skin issues ising and a skin rash.					
	1:17 p.m. R12 was purple bruise on th R12 stated she dic obtained and furth questioned her abo	tion/interview on 9/30/14, at s observed with a quarter size e top aspect of her right wrist. I not know how the bruise was er stated that staff had also but it. ificant change minimum data nent dated 8/15/14 revealed a			RECEIVE OCT 2720	D 14.	
	brief interview for r 13 indicating R12 a assessment furthe extensive assistan dressing, toilet use When interviewed	nental status (BIMS) score of as cognitively intact. The ir indicated R12 required ce with bed mobility, transfer, a, and personal hygiene. on 10/2/2014, at 3:30 p.m. RN)-A stated that when a			Marshall	lealth	
FORM CMS-2	bruise is identified measured, and mo Documentation rel	on a resident it is investigated, onitored until healed. ated to the bruise is recorded ecord. RN-A further stated that		Fa	cility ID: 00542 If continu	ation shee	t Page 4 of 14

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CENTE	KS FOR MEDICARE	E & MEDICAID SERVICES			0		0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245594	B. WING	i		10/	03/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MO	RMANOR		,		6 THIRD STREET EAST IORGAN, MN 56266		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	skin is visualized v nursing assistant w also by the licensed record was reviewe monitoring of any k confirmed by RN-A that R12 had a bat further confirmed th skin assessment a identified. RN-A confirmed th bruise to the top as RN-A further confir been identified, inv healed with docum treatment book. R observed the bruis and confirmed she when completing F the day. RN-B que knew how long she responded, "for aw bruise looked good worse, as evidence a swollen appeara R12's bruise shoul investigated and m documented evide No further docume related to the ident alerted to the obse Unwitnessed Injury was documented a	veekly on bath day by the <i>v</i> ho assisted with bathing and d nurse. R12's treatment ed and did not include snown bruises; and this was A. RN-A and RN-B confirmed h earlier on 10/2/14. RN-B hat she had performed R12's nd no bruising had been e presence of a quarter size spect of R12's right wrist. med this bruise should have restigated, and monitored until rented evidence in the N-B then entered R12's room, e to the resident's right wrist, had not identified the bruise R12 skin assessment earlier in estioned R12 whether she e'd had the bruise. R12 <i>v</i> hile". R12 further indicated the d now as it had been much ed by a darker purple color and nce. RN-B confirmed that d have been identified, nonitored until healed with nce in the treatment record. entation was available to review tified bruise. After staff were ervable bruise, a Witnessed or y Incident Report dated 10/2/14 at 4:15 p.m. and identified the ht forearm to measure 3		309	RECEIVED OCT 27 2014 Manestoa Department of Health Marsivali		

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Event ID:8EJI11

Facility ID: 00542

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CENTER	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245594	B. WING		10/03/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GIL- MOI	RMANOR			96 THIRD STREET EAST MORGAN, MN 56266	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CRO SS -REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTION
F 309	interview, R23 statt (below breast area shirt to display a re extended across h reddened marks au stated he had beer "itched" but it did n that staff applied to R23's care plan, w 7/23/2014, identifie or interference with skin caused by pro immobility, oxygen incontinence. The non-pressure relat nor were interventi Document review n notification dated S with the following: underneath bilater interventions which and gold bond pow responded with an Silvadene cream t of the September identified the phys to apply under bila had been initiated related to this skin the medical record skin condition had During an interview registered nurse (fr rash was initially id physician was noti	D p.m., during the initial ed he had a rash on his chest s) and subsequently, lifted his addened, scaly area which is chest. There were visible cross the chest area and R23 in scratching the area as it for "hurt". R23 also indicated opical cream to the area. with a revision date of ed R23 at low risk for ulceration in structural integrity of layers of olonged pressure related to it tubing; fatigue and urinary e care plan lacked reference to red skin issues including rashes ions identified revealed a medical doctor (MD 9/17/14, which identified R23 "red and raw [area] al breasts" and nursing in had been attempted (Nystatin vder). Upon notification, the MD order dated 9/17/14, for wo times daily (BID). Review 2014 treatment record ician ordered Silvadene cream iteral breasts BID until healed on 9/18/14. Documentation in condition was not evident in d nor was there evidence the been monitored. w on 10/02/2014, at 12:15 P.M. RN)- A, verified the chest skin dentified on 9/17/14 and the ified with a request for an		RECEIV DCT 2.7 Menestoa Department Marshair	2014
FORM CMS-2	567(02-99) Previous Versior	ns Obsolete Event ID:8EJI	11	Facility ID: 00542 If con	anuation sheet raye o 0114

PRINTED: 10/15/2014 FORM APPROVED

GENTER	AS FOR MEDICARE	E & MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245594	B. WING	B. WING		10/03/2014
	PROVIDER OR SUPPLIER R MANOR			STREET ADDRESS, 96 THIRD STREET MORGAN, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTIO DRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 309	verified that R23, " various areas of his RN-A confirmed the identification of this any treatment reco area had been mod documentation sho related to R23's sk the progress note of notations regarding progression were of During interview or verified the treatmed cream under bilate then confirmed the of the condition an to indicate whether the skin rash. RN- have expected thi the nursing progre On 10/2/14, at 2:2 (DON), was intervit expect the skin co of the care plan, ex- received ongoing the stated, that if staff entries would have treatment record. is on the record it of Facility procedure Documentation Pr and the following we Bullet #1-To be co that is not a pressi	kin condition. RN-A further had ongoing skin issues on s body since he was admitted". e care plan lacked any s ongoing skin issue nor were ords available that identified the nitored. RN- A indicated build have been available in issues. RN-A also reviewed documentation and verified no g R23's rash nor it's evident. h 10/02/2014, at 2:19 p.mB ent sheet listed Silvadene eral breasts until healed. RN-B ere was no ongoing monitoring d documentation was lacking r the treatment had improved -B further stated that she would s information to be recorded in ss documentation. 20 p.m. the director of nursing iewed and stated she would ndition to be identified as part specially since the resident had treatments. The DON further f had monitored the condition, been documented on the She further stated, "if nothing wasn't done". titled: Weekly Wound ogress Sheet was reviewed	ł	009	RECEIVI OCT 272 Mianesioa Depariment o Marchall	014
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:8EJI	11	Facility ID: 00542	If continu	ation sheet Page 7 of 14

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245594	B. WING		10/03/2014		
NAME OF F	PROVIDER OR SUPPLIEF		1	STREET ADDRESS, CITY, STATE, ZIP C		/00/2014	
GIL- MOI	RMANOR						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE	
F 309	skin condition and thereafter; and Bullet#8- Once the	age 7 mpleted upon discovery of a then at least weekly e area is healed, the other skin to be filed into resident medical	F3		. 0		
F 329 SS=D	483.25(I) DRUG F UNNECESSARY Each resident's dr unnecessary drug drug when used ir duplicate therapy) without adequate indications for its u adverse conseque should be reduced combinations of th Based on a comp resident, the facili who have not use given these drugs therapy is necess as diagnosed and record; and reside drugs receive gra- behavioral interve	ug regimen must be free from s. An unnecessary drug is any nexcessive dose (including ; or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose d or discontinued; or any	F3	Plan of con RECT OCT 2 Minnesion Depa	EIVED To 2014	101 <i>301 p</i>	
	by:	ENT is not met as evidenced ew and document review the					

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

PRINTED: 10/15/2014 FORM APPROVED OMB NO, 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245594	B. WING			10/	03/2014	
	NAME OF PROVIDER OR SUPPLIER GIL- MOR MANOR			96	REET ADDRESS, CITY, STATE, ZIP CODE THIRD STREET EAST ORGAN, MN 56266			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	reviewed for unneo defined parameters (Tylenol) with a dos recommended dail Findings include: R42 was admitted diagnoses of multig mild cognitive impa September 2014 m record (MAR) indio (Acetaminophen) a (mg) tablets 1-2 w daily (total potentia Medication adminis AM (morning) and number of tablets t medication adminis the MAR did not in that were administ the MAR also indio tablets 1000 mg tw pain. Although R4 prescription in Sep dose totaled 2000 parameters for use order and/or on the tablets to administ daily dose of Aceta current physician of per 24 hrs was 460 recommended limi When interviewed pharmacist consul-	ure that 1 of 5 residents (R42) ressary medications had a for the use of Acetaminophen are not to exceed the maximum y dose. to the facility 7/25/14 with the ole myeloma, chronic pain and airment. Review of the nedication administration rated that Tylenol arthritis strength 650 milligram are to be administered twice I dose in 24 hrs= 2600 mg). stration times were scheduled HS (hour of sleep) and the hat were given for the AM stration was documented but dicate the number of tablets ered at HS. Documentation on rated a prescription for Tylenol <i>vice</i> a day as needed (PRN) for 2 had not utilized the PRN tember, the potential daily mg. However, there were no a identified on the physician e MAR to determine how many er to remain within in the safe uminophen (Tylenol). The orders for Acetaminophen dose 00 mg which exceeds the daily	F	329	RECEIVEI OCT 2 7 201 Manestoa Department of He Marchall			

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		AND HUMAN SERVICES			FORM	10/15/2014 APPROVED 0938-0391
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245594			B. WING		10/0	03/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MOR MANOR			1	5 THIRD STREET EAST IORGAN, MN 56266		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD I REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) DEFICIENCY)				
F 329 F 428 SS=D	verified that safe da acetaminophen she When interviewed director of nursing would expect staff the amount of med medication order ic It was also verified dosing parameters MAR and it should administration not 483.60(c) DRUG F IRREGULAR, ACT The drug regimen reviewed at least of pharmacist. The pharmacist mithe attending phys	aily dosing parameters of build be indicated on the MAR. on 10/1/14, at 12:00 p.m. the (DON) indicated that she documentation which identified ication administered when the lentified a range of 1-2 tablets. there were no safe daily for acetaminophen on the have indicated that exceed 4000 mg daily. REGIMEN REVIEW, REPORT	F 329 F 428	Ptease see attache prin of correction	d ~	10/30/1Y
	by: Based on interview pharmacist consul residents (R42) rev medications had d of Acetaminophen	NT is not met as evidenced w and document review the tant failed to ensure that 1 of 5 viewed for unnecessary efined parameters for the use (Tylenol) with a daily dose not imum recommended daily		RECEIVED OCT 272014 Manneston Department of Heald Marchall		

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Event ID:8EJI11

Facility ID: 00542

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CENTER	<u>AS FOR MEDICARE</u>	E & MEDICAID SERVICES			(<u>. טעו פוער.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245594	B. WINC	à		10/03/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MOR MANOR				1	ORGAN, MN 56266		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	I	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	R42 was admitted diagnoses of multi	to the facility 7/25/14 with the ple myeloma, chronic pain an		428			
	 diagnoses of matple inyclonal, 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 						
			у				
	per 24 hrs was 46 recommended lim	00 mg which exceeds the dail	У		RECEIVI		
	pharmacist consul tablets of Tylenol a should be identifie verified the daily p	on 10/2/14, at 10:15 a.m. the Itant verified the number of arthritis administered to R42 of on the MAR. He further parameters of acetaminophen of on the MAR. The monthly			OCT 272 Manestoa Department or Marchall	l]]4 'Health	
	drug therapy revie pharmacist consu no noted irregular When interviewed	w was completed by the Itant on 9/9/14 and there were rities. I on 10/1/14, at 12:00 p.m. the				ation sheet	t Page 11 of 14
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:8E	JUII	ra	cility ID: 00542 If continu		ingo non

OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 245594 B. WING 10/03/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 96 THIRD STREET EAST **GIL- MOR MANOR** MORGAN, MN 56266 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 428 Continued From page 11 F 428 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. Please see attached plan of correction 10/30/14 F 431 i 483.60(b), (d), (e) DRUG RECORDS, F 431 LABEL/STORE DRUGS & BIOLOGICALS SS≖E 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 RECEIVED facility must store all drugs and biologicals in locked compartments under proper temperature OCT 2 7 2014 controls, and permit only authorized personnel to have access to the keys. Manestoa Department of Health Marshall 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 12 of 14

PRINTED: 10/15/2014 FORM APPROVED

PRINTED: 10/15/2014 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245594	B. WING	à		10/	03/2014
	NAME OF PROVIDER OR SUPPLIER GIL- MOR MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST MORGAN, MN 56266		
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F 431	package drug distr quantity stored is m be readily detected This REQUIREME by: Based on observa review the facility f medications on 1 of carts (west-central Findings include: During observation trained medication placing medication medication cart for pushed the locking medication cart an were supposed to cart was in the lock observed to be par was also not locke the cart was not fu further verified that approximately "a w director of nursing lock on the cart. It (1 & 4) had individu resident prescriptio medications were for residents who r and/or center wing During an interview	n the facility uses single unit ibution systems in which the ninimal and a missing dose can l. NT is not met as evidenced tion, interview and document ailed to maintain the security of of 2 medication administration). n on 10/01/14, at 10:02 a.m. aide (TMA)-C was observed cards into drawer one of the the center/west unit. TMA-C g mechanism to secure the d verified the cart drawers be locked. Even though the ked position, drawer one was rtially open and drawer four d. TMA-C stated the lock on nctioning properly. TMA-C t a request had been filled out week or so ago" notifying the (DON) of the malfunctioning twas noted that both drawers ual punch cards that contained on medications. The stored in the medication cart reside on the either the west IS. w on 10/1/14, at 10:57 a.m. the		43	1 RECEIN OCT 2.7 Marshall	2014 nt of Health	
	DON verified the n	nedication cart was to be					

Facility ID: 00542

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 431	locking mechanism The DON further st been notified of the cart and she was w a new medication of it was observed on west/central medica of the nursing statio the immediate area resident was obser nursing station whil the area. At 12:30 nurse(RN)-A and T station and verified opened while in the nursing staff were i Review of the polic Medications dated policy interpretation stated: "During adi medication cart is k out of sight of the n cart must be clearly administering medi	use and she was aware the was not functioning properly. ated the administrator had improperly locking medication vaiting for approval to purchase	F	431	RECEIVED OCT 2 7 2014 Marchall	t h	

Facility ID: 00542

If continuation sheet Page 14 of 14

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

<u>F279 (Scope/Severity = D)</u> 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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OCT 2 7 2014

R@meetoa Department of Health Marshall

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.

RECEIVED OCT 2 7 2014 Manestos Department of Health

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

F329 (Scope/Severity = D) 483.25(I) 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 discussed at our quarterly Quality Assurance and Assessment meeting. Completion date is October 30, 2014.

RECEIVED OCT 2 7 2014 Managenesion Department of Health

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.

RECEIVED OCT 2 7 2014 Manestoa Department of Health

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

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

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.

OCT 2 7 2014 Manestoa Department of Ficalth

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COU 96 THIRD STREET EAST MORGAN, MN 56266	DE	
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-14	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST S FORM-2567 WILL BE ATION OF COMPLIANCE.		Por ok 10-29-14		
C: 11-12-14	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
Q /1-2	Minnesota Departn Fire Marshal Divisio time of this survey, in substantial comp for participation in I Subpart 483.70(a), 2000 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, State on, on October 1, 2014. At the Gil-Mor Manor was found not bliance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the cional Fire Protection) Standard 101, Life Safety oter 19 Existing Health Care		RECEN OCT 27 2	VED 2014	
10-3-14	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		MN DEPT. OF PUBLI STATE FIRE MARSHA	CONTEN	
	Health Care Fire In State Fire Marshal 445 Minnesota Stre	Division				

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.

ATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY
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K 000	Continued From pa By eMail to: Marian.Whitney@s	state.mn.us	к ос	0			
	DEFICIENCY MUS	what has been, or will be, done					
		roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
K 062 SS=E	The original buildir one-story in height sprinkler protected Type II(111) constr addition is one-sto is fully fire sprinkle determined to be o	s constructed as follows: ng was constructed in 1963, is t, has no basement, is fully fire I and was determined to be of ruction; The 1989 building ry in height, has no basement, r protected and was of Type II(111) construction. AFETY CODE STANDARD	K 06	52 P.	ease see attach	Dain	10)14/10
33-E	continuously main condition and are	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,			per · · · ·		
	Based on observation facility failed to ma	is not met as evidenced by: ation and staff interview, the aintain the fire sprinkler system of the requirements of 2000					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00542

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		0938-039 E SURVEY PLETED
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K 062	1998 NFPA 25, see	age 2 is 19.3.4.1 and 9.6, as well as ction 2-2.1.1 and 2-2.2. This could affect all 35 out 35	K 062	2		
K 144 SS=F	10/01/2014, obser following were four 1. Kitchen- Dishw heads located in the NFPA 101 LIFE SA	ashing area, the fire sprinkler his area were corroded. AFETY CODE STANDARD	K 144	Please see attack plan of corre	10 hed ction	- J - 14 - 9 29
	under load for 30 r	spected weekly and exercised ninutes per month in IFPA 99. 3.4.4.1.				
	NFPA 101 (2000) REGULATION - G weekly and exerci- 30% of the EPS na per month and sha	is not met as evidenced by: LIFE SAFETY CODE SURVEY enerators must be inspected sed under load at not less than ameplate rating, for 30 minutes all be in accordance with NFPA and NFPA 110 (1999 edition).				
	99 (1999 edition) a This STANDARD	all be in accordance with NFPA and NFPA 110 (1999 edition). is not met as evidenced by: f interview and review of				

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
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К 144	available records, t document weekly in generator. In a fire deficient practice corresidents, staff and FINDINGS INCLUE On 10/01/2014 at 1 interview and review documentation courrequired weekly ins generator had been 01/10/14-02-02/20 08-26-2014-09-28- was not in accorda	he facility did not properly hspections for the emergency or other emergency, this build adversely affect 35 of 35 visitors. DE: 1:15 AM, during a staff w of available records, no ld be provided verifying the spection of the emergency in performed between 14 and 2014. This deficient practice nce with NFPA 110 (1999), 6-4.2 and NFPA 99 (1999),	К 1	44		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 8EJI21	1	Facility ID: 00542	If continuation sh	heet Page 4 of 4

PRINTED: 10/15/2014

October 6, 2014

Plan of Correction Minnesota Fire Marshal Survey completed on 10/01/2014

<u>K62 (SS = E)</u>

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.

<u>K144 (SS = F)</u>

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.



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

Gil- Mor Manor October 15, 2014 Page 2 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,

Kumalu 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 Gil- Mor Manor October 15, 2014 Page 3

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
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	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	and 2nd, 2014, sur staff, visited the ab- correction orders a are completed, plea copy of these order	TS: n and 30th, and October 1st veyors of this Department's ove provider and the following re issued. When corrections ase sign and date, make a rs and return the original to the nent of Health, Division of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nursi Homes.	

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

TITLE

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/03/2014	
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GIL- MO	R MANOR) STREET E/ N, MN 56266			
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	Compliance Monito Certification Progra MN 55164-0900	ring, Licensing and m, P.O. Box 64900 St. Paul,		The assigned tag number ap far left column entitled "ID Pr The state statute/rule numbe corresponding text of the state out of compliance is listed in "Summary Statement of Defic column and replaces the "To portion of the correction orde column also includes the fin are in violation of the state sta statement, "This Rule is not r evidenced by." Following the findings are the Suggested M Correction and the Time Peric Correction. PLEASE DISREGARD THE I THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPLI FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREME SUBMIT A PLAN OF CORREC VIOLATIONS OF MINNESO STATUTES/RULES.	efix Tag." r and the e statute/rule the ciencies" Comply" r. This dings which atute after the net as e surveyors lethod of od For HEADING OF IICH N OF ES TO NLY. THIS GE. NT TO CCTION FOR	
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	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c	of plan of care. The n of care must list measurable stables to meet the resident's n goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan				

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If continuation sheet 2 of 19

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		00542	B. WING		10/03/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GIL- MO	R MANOR		STREET EAS I, MN 56266	ST		
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETI
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 560	Continued From pa	ige 2	2 560			
	required by Minnes subdivision 14, para	ota Statutes, section 626.557, agraph (b).				
	•	ent is not met as evidenced				
	review the facility fa for 1 of 1 resident (ion, interview and document ailed to develop a plan of care R 23) reviewed who had an				
	Findings include:	ocated on the chest area.				
	interview, R23 state (below breast areas shirt to display a re- extended across his reddened marks ac stated he had been "itched" but it did no	p.m., during the initial ed he had a rash on his chest s) and subsequently, lifted his ddened, scaly area which s chest. There were visible cross the chest area and R23 a scratching the area as it ot "hurt". R23 also indicated pical cream to the area.				
	7/23/2014, identifie or interference with skin caused by prol immobility, oxygen incontinence. The	th a revision date of d R23 at low risk for ulceration structural integrity of layers of longed pressure related to tubing; fatigue and urinary care plan lacked reference to ed skin issues including rashes manage them.				
	notification dated 9, with the following: underneath bilatera interventions which and gold bond pow responded with an Silvadine cream two	evealed a medical doctor (MD) /17/14, which identified R23 "red and raw [area] I breasts" and nursing had been attempted (Nystatin der). Upon notification, the MD order dated 9/17/14, for o times daily (BID). Review of 4 treatment record identified				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00542	B. WING		10/03/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GIL- MO	R MANOR) STREET EAS 1, MN 56266	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 3	2 560			
	under bilateral brea initiated on 9/18/14 this skin condition v record nor was then had been monitored During an interview registered nurse (R rash was intially ide physician was notifi evaluation of the sk verified that R23, "h various areas of his RN-A confirmed the identification of this any treatment record area had been mor On 10/2/14, at 2:20 (DON), was intervite expect the skin com of the care plan, es received ongoing tr	y on 10/02/2014, at 12:15 P.M. N)- A, verified the chest skin entified on 9/17/14 and the ied with a request for an kin condition. RN-A further had ongoing skin issues on s body since he was admitted". e care plan lacked any ongoing skin issue nor were rds available that identified the hitored. 0 p.m. the director of nursing ewed and stated she would didition to be identified as part specially since the resident had reatments.				
	Documentation Pro and the following w Bullet #1-To be con that is not a pressu venous wo und, or Bullet #7-To be con skin condition and t thereafter; and Bullet#8- Once the	itled: Weekly Wound ogress Sheet was reviewed vas noted: npleted on any skin concern re ulcer, arterial wound, neuropathic wound; npleted upon discovery of a then at least weekly area is healed, the other skin o be filed into resident medical				
		THOD OF CORRECTION: sing could in-service licensed				

	ota Department of He	aith (X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00542	B. WING		10/	10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
GIL- MO	R MANOR		STREET EAS I, MN 56266	ST			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETI DATE	
2 560	Continued From pa	ge 4	2 560				
		are plan to include appropriate identified care needs. The could monitor staff					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830				
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					
	by: Based on observati review the facility fa and/or monitor 1 of	ent is not met as evidenced on, interview, and document illed to identify, investigate, 1 resident (R12) reviewed for of skin issue which included					
	Findings include:						
	1:17 p.m. R12 was	ion/interview on 9/30/14, at observed with a quarter size a top aspect of her right wrist.					

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00542	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GIL- MO	R MANOR) STREET EAS 1, MN 56266	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 5	2 830			
	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.					
	registered nurse (R bruise is identified of measured, and more Documentation relation on the treatment re- skin is visualized w nursing assistant w also by the licensed record was reviewed monitoring of any k confirmed by RN-A that R12 had a bath further confirmed th	on 10/2/2014, at 3:30 p.m. N)-A stated that when a on a resident it is investigated, nitored until healed. tted to the bruise is recorded cord. RN-A further stated that veekly on bath day by the ho assisted with bathing and d nurse. R12's treatment d and did not include nown bruises; and this was . RN-A and RN-B confirmed n earlier on 10/2/14. RN-B hat she had performed R12's and no bruising had been				
	bruise to the top as RN-A further confirr been identified, inve healed with docume treatment book. RI observed the bruise and confirmed she when completing R the day. RN-B que	e presence of a quarter size pect of R12's right wrist. med this bruise should have estigated, and monitored until ented evidence in the N-B then entered R12's room, to the resident's right wrist, had not identified the bruise 12 skin assessment earlier in stioned R12 whether she 'd had the bruise. R12				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00542	B. WING		10/	10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
GIL- MO	R MANOR		STREET EAS	т			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	bruise looked good worse, as evidence a swollen appearan R12's bruise should investigated and mo documented eviden No further documer related to the identifi alerted to the obser Unwitnessed Injury was documented at bruise to R12's righ centimeters (cm) x SUGGESTED MET The DON or design document new skin these on a regular b designee could perf compliance TIME PERIOD FOF (21) days. MN Rule 4658.0800 Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for	hile". R12 further indicated the now as it had been much d by a darker purple color and ce. RN-B confirmed that have been identified, ponitored until healed with ice in the treatment record. Attation was available to review fied bruise. After staff were vable bruise, a Witnessed or Incident Report dated 10/2/14 4:15 p.m. and identified the t forearm to measure 3	2 830				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00542	B. WING		10/03/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
GIL- MO	R MANOR		STREET EAS I, MN 56266	т				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE		
21390	immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence produce I. methods for	trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and	21390					
	by: Based on interview facility failed to have that assured each e received a tubercul the potential to affe in the facility. Findings include: During review of en following document 1. Certified nursing on 7/2/14 and failed immunization recor conducted.	ent is not met as evidenced and document review the e an infection control program employee 8 of 11 reviewed had in skin test (TST) which had ct 34 of 34 residents residing nployee TST records the ation was noted: assistant (NAR)-D was hired d to have any evidence in her d to identify a TST had been)-A, hired 5/22/14, was						

Minnesota Department of Health STATE FORM

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If continuation sheet 8 of 19

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00542	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
			STREET EAS			
GIL- MO	R MANOR	MORGAN	N, MN 56266			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ge 8	21390			
	checked on 5/21/14 tuberculin skin test TB Blood Test docu indicate the results test. 3. Social services (noted to have a tub previous employer of immunization record SS-A had declined hire. 4. Maintenance em immunization record of a tuberculin skin 5. Laundry aide (LA immunization record of a tuberculin skin 6. Dietary aide (DA) immunization record of a tuberculin skin 6. Dietary aide (DA) immunization record of a tuberculin skin 7. NAR-E, hired 9/ failed to reveal any test being conducte 8. NAR-F, hired 8/2 failed to reveal any conducted. During interview witt (DON) on 2/10/14, a the facility infection stated she was uns test records were in the facility policy rec two-step tuberculin The DON also state tuberculin skin test staff person, upon f reading on the first	 A, hired 9/8/14, d failed to reveal any evidence test. B, hired 6/13/14, d failed to reveal any evidence test. (12/14, immunization record evidence of a tuberculin skin ed. 12/14, immunization record evidence of a TST being th the director of nursing at 2:19 p.m. who served as control professional, she ure why the tuberculin skin nocomplete. The DON stated quired all staff and residents a skin test upon admission/hire. ed the facility procedure for administration was for each hire, to get their initial Mantoux day of work. The DON stated tact with residents before first 				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00542	B. WING		10/	10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
GIL- MO	R MANOR		STREET EAS	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21390	 staff to receive their work then have the nurses station for the nurses station for the 72 hours and condulater. The DON verification of the missed or payrerified by the DON staff member would conducted they wour method to verify the (i.e. chest x-ray). The facility policy for Employees, dated 2 standard: 1. New employees a negative two-step within the previous TB screen repeated tool will be completed for baseline second step. 3. New employees a negative skin test wi will undergo a ches have a documented positive TST. 4. Individuals with d negative CXR will be symptoms of active 	blained by the DON was for r first TST on the first day of TB Test form left at the ne nursing staff to read within uct a second step 2-3 weeks fied the system was not ded. All findings were verified artially missed TST's were I. The DON also verified if a d refuse to have the TST uld have to find an alternative ey were free of Tuberculosis or Tuberculosis Screening for 2013, identified the following who present a written report of o Tuberculin Skin Test (TST) 12 months will not need their d and the employee screening	21390	DEFICIENC	ΥY)		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00542	B. WING		10/	10/03/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
GIL- MO	R MANOR) STREET EAS 1, MN 56266	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	ge 10	21390				
	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.						
		[⊂] can have a time frame eeks, but not greater than 365					
	employee's medica a. Skin test resu millimeters of indura is "positive" o b. The tuberculir will be recorded. c. A record of al available to facilitate	ults will be documented in ation rather than stating result					
	ensure all new emp and that employees	follow their own policy to loyees are screened for TB do not begin to provide ts until their first step TST has					
	The DON (Director one staff to be in ch tuberculin skin test upon hire. The DO	HOD OF CORRECTION: of Nursing) could designate harge of ensuring 2-step are completed for employees N could complete random ntinued compliance.					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00542	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		96 THIRD	STREET EAS	ST		
	R MANOR	MORGAN	I, MN 56266			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ge 11	21390			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310) A.B.C Drug Regimen Review	21530			
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ad report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the me the attending physic justification for the o physician does not must be referred fo	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the irposes of this part, "acted coeptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is eacted, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00542	B. WING		10/	03/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GIL- MO	R MANOR		O STREET EAS N, MN 56266	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 12	21530			
	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:					
	diagnoses of multip mild cognitive impa September 2014 m record (MAR) indica (Acetaminophen) a (mg) tablets 1-2 we daily (total potential Medication adminis AM (morning) and H number of tablets th medication administ the MAR did not inco that were administe the MAR also indica tablets 1000 mg twi pain. Although R42 prescription in Sept dose totaled 2000 m parameters for use	o the facility 7/25/14 with the le myeloma, chronic pain and irment. Review of the edication administration ated that Tylenol rthritis strength 650 milligram re to be administered twice dose in 24 hrs= 2600 mg). tration times were scheduled HS (hour of sleep) and the nat were given for the AM tration was documented but dicate the number of tablets ered at HS. Documentation on ated a prescription for Tylenol ice a day as needed (PRN) for 2 had not utilized the PRN ember, the potential daily ng. However, there were no identified on the physician MAR to determine how many				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00542	B. WING		10/	03/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BIL- MOF	R MANOR		D STREET EAS N, MN 56266	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530		ge 13 minophen (Tylenol). The ders for Acetaminophen dose	21530			
		0 mg which exceeds the daily				
	pharmacist consulta tablets of Tylenol ar should be identified verified the daily pa should be indicated drug therapy review	on 10/2/14, at 10:15 a.m. the ant verified the number of thritis administered to R42 on the MAR. He further rameters of acetaminophen on the MAR. The monthly was completed by the ant on 9/9/14 and there were ies.				
	director of nursing (would expect staff of the amount of medi medication order id It was also verified dosing parameters MAR and it should	on 10/1/14, at 12:00 p.m. the DON) indicated that she documentation would identify cation administered when the entified a range of 1-2 tablets. there were no safe daily for acetaminophen on the have indicated that exceed 4000 mg daily.				
	The director of nurs the consultant phar review and/or revise ensure medication potential for overdo	THOD OF CORRECTION: sing (DON) or designee, and macist (CP) could develop, e policies and procedures to orders are reviewed for the se with mulitiple drug orders ion of dosage limits.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary al	21535			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00542	B. WING		10/	03/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GIL- MO	R MANOR		D STREET EAS N, MN 56266	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	ge 14	21535			
21535	 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. 					
	by: Based on interview facility failed to ensi- reviewed for unnec- defined parameters	ent is not met as evidenced and document review the ure that 1 of 5 residents (R42) essary medications had for the use of Acetaminophen e not to exceed the safe e				
	Findings include:					
	diagnoses of multip	o the facility 7/25/14 with the le myeloma, chronic pain and irment. Review of the				

STATE FORM

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00542	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
GIL- MC	R MANOR		STREET EAS I, MN 56266	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	September 2014 m record (MAR) indica (Acetaminophen) a (mg) tablets 1-2 we daily (total potential Medication adminis AM (morning) and H number of tablets th medication administ the MAR did not indi- that were administe the MAR also indica tablets 1000 mg twi pain. Although R42 prescription in Sept dose totaled 2000 r parameters for use order and/or on the tablets to administe daily dose of Acetar current physician on per 24 hrs was 460 recommended limit When interviewed of pharmacist consulta tablets of Tylenol ar should be identified verified that safe da acetaminophen sho	edication administration ated that Tylenol rthritis strength 650 milligram re to be administered twice dose in 24 hrs= 2600 mg). tration times were scheduled HS (hour of sleep) and the nat were given for the AM tration was documented but dicate the number of tablets ared at HS. Documentation on ated a prescription for Tylenol ice a day as needed (PRN) for 2 had not utilized the PRN ember, the potential daily mg. However, there were no identified on the physician MAR to determine how many rt to remain within in the safe minophen (Tylenol). The rders for Acetaminophen dose 0 mg which exceeds the daily s of 4000 mg. on 10/2/14, at 10:15 a.m. the ant verified the number of thritis administered to R42 on the MAR. He further ally dosing parameters of build be indicated on the MAR. on 10/1/14, at 12:00 p.m. the DON) indicated that she documentation which identified cation administered when the entified a range of 1-2 tablets. there were no safe daily for acetaminophen on the				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00542	B. WING		10/	03/2014
NAME OF	IAME OF PROVIDER OR SUPPLIER STREET AD			TATE, ZIP CODE		
GIL- MO	R MANOR		STREET EAS	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ge 16	21535			
	The director of nurs review policies/proc medications, educa ensure compliance.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage		21610			
	must store all drugs under proper tempe	e of drugs. A nursing home is in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document iled to maintain the security of f 2 medication administration				
	Findings include:					
	trained medication placing medication medication cart for pushed the locking medication cart and were supposed to b cart was in the lock observed to be part was also not locked	on 10/01/14, at 10:02 a.m. aide (TMA)-C was observed cards into drawer one of the the center/west unit. TMA-C mechanism to secure the d verified the cart drawers be locked. Even though the ed position, drawer one was ially open and drawer four d. TMA-C stated the lock on actioning properly. TMA-C				

	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00542	B. WING		10/03/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
GIL- MC	OR MANOR		STREET EAS , MN 56266	ST				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE		
21610	further verified that approximately "a we director of nursing (lock on the cart. It (1 & 4) had individu resident prescriptio medications were s for residents who re and/or center wings During an interview DON verified the m locked when not in locking mechanism The DON further st been notified of the cart and she was w a new medication c It was observed on west/central medica of the nursing station the immediate area resident was observ nursing station whil the area. At 12:30 nurse(RN)-A and T station and verified opened while in the nursing staff were in Review of the policy Medications dated 2 policy interpretation stated: "During adr medication cart is k out of sight of the m cart must be clearly	a request had been filled out eek or so ago" notifying the (DON) of the malfunctioning was noted that both drawers al punch cards that contained n medications. The tored in the medication cart eside on the either the west s. Ton 10/1/14, at 10:57 a.m. the edication cart was to be use and she was aware the was not functioning properly. ated the administrator had improperly locking medication aiting for approval to purchase	21610					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00542	B. WING		10/	03/2014
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GIL- MOI	R MANOR		D STREET EAS N, MN 56266	5T		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21610	Continued From pa	age 18	21610			
	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 FOI (21) days.	R CORRECTION: Twenty-one				