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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 93UH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**
2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor — 06/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 08/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/28/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2017
(L33)

DETERMINATION APPROVAL

CCN: 24-5263

On April 14, 2017, an abbreviated standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of D.

On May 11, 2017 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of D.

As a result of these findings, the facility was not in substantial compliance and State monitoring was imposed, effective May 29, 2017.

In addition, the facility was notified of imposition of the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective July 14, 2017

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning July 14, 2017.

On May 23, 2017 and June 30, 2017, Office of Health Facility Complaints and Licensing and Certification Program verified correction of all deficiencies.

As a result of the revisit findings, State monitoring was discontinued.

In addition, Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective July 14, 2017, was be rescinded.

Since DPNA did not go into effect, the two year loss of NATCEP, which was to begin July 14, 2017 was also rescinded.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24-5263 August 25, 2017

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Dear Mr. Braband:

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 June 30, 2017 the above facility is certified for or recommended for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 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,

Shellae Dietrich

Shellae Dietrich, Certification Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 6, 2017

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: Project Number H5263010 and S5263026

Dear Mr. Braband:

On May 24, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective May 29, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 14, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 24, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 14, 2017.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on April 14, 2017 and a standard survey completed on May 11, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 23, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on June 30, 2017 the Licensing and Certification Program completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on April 14, 2017 and a standard survey completed on May 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey completed on April 14, 2017 and standard survey completed on May 11, 2017, as of June 30, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 30, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 24, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 14, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 14, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 14, 2017, is to be rescinded.

In our letter of May 24, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 14, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 30, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

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

cc: Office of Health Facility Complaints File
Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 6, 2017

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

Re: Enclosed Reinspection Results - Complaint Number H5263010

Dear Mr. Braband:

On May 23, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on April 14, 2017. At this time these correction orders were found corrected.

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

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

Sincerely,

Mark Meath

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 93UH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**
2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Andrea Schmitz, HFE NE II 06/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/03/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2017

Mr. Jon Braband, , Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: Project Number S5263026 & H5263010

Dear Mr. Braband:

On May 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on April 14, 2017. This abbreviated standard survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 11, 2017, the Minnesota Department of Health and on May 10, 2017, the Minnesota Department of Public Safety completed a standard survey to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) , as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 29, 2017. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 14, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 14, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 14, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Estates At Linden Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 30, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
kathy.lucas.state.mn.us
Telephone: (320)223-7343 Fax: (320)223-7348

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132

Director, Civil Remedies Division

330 Independence Avenue, S.W.

Cohen Building – Room G-644

Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor

Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		6/15/17

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

Electronically Signed | 06/02/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess resident's safety with the use of bed rails for 1 of 2 residents (R75) reviewed for accidents. In addition, the facility failed to ensure staff used appropriate brand of sling when using sit to stand lifts, which had the potential to affect 2 of 15 residents (R57, R49) who used the lifts in the 400 wing. Findings include: R75's quarterly Minimum Data Set (MDS), dated 1/25/17, identified R75 was cognitivelly intact, required extensive assistance with bed mobility and transfers, had diagnoses of dementia and seizure disorder, and received anticoagulation (blood thinning) therapy. An incident note dated 4/23/17, at 3:16 p.m. identified R75 had sustained a skin tear to his right forearm measuring 1.4 cm (centimeters) x (by) 1.6 cm. The note indicated R75 had sustained the skin tear that morning and was observed by nursing assistant (NA)-A, who had updated registered nurse (RN)-B of the skin tear. It further identified that at the time of the incident R75's arms were inbetween the side rail, with the call light wrapped around he side rails. The area was cleansed and a bandage was applied. The note indicated R75's wife and physician were notified, and the cause of the skin tear was identified: R75's was sleeping, placed his arm	F 323	F 323: Free of Accident Hazards/Supervision/Devices is the policy of this facility to ensure that the resident environment remains as free from accident hazards as is possible; Each resident receives adequate supervision and assistance devices to prevent accidents; facility attempts to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, it is the policy of this facility to ensure correct installation of bed rails, including but not limited to the following elements: (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3)Ensure that the bed(s) dimensions are appropriate for the resident(s) size and weight. Bed Rail deficiency: The facility bed entrapment policy and procedure was reviewed and no changes are indicated at this time. A Bed Rail Assessment Policy and Procedure was developed. A new assessment packet was developed. This packet includes the assessment, risk/benefit analysis and informed consent. An assessment will be completed on all residents with side rails	

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F 323	Continued From page 2 through the side rails, and bump into the metal clip of his call light. The note identified R75 was instructed to place the call light on his blanket, not around the side rails, as "he tends to like to place hands on side rail when sleeping." A facility document entitled Bed Checks, dated 4/26/17, indicated R75's side rail and mattress were measured for the U.S. Food and Drug Administration (FDA) recommended criteria for entrapment risks. However, the document lacked attempts to use appropriate alternatives prior to installing side rails, lacked review of risk vs. benefits of bed rails, and lacked that informed consent was obtained prior to use. R75's care plan dated 5/10/17, identified he was at risk for uncontrolled bleeding and bruised easily related to anticoagulation therapy with Coumadin (a blood thinning medication). The care plan indicated R75 had a self care deficit and used "turn rails on bed to aid in mobility." It further identified R75 was at risk for seizures, to keep call light within reach, and indicated R75 was at risk for injury related to falls with an unsteady gait, requiring staff assistance with transfers and ambulation. R75's care plan lacked information regarding his safety with the side rail and potential for further injury after sustaining the skin tear. During observation on 5/10/17, 7:09 a.m. R75 was lying on his left side in bed. A call light was observed lying across R75 and wrapped around a quarter side rail on the left side of the bed; the side rail had five holes within the inside of the rail. The metal clip of the call light was exposed and did not contain any covering. The right side of the bed was against the bedroom wall and did not	F 323	by June 16, 2017. Future residents will have an assessment as well. A bed rail assessment (including informed consent) was completed by therapy for R75 on 5/30/17. The findings of the assessment require R75 to use bed rails to safely perform bed mobility and transfers in/out of bed with SBA. In addition, bed rails provide stability for decreased balance and enables R75 to be more independent. On June 6, 2017, education will be provided to licensed staff that will be completing the bed rail assessment packet. The education will include instructions on how to complete the assessment and the Bed Rail Policy and Procedure. For three months, the Director of Nursing (or designee) will monitor the implementation of the bed rail policy and procedure by ensuring that individual bed rail assessments are performed on all current and future residents. The DON (or designee) will report the results of the audits to the QAPI steering team for review and follow-up action if needed. Pro-Assist deficiency: The facility immediately removed the Professional Assistance Lift (PAL) Pro-1 Model PC350 (Pro-Assist lift) from use on 5/11/17. All mechanical lifting devices used in the facility were reassessed to	

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F 323	Continued From page 3 contain a side rail. R75 arms were near the side rail; his right hand rested on top of the side rail. During observation, NA-B unwrapped and unclipped the call light from the side rail. NA-B assisted R75 to sit up at the edge of the bed, and R75 was able to assist in sitting up by using his right hand to push off the side rail. NA-B proceeded to complete R75's morning cares. During interview on 5/10/17, at 12:23 p.m. NA-B stated R75 used the side rail to turn in bed and transfer out of bed. NA-B stated R75 had just moved to a different room, now the bed was on the opposite side of the room, and R75 usually transferred more independently; however, he wasn't use to getting out on the left side of the bed and needed more assistance since the move. NA-B was not aware of any incidents involving R75's side rail. During interview on 5/10/17, at 1:15 p.m. NA-A stated R75 used the side rail to assist him with getting out of bed. NA-A further stated R75 would wrap his arm up, through, and around the side rail hole in order to hoist himself up in bed. NA-A stated she had witnessed R75's skin tear on 4/23/17. NA-A stated R75 liked to sleep with his arm in the side rail hole. NA-A reported staff wrapped R75's call light around his side rail per his preference, and when he stuck his arm through the side rail hole, the metal clip of the call light must have scraped his arm causing the skin tear. NA-A stated she had noticed dried blood on R75's arm the morning of 4/23/17 and had notified RN-B. NA-A stated she had wrapped tape around R75's call light to cover the metal clip but had not received any direction after the incident. NA-A further stated R75 was "a creature of habit" and staff continued to wrap his call light around	F 323	ensure devices and slings are made by the same manufacturer. The facility Minimal Lifting Policy and Procedure was reviewed and no changes are indicated at this time. Reeducation regarding proper use of mechanical lifting devices and slings will be provided to direct care staff by June 15, 2017. Submitted by: Jon C. Braband, President & CEO	

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F 323	Continued From page 4 the side rail. During interview on 5/11/17, at 8:38 a.m. RN-B stated she was getting ready for her medication pass when NA-A notified her of R75's skin tear. RN-B stated R75 had a tendency to place his arm in the side rail and wondered if R75 had brushed against the call light causing the skin tear. RN-B reported she cleaned R75's skin tear, continued to monitor it on the electronic treatment record (eTAR), and the skin tear healed shortly after the incident. RN-B stated the incident was passed along in report to the oncoming shift, and then R75 transferred to a different wing of the facility. RN-B thought the evening staff were going to check with R75 that night and see if he would be okay clipping the call light to the blanket instead of the side rail. RN-B was not aware of any follow up after the incident, and did not know if the clip or call light had been replaced. During interview on 5/11/17, at 9:12 a.m. director of nursing (DON) stated all residents had side rails on their bed unless the resident preferred not to have them, and most residents liked having side rails to assist with turning and transfers. The DON stated the shorter length of the rails made them assist rails not side rails. The DON further stated currently the facility measured the rails for entrapment risk, but had no procedure, policy, or assessment on assessing the rails for safe use by the resident or if the rails posed a restraint risk and hindered residents from freely transferring out of bed. The DON report if equipment caused an injury, a maintenance slip was filled out so maintenance could look at the equipment to prevent further injuries. The DON remembered R75's skin tear had been discussed during an interdisciplinary team meeting, but was not aware	F 323		

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F 323	Continued From page 5	F 323		

of the follow up afterward. The DON would have expected staff to assess and identify the cause of the injury, and attempt interventions to prevent the incident from re-occurring. During interview, the DON observed R75's call light, which was again wrapped around his side rail, and stated the metal clip didn't feel sharp unless she pushed hard. However, the DON stated it would be important to assess R75's risk for injury related to the call light and side rail use because he was on Coumadin and was at risk for bleeding.

During interview on 5/11/17, at 9:31 a.m. occupational therapist (OT)-A stated therapy did not assess side rails for safety and only looked at residents' side rails if they would be helpful at discharge.

A facility policy entitled Bed Rail Assessments undated directed all long term care beds will be checked annually to meet the FDA recommendations to reduce entrapment. The policy further directed maintenance staff to measure zones of entrapment annually, and with new mattresses. The policy lacked direction for nursing staff to assess residents' safety in using the side rails for mobility.

R57's quarterly MDS, dated 2/21/17, identified R57 was cognitivelly intact, required extensive assistance with transfers and toileting, and had a diagnosis of Parkinson's disease.

R57's care plan, dated 3/1/17, indicated a self care deficit due to muscle weakness, decreased mobility, and Parkinson's disease. The care plan further indicated staff used an EZ stand (sit to stand) mechanical lift to assist R49 with transfers. In addition, the care plan identified R57 was on

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an ambulation program, and staff assisted R57 to stand using the EZ stand lift and hip sling.

R49's quarterly MDS, dated 3/23/17, identified moderate cognitive impairment, needed extensive assistance with transfers, and toileting, and had a diagnosis of dementia.

R49's care plan dated 3/28/17, indicated R49 had a self care deficit due to muscle weakness and cognitive impairment. It further indicated staff used an EZ stand mechanical lift to assist R49 with transfers and toileting.

During initial tour observation on 5/8/17, at 12:48 p.m. a Pro Assist brand sit to stand lift was observed along the wall of the 400 wing unit. An EZ lift brand sling was draped over the Pro Assist lift.

During observation on 5/11/17, at 10:52 a.m. a Pro Assist brand sit to stand lift was again observed along the wall of the 400 wing unit. An EZ stand brand sling was again draped over the Pro Assist lift.

During interview on 5/11/17, at 10:52 a.m. NA-A stated Pro Assist brand slings were not available anymore so staff had to use the EZ brand sling with the Pro Assist sit to stand lift. NA-A stated she had never personally used the Pro Assist lift but thought staff used it for R49. NA-A reported the facility had the Pro Assist lift for many years. She thought the slings brands were interchangeable, and stated the DON had instructed her it was okay.

During interview on 5/11/17, at 10:54 a.m. the DON stated she was not aware staff were using

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an EZ brand sling with the Pro Assist brand lift; however, stated staff "must be" using them together and would need to check if the slings were interchangeable between brands.

During interview on 5/11/17, 10:57 a.m. LPN-A stated staff used the Pro Assist brand lift for another resident, R57, before he moved to a different wing. LPN-A stated R57 had ongoing requests for the restroom which required the sit to stand lift. LPN-A was not aware if the Pro Assist lift and EZ stand slings were interchangeable.

During interview on 5/11/17, at 11:01 a.m. NA-C stated the Pro Assist sit to stand lift had been down the 400 wing for at least a year. NA-C stated both R57 and R49 frequently needed sit to stand lifts for toileting and needed the Pro Assist stand for both residents, but that R57 disliked the Pro Assist lift because it fit snugger when using the EZ brand sling. NA-C reported the Pro Assist stand had not been used in a while as R57 had moved to a different wing; however, NA-C stated they had not received any direction on using the Pro Assist brand lift with the EZ brand sling. NA-C further stated she was given education during orientation on the EZ brand sit to stand lifts, but had not received training on the Pro Assist lift, stating she had just walked into a resident room and was asked to operate it without knowing what the buttons were for. NA-C reported the DON instructed her to place the Pro Assist lift into the tub room off the unit floor. NA-C demonstrated how the Pro Assist lift worked with the EZ sling, noting it hooked on similarly to the EZ stand lift, but lifted the resident up vertically and not at an angle like the EZ stand brand.

During interview on 5/11/17, at 11:33 a.m. R49

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F 323	Continued From page 8 stated she had never been injured or experienced discomfort while using sit to stand lifts. During interview on 5/11/17, at 11:39 a.m. R57 stated he had never been injured or experienced discomfort while using sit to stand lifts. During interview on 5/11/17, at 11:48 a.m. the DON and Vice President of Long Term Care (VP) stated the prior DON had ordered the EZ brand slings and thought the slings were universal. The DON and VP stated they would need to pull the Pro Assist lift from use on the floor, clarify the slings with the manufacturers, and re-assess their resident care lifts policy. The DON further stated staff had just been educated on the EZ lifts and was under the impression all the lifts in the care facility were EZ brand lifts and slings. The manufacturer's guidelines for the Professional Assistance Lift (PAL) Pro-1 Model PC350 (the Pro-Assist lift) undated, directed "Use only PAL slings and accessories designed for the Pro-1 modle PAL lift." The facility policy Minimal Lifting Policy undated, directed to use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training. The policy further directed supervisors were responsible for ensuring lifts and associated equipment were accessible, well maintained, and stored safely.	F 323		

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	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2017**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 10, 2017. At the time of this survey, Glencoe Regional Health Services C & NC was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Glencoe Regional Health Services C & NC was constructed in 1984, with one building addition constructed in 1995. Both buildings are one-story in height, has no basement, are fully fire sprinkler protected and were determined to be of Type I(332) construction. The facility has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility is separated from both a hospital and a senior apartment building, by complying two-hour fire wall assemblies. The facility has a capacity of 110 beds and had a census of 85 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2017

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

Re: State Nursing Home Licensing Orders - Project Number S5263026

Dear Mr. Braband:

The above facility was surveyed on May 8, 2017 through May 11, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathy Lucas, Unit Supervisor at (320)223-7343 or kathy.lucas.state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates 5/8/17, 5/9/17, 5/10/17, and 5/11/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess resident's safety with the use of bed rails for 1 of 2 residents (R75) reviewed for accidents. In addition, the facility failed to ensure staff used appropriate brand of sling when using sit to stand lifts, which had the potential to affect 2 of 15 residents (R57, R49) who used the lifts in the 400 wing. Findings include: R75's quarterly Minimum Data Set (MDS), dated	2 830	Corrected	6/15/17

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2 830	Continued From page 3 1/25/17, identified R75 was cognitively intact, required extensive assistance with bed mobility and transfers, had diagnoses of dementia and seizure disorder, and received anticoagulation (blood thinning) therapy. An incident note dated 4/23/17, at 3:16 p.m. identified R75 had sustained a skin tear to his right forearm measuring 1.4 cm (centimeters) x (by) 1.6 cm. The note indicated R75 had sustained the skin tear that morning and was observed by nursing assistant (NA)-A, who had updated registered nurse (RN)-B of the skin tear. It further identified that at the time of the incident R75's arms were inbetween the side rail, with the call light wrapped around he side rails. The area was cleansed and a bandage was applied. The note indicated R75's wife and physician were notified, and the cause of the skin tear was identified: R75's was sleeping, placed his arm through the side rails, and bump into the metal clip of his call light. The note identified R75 was instructed to place the call light on his blanket, not around the side rails, as "he tends to like to place hands on side rail when sleeping." A facility document entitled Bed Checks, dated 4/26/17, indicated R75's side rail and mattress were measured for the U.S. Food and Drug Administration (FDA) recommended criteria for entrapment risks. However, the document lacked attempts to use appropriate alternatives prior to installing side rails, lacked review of risk vs. benefits of bed rails, and lacked that informed consent was obtained prior to use. R75's care plan dated 5/10/17, identified he was at risk for uncontrolled bleeding and bruised easily related to anticoagulation therapy with Coumadin (a blood thinning medication). The	2 830		

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2 830	Continued From page 4 care plan indicated R75 had a self care deficit and used "turn rails on bed to aid in mobility." It further identified R75 was at risk for seizures, to keep call light within reach, and indicated R75 was at risk for injury related to falls with an unsteady gait, requiring staff assistance with transfers and ambulation. R75's care plan lacked information regarding his safety with the side rail and potential for further injury after sustaining the skin tear. During observation on 5/10/17, 7:09 a.m. R75 was lying on his left side in bed. A call light was observed lying across R75 and wrapped around a quarter side rail on the left side of the bed; the side rail had five holes within the inside of the rail. The metal clip of the call light was exposed and did not contain any covering. The right side of the bed was against the bedroom wall and did not contain a side rail. R75 arms were near the side rail; his right hand rested on top of the side rail. During observation, NA-B unwrapped and unclipped the call light from the side rail. NA-B assisted R75 to sit up at the edge of the bed, and R75 was able to assist in sitting up by using his right hand to push off the side rail. NA-B proceeded to complete R75's morning cares. During interview on 5/10/17, at 12:23 p.m. NA-B stated R75 used the side rail to turn in bed and transfer out of bed. NA-B stated R75 had just moved to a different room, now the bed was on the opposite side of the room, and R75 usually transferred more independently; however, he wasn't use to getting out on the left side of the bed and needed more assistance since the move. NA-B was not aware of any incidents involving R75's side rail. During interview on 5/10/17, at 1:15 p.m. NA-A	2 830		

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2 830	Continued From page 5 stated R75 used the side rail to assist him with getting out of bed. NA-A further stated R75 would wrap his arm up, through, and around the side rail hole in order to hoist himself up in bed. NA-A stated she had witnessed R75's skin tear on 4/23/17. NA-A stated R75 liked to sleep with his arm in the side rail hole. NA-A reported staff wrapped R75's call light around his side rail per his preference, and when he stuck his arm through the side rail hole, the metal clip of the call light must have scraped his arm causing the skin tear. NA-A stated she had noticed dried blood on R75's arm the morning of 4/23/17 and had notified RN-B. NA-A stated she had wrapped tape around R75's call light to cover the metal clip but had not received any direction after the incident. NA-A further stated R75 was "a creature of habit" and staff continued to wrap his call light around the side rail. During interview on 5/11/17, at 8:38 a.m. RN-B stated she was getting ready for her medication pass when NA-A notified her of R75's skin tear. RN-B stated R75 had a tendency to place his arm in the side rail and wondered if R75 had brushed against the call light causing the skin tear. RN-B reported she cleaned R75's skin tear, continued to monitor it on the electronic treatment record (eTAR), and the skin tear healed shortly after the incident. RN-B stated the incident was passed along in report to the oncoming shift, and then R75 transferred to a different wing of the facility. RN-B thought the evening staff were going to check with R75 that night and see if he would be okay clipping the call light to the blanket instead of the side rail. RN-B was not aware of any follow up after the incident, and did not know if the clip or call light had been replaced. During interview on 5/11/17, at 9:12 a.m. director	2 830		

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2 830	Continued From page 6 of nursing (DON) stated all residents had side rails on their bed unless the resident preferred not to have them, and most residents liked having side rails to assist with turning and transfers. The DON stated the shorter length of the rails made them assist rails not side rails. The DON further stated currently the facility measured the rails for entrapment risk, but had no procedure, policy, or assessment on assessing the rails for safe use by the resident or if the rails posed a restraint risk and hindered residents from freely transferring out of bed. The DON report if equipment caused an injury, a maintenance slip was filled out so maintenance could look at the equipment to prevent further injuries. The DON remembered R75's skin tear had been discussed during an interdisciplinary team meeting, but was not aware of the follow up afterward. The DON would have expected staff to assess and identify the cause of the injury, and attempt interventions to prevent the incident from re-occurring. During interview, the DON observed R75's call light, which was again wrapped around his side rail, and stated the metal clip didn't feel sharp unless she pushed hard. However, the DON stated it would be important to assess R75's risk for injury related to the call light and side rail use because he was on Coumadin and was at risk for bleeding. During interview on 5/11/17, at 9:31 a.m. occupational therapist (OT)-A stated therapy did not assess side rails for safety and only looked at residents' side rails if they would be helpful at discharge. A facility policy entitled Bed Rail Assessments undated directed all long term care beds will be checked annually to meet the FDA recommendations to reduce entrapment. The policy further directed maintenance staff to	2 830		

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2 830	Continued From page 7 measure zones of entrapment annually, and with new mattresses. The policy lacked direction for nursing staff to assess residents' safety in using the side rails for mobility. R57's quarterly MDS, dated 2/21/17, identified R57 was cognitivelly intact, required extensive assistance with transfers and toileting, and had a diagnosis of Parkinson's disease. R57's care plan, dated 3/1/17, indicated a self care deficit due to muscle weakness, decreased mobility, and Parkinson's disease. The care plan further indicated staff used an EZ stand (sit to stand) mechanical lift to assist R49 with transfers. In addition, the care plan identified R57 was on an ambulation program, and staff assisted R57 to stand using the EZ stand lift and hip sling. R49's quarterly MDS, dated 3/23/17, identified moderate cognitive impairment, needed extensive assistance with transfers, and toileting, and had a diagnosis of dementia. R49's care plan dated 3/28/17, indicated R49 had a self care deficit due to muscle weakness and cognitive impairment. It further indicated staff used an EZ stand mechanical lift to assist R49 with transfers and toileting. During initial tour observation on 5/8/17, at 12:48 p.m. a Pro Assist brand sit to stand lift was observed along the wall of the 400 wing unit. An EZ lift brand sling was draped over the Pro Assist lift. During observation on 5/11/17, at 10:52 a.m. a Pro Assist brand sit to stand lift was again observed along the wall of the 400 wing unit. An EZ stand brand sling was again draped over the	2 830		

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2 830	Continued From page 8 Pro Assist lift. During interview on 5/11/17, at 10:52 a.m. NA-A stated Pro Assist brand slings were not available anymore so staff had to use the EZ brand sling with the Pro Assist sit to stand lift. NA-A stated she had never personally used the Pro Assist lift but thought staff used it for R49. NA-A reported the facility had the Pro Assist lift for many years. She thought the slings brands were interchangeable, and stated the DON had instructed her it was okay. During interview on 5/11/17, at 10:54 a.m. the DON stated she was not aware staff were using an EZ brand sling with the Pro Assist brand lift; however, stated staff "must be" using them together and would need to check if the slings were interchangeable between brands. During interview on 5/11/17, 10:57 a.m. LPN-A stated staff used the Pro Assist brand lift for another resident, R57, before he moved to a different wing. LPN-A stated R57 had ongoing requests for the restroom which required the sit to stand lift. LPN-A was not aware if the Pro Assist lift and EZ stand slings were interchangeable. During interview on 5/11/17, at 11:01 a.m. NA-C stated the Pro Assist sit to stand lift had been down the 400 wing for at least a year. NA-C stated both R57 and R49 frequently needed sit to stand lifts for toileting and needed the Pro Assist stand for both residents, but that R57 disliked the Pro Assist lift because it fit snugger when using the EZ brand sling. NA-C reported the Pro Assist stand had not been used in a while as R57 had moved to a different wing; however, NA-C stated they had not received any direction on using the Pro Assist brand lift with the EZ brand sling. NA-C	2 830		

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2 830	Continued From page 9 further stated she was given education during orientation on the EZ brand sit to stand lifts, but had not received training on the Pro Assist lift, stating she had just walked into a resident room and was asked to operate it without knowing what the buttons were for. NA-C reported the DON instructed her to place the Pro Assist lift into the tub room off the unit floor. NA-C demonstrated how the Pro Assist lift worked with the EZ sling, noting it hooked on similarly to the EZ stand lift, but lifted the resident up vertically and not at an angle like the EZ stand brand. During interview on 5/11/17, at 11:33 a.m. R49 stated she had never been injured or experienced discomfort while using sit to stand lifts. During interview on 5/11/17, at 11:39 a.m. R57 stated he had never been injured or experienced discomfort while using sit to stand lifts. During interview on 5/11/17, at 11:48 a.m. the DON and Vice President of Long Term Care (VP) stated the prior DON had ordered the EZ brand slings and thought the slings were universal. The DON and VP stated they would need to pull the Pro Assist lift from use on the floor, clarify the slings with the manufacturers, and re-assess their resident care lifts policy. The DON further stated staff had just been educated on the EZ lifts and was under the impression all the lifts in the care facility were EZ brand lifts and slings. The manufacturer's guidelines for the Professional Assistance Lift (PAL) Pro-1 Model PC350 (the Pro-Assist lift) undated, directed "Use only PAL slings and accessories designed for the Pro-1 modle PAL lift." The facility policy Minimal Lifting Policy undated,	2 830		

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2 830	Continued From page 10 directed to use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training. The policy further directed supervisors were responsible for ensuring lifts and associated equipment were accessible, well maintained, and stored safely. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could assess side rails and sit to stand lifts for safety. The DON or designee could audit for proper use of side rails and sit to stand lifts, and inservice staff on identifying concerns or incidents of safety concerns and how to correct them. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426		6/15/17

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21426	Continued From page 11 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) baseline screening and tuberculin skin test (TST) were interpreted and completed for 2 of 5 residents (R115, R49) according to the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: The CDC guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. R115 was admitted to the facility on 11/28/16. The facility's Long Term Care Standing Orders initiated at the time of admission directed the facility to administer Mantoux [tuberculin skin test] on admission and repeat in two weeks if negative. Chest x-rays will be done following a positive Mantoux or if the person is immuno-suppressed. If Mantoux has been given within 6 weeks, give one step only. R115's electronic medical record (eMAR)	21426	Corrected	

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21426	Continued From page 12 indicated R115 received the first step TST on 11/28/16. On 12/1/16, documentation indicated a negative result with 0 millimeter (mm) induration. R115's record lacked documentation of a second step TST or a date of a TST prior to admission. During an interview on 5/11/17, at 8:52 a.m. registered nurse (RN)-A confirmed R115 did not receive a second TST. RN-A stated R115 should have received a second TST fourteen days after admission and stated, "I don't know what happened." R49 was admitted to the facility on 12/16/2016. R49's eMAR indicated staff administered the first step TST to R49 on 12/16/16. 12/19/16 documentation indicated a result of negative however, the record lacked documentation of an induration in millimeters. During an interview on 5/11/17, at 8:52 a.m. RN-A stated staff are to document the induration and whether the Mantoux result was positive or negative on the eMAR. RN-A confirmed R49's record lacked documentation of the induration of the first step TST. The facility policy Tuberculosis Exposure Control Plan dated 5/15, under Procedure: TST Administration, Documentation, Reading and Interpretation directed staff to record TST induration in 'mm'. Do not record as just positive or negative. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the procedures for TST	21426		

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21426	Continued From page 13 testing and documentation. The DON could monitor resident TB testing to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		