#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 9F3O

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	Γ I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	I	Facility ID: 00619
1. MEDICARE/MEDICAID PRO (L1) 245473 2.STATE VENDOR OR MEDICA (L2) 747642000		3. NAME AND ADD (L3) OAK TE (L4) 640 THIS (L5) GAYLOR	RRACE HE RD STREET	ALTH (	CARE CEN			
5. EFFECTIVE DATE CHANGE (L9)		7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD		L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
	11/25/2014 (L34) (L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	46 (L18) 46 (L17)	B. Not in Com	equirements	1	2. Te 3. 24 4. 7-	oroved Waivers Of The echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code	e Following Requirements:	tor
	KDOWN  19 SNF 19 SNF  46  L38) (L39)	ICF (L42)	IID (L43)		15. FACILITY	MEETS or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY	REMARKS (IF APPLICABLE	SHOW LTC CANCELL	.ATION DATE):					
17. SURVEYOR SIGNATURE  Mary Roge	rs, HFE NE II	Date :	1/25/2014	(L19)	18. STATE SURVEY AGENCY APPROVAL Date:  Kate JohnsTon, Enforcement Specialist 12/12/2014 (L2)			
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAI	OFFICE OF	R SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIC  _X 1. Facility is Eligi  2. Facility is not	ble to Participate		IPLIANCE WITH C	CIVIL	2		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  05/01/1987  (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		VOLUNTARY 01-Merger, Clo 02-Dissatisfact	osure tion W/ Reimburseme	0 INVOLUNT 05-Fail to M	L30)  CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV A. Suspension B. Rescind Su	of Admissions:	(L44) (L45)			oluntary Termination	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	9. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARK	s ted 12/15/20	14 Co.	
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION ( 12/03/2014	OF APPROVAL DAT	ΓΕ (L33)	DETERMIN	NATION APPRO		
					İ			



#### Protecting, Maintaining and Improving the Health of Minnesotans

December 2, 2014

Ms. Deborah Barnes, Administrator Oak Terrace Health Care Center 640 Third Street Gaylord, Minnesota 55334

RE: Project Number S5473025

Dear Ms. Barnes:

On October 27, 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 16, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 16, 2014, effective November 5, 2014 and therefore remedies outlined in our letter to you dated October 27, 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,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245473 December 2, 2014

Ms. Deborah Barnes, Administrator Oak Terrace Health Care Center 640 Third Street Gaylord, Minnesota 55334

Dear Ms. Barnes:

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 November 5, 2014 the above facility is certified for or recommended for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 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,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245473	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/25/2014
Name	of Facility		Street Address, City, State, Zip Code	
OAK TERRACE HEALTH CARE CENTER			640 THIRD STREET	
			GAYLORD, MN 55334	

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
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0241		11/05/2014		ID Prefix	F0247		11/04/2014		ID Prefix	F0253		11/04/2014
•	483.15(a)				_	483.15(e)(2)				•	483.15(h)(2)		_
LSC				<u> </u>	LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0353		Completed 11/05/2014		ID Prefix			Completed		ID Prefix			Completed
Rea.#	483.30(a)		-		Reg.#			-		Rea #			<del>_</del>
					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix			-		ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC				_	LSC			_
			Composition					Carra atian					Competion
			Correction Completed					Correction Completed					Correction Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
			-										
Reg. # LSC					Reg. # LSC					Reg. #			_
				-					+				_
Reviewed By	F	Reviewed E	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	/	JS/	/KJ	12	/02/20	14		29437				11/25	5/2014
Reviewed By	·	Reviewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Complet	ed on:				Check f	or any	Uncorrected I	Defic	ciencies. Was	a Summary of	,	
	10/16/	2014				Unco	orrecte	d Deficiencies	(CN	/IS-2567) Sent	to the Facility?	YES	NO

#### 

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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
		Correction			Correction				Correction
ID Desfer		Completed	ID Desfer		Completed		ID Desfer	04005	Completed
ID Prefix	-	11/05/2014	ID Prefix		11/25/2014		ID Prefix		11/04/2014
-	MN Rule 4658.0510 Subp.			MN St. Statute 144A.04 Sul			•	MN Rule 4658.1415 Su	bp. 4
			Loc			+-			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	21805	11/04/2014	ID Prefix				ID Prefix		
•	MN St. Statute 144.651 Sul		Reg. #				Reg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg.#			Reg. #				Reg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg.#			Reg. #				Reg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg.#			Reg. #				Reg. #		
LSC			LSC				LSC		
Reviewed By	Reviewed E	Зу	Date:	Signature of Surve	yor:			Date:	
State Agency	JS	/KJ	12/02/20	014	2943	7		11	/25/2014
Reviewed By CMS RO	Reviewed E	Зу	Date:	Signature of Surve	yor:			Date:	
Followup to	Survey Completed on:			Check for any				to the Engility?	
	10/16/2014			Oncorrected	u Denciencies	CIVIO-	2337 3 3 8 111	to the Facility? YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 9F3O

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGE	ENCY	I	acility ID: 00619
MEDICARE/MEDICAID PROVIDER No.     (L1) 245473      STATE VENDOR OR MEDICAID NO.     (L2) 747642000	0.	3. NAME AND ADD (L3) OAK TEI (L4) CENTER (L5) GAYLOF	RRACE HE 2 640 THIRI	ALTH (	CARE ET (L6)	55334	4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation 7. On-Site Visit	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUR 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey After Co	
6. DATE OF SURVEY 10/1  8. ACCREDITATION STATUS:  0 Unaccredited 1 TIC 2 AOA 3 Other	<b>6/2014</b> (L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds	<b>46</b> (L18) <b>46</b> (L17)	B. Not in Com	equirements	n	2. Techn 3. 24 Ho	ical Personnel our RN RN (Rural SNF)	Following Requirements:  6. Scope of Servi 7. Medical Direc 8. Patient Room 9. Beds/Room  (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN	10 CMT	I KOT	IIID.		15. FACILITY MEI		(L15)	
18 SNF 18/19 SNF 46 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 18	861 (J) (1):	(L13)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	.ATION DATE):					
17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:								
Mary Rogers, HFI	E NE II		11/10/2014	(L19)	Kate Johns	Ton, Enfo	orcement Specia	alist 12/02/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR SI	INGLE STATI	E AGENCY	
19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Part			IPLIANCE WITH C HTS ACT:	CIVIL	2. Ov		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 05/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DAT (L25)		26. TERMINATION OF THE PROPERTY OF THE PROPERT	<u>00</u>		L30) CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involunt 04-Other Reason fo		OTHER 07-Provider 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)	Posted	12/03/201	14 Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	TE				
	(L32)			(L33)	DETERMINAT	ΓΙΟΝ APPROV	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0716

October 27, 2014

Ms. Deborah Barnes, Administrator Oak Terrace Health Care Center 640 Third Street Gaylord, Minnesota 55334

RE: Project Number S5473025

Dear Ms. Barnes:

On October 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

### **DEPARTMENT CONTACT**

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7365

Fax: (320)223-7365

### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 25, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 16, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 16, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 10/27/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245473	B. WING_			10/	16/2014	
	ROVIDER OR SUPPLIER	ENTER		64	TREET ADDRESS, CITY, STATE, ZIP CODE 40 THIRD STREET BAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
	as your allegation of Department's accepta	ance. Your signature at the ge of the CMS-2567 form will						
F 241 SS=D	revisit of your facility validate that substant regulations has been your verification. 483.15(a) DIGNITY A	tial compliance with the attained in accordance with	F:	241				
	manner and in an en	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.						
	by: Based on observation review, the facility fail and services with toil	is not met as evidenced in, interview, and document led to provide dignified care eting assistance for 1 of 1 ed for toileting assistance.			College Colleg	and the second		
	Findings include:							
							<i>f</i>	
	10/8/14, indicated, "[F	der assessment dated R3] is continent of bowel and and oriented and is aware of						
.ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E ()	do.	THE OLD !	_	(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.

PRINTED: 10/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245473	B. WING_	,	10/16/2014
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 241	the need to void, so need for assistance assessment identifit transfers and was to decreased mobile dexterity, and daily Staff were to assist per the residents reconstruction of the part	o is able to alert staff to the e PRN [as needed]." The ied R3 required 1:1 assist with at risk for incontinence related lity, decreased manual use of diuretic medication.  R3 with toileting as needed equest.  ed 8/14/14, identified R3 had not related to requiring transfers, and the residents dentified as, "Per his request."  on 10/15/14, at 9:28 a.m. R3 ecliner in his room and was king. R3 stated he needed to . R3's son was in the hallway had gone to the desk 10 some help from staff to assist and he was looking all over to find someone. About a room.  9:47 a.m. R3 was in his the hallway. When R3 was doing, R3 looked down, ook his head, and stated, "Just My son walked all over looking to go so bad, I was just much." R3 stated he had been for the staff to come and athroom, and he couldn't wait g in incontinence of stool. R3 own and shake his head and	F2	F241: Director of Nurses seresident R3 and his son on 11:13 a.m. and apologized embarrassment and lack of response. DON also reiter staff on 10/15/14 that time is our goal.  Dignified care is always our resident's rights pertaining reviewed by the DON at the on 11/5/14. All licensed stathave been instructed to assembled by the Certified Nursing Assists. The call light software was 10/21/14 and the call light reviewed daily and printed needed by the DON or her response time greater than investigated with staff and, This will be reviewed at our Assurance Quarterly meeting 2015.	in 10/15/14 at differential of for his of timely rated with all the ely call response or goal and all goal to such were the staff meeting aff personal sist with call to daily monitor tants response.  The provided the provided the provided the provided tants are sponse.  The provided tants response to the provided tants response to the provided tants response.  The provided tants are provided tants response to the provided tants re

Facility ID: 00619

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245473	B. WING_		10	/16/2014
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	•	
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F 241	NA-D stated R3 had be that morning and state before. He always may was embarrassed! It stated a man had told bathroom and R3's can however, NA-D was relight had been on.  Review of R3's Bowel R3 was continent with documented bowel mand 10/14/14. On 10/episode was documented was sistance to go to a long time to get help he walked all over loo R3 use the bathroom. anyone, he went to the R3 needed to use the stated, "[R3] was just much pain from trying Depends [a product us [staff] tell him to just ghold it." FM-C stated about 20 minutes for a morning. FM-C stated thad an incontinent sto	0/15/2014, at 12:14 p.m. been incontinent of stool ed R3 had, "Never done that skes it on time!'m sure he had to clean him up." NA-D is her R3 needed to go to the fill light had been on, not sure how long the call  Log for the month of 10/14, each of the 16 overments between 10/1/14, f15/14, an incontinent bowel heted.  0/15/14, at 1:14 pm R3's C stated they had been in n R3 turned his call light on the bathroom and it takes b. FM-C stated this morning king for someone to heip When he couldn't find e front desk and told them bathroom, "Bad." FM-C shaking[R3] was in so to hold it" [R3] is wearing sed for incontinence]. They o in his Depends if he can't he thought R3 had waited assistance earlier that if he had told staff R3's, if over last couple weeks as he walks into R3's is is not the first time R3 ol, and it happens when he riods of time for assistance.	F 2	System Enhancement: As of have implemented a change duties requiring housekeeping to pass water to residents are resident beds. This staffing colliminates these duties for massistants and gives them manswer call lights. We have an "all hands on deck" call so heavy call light times, other can be summoned to the flow will be shared with all depart	in staffing org personnel d make nange ursing ore time to also institute that during departments or. This policy	d

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	RIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245473	B. WING_			10/	16/2014	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 241	maintence (M)-B startechnical difficulties was only able to prove response times for swhich was not a commonth, and was not a Cotober 2014, call look a review of R3's incopartial month of 9/14 the following:  On 9/1/14, at 5:04 p. 36:51 minutes. On 9/4/14, at 6:39 a. 38:24 minutes. On 9/8/14, at 5:31 a. 36:10 minutes. On 9/27/14, at 4:45 p. 48:10 minutes.  During interview on director of nursing (Exercised a complaint who stated R3 had to use the bathroom. to review the call light the resident had to wishe was unable to be having, "Technical did DON stated she listed complaint and told his DON had no formal of the resident and t	round."  10/16/14, at 1:26 p.m.  ted the facility was having with their call log system, and vide some call light log ome residents for 9/14, aplete log for the whole able to provide any of g response time.  Implete call light logs for the provided by M-B indicated m. R3's call light was on for m. R3's call light was on for p.m. R3's call light was on for p.m. R3's call light was on for m. R3's call light was on for p.m.	F2	241				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	SURVEY LETED
		245473	B. WING		10/	16/2014
ı	PROVIDER OR SUPPLIER	ENTER	6-	TREET ADDRESS, CITY, STATE, ZIP CODE 40 THIRD STREET AYLORD, MN 55334		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 247 SS=D	A policy for dignified or residents was reques 483.15(e)(2) RIGHT ROOM/ROOMMATE  A resident has the rig the resident's room or changed.  This REQUIREMENT by: Based on interview a facility failed to ensure room/ roommate charresidents (R11, R41 a were not informed pric roommate change.  Findings include: R11's Minimum Data identified the resident impairment.  During interview on 10 stated they had not refacility prior to the current their shared resident resi	care and services of ted, but not provided. FO NOTICE BEFORE CHANGE  Int to receive notice before roommate in the facility is  is not met as evidenced and document review, the exappropriate notice of age was provided for 3 of 5 and R26), who reported they or to a room and/or  Set (MDS) dated 8/18/14, had no cognitive  0/13/14, at 4:53 p.m. R11 ceived notification from the rent roommate moving in to oom.	F 247	F247: During the week of 10/26 - 10/31/14, all licensed staff membe approached, and oral education was provided about the new Room More Procedure (see attachment B) and resident's right to receive a notifica On November 5 <sup>th</sup> , 2014, education provided to all licensed staff at the Licensed Staff Meeting about the n Room Move Procedure and the resight to receive a notification of a recommate change. All licensed staff recognizes that the resident, his/he family, and /or responsible party m	ew ident's	
	to the current roomma resident room.	te moving in to their shared		informed of a room change or that resident will have anew roommate.	the	

PRINTED: 10/27/2014

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				1	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	MULTIPLE CONSTRUCTION UILDING			SURVEY LETED
		245473	B. WING			10/1	16/2014
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		- A 1-4		64	10 THIRD STREET		
OAK TER	RACE HEALTH CARE CE	INTER		G.	AYLORD, MN 55334		
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F 247	Continued From page	÷ 5	F	247	Social Services will initiate the pro	cess by	
	· -	0/14/14, at 3:50 p.m. the			informing Licensed Nursing staff o	fall	
		ices verified R11 was not			resident moves and the room num	ber the	
		roommate moving in to the			resident is going to move to. A sch	edule	
		on 8/12/14, and R41 was to a roommate moving in to			for the move will include date, tim	e frame	
	the shared resident ro				for the move, and departmental/s		
				İ	responsibilities before, during and		
		8/14, identified the resident			the move. Social Services will verb		
	had no cognitive impa	annen.			or with the Room Change Dispute		
		0/15/14, at 11:20 a.m. R26			inform the resident, his/her family		r
		ication from the facility prior		Ì	responsible party of the date and	time of	
		mates moving in their within the past several			the move and reason for the move		
		They [roommates] just			resident, his/her family, and/or		
	showed up."				responsible party chose to dispute	the	
	During interview on 1	0/15/14 at 2·17 n m			room move, a Room Change Dispu		
		ON) stated there should			will be filled out per resident's rigi		
		cumentation in the chart			Social Services will inform the roo		
	regarding a roommate who had a room or ro	e change for any resident			his/her family, and/or responsible		
	who had a room or re	ommate change.			that the resident will have a new	F,	
	, =	0/16/14, at 10:25 a.m.			roommate. If Social Services is un	availahle	<b>1</b>
		rices stated R26 was not			for the notification, the person as		
		either roommate moving in t room which had taken	İ		·	•	1
	place in the last seve				Social Services or the Director of N		
	*				will initiate the notification and do		
		d Room Move Procedure			the notification in the residents el	ectronic	
		d social services was to			chart.		oc D:
		y sending out a change of d schedule for move. Social			/ :	11/4/14	SS Director
		n the resident, his/her					
		party of the date/time and					

reason for a move occurring.

F 253 | 483.15(h)(2) HOUSEKEEPING & SS=D MAINTENANCE SERVICES

F 253

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		245473	B. WING_			10/16/2014
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	The facility must pro	ge 6 ovide housekeeping and les necessary to maintain a	F 25	53		
		nd comfortable interior.				
	by: Based on observat review, the facility fa and maintenance so an odor free and sa provided for 1 of 2 r environmental cond Findings include:	ion, interview, and document ailed to ensure housekeeping ervices necessary to maintain initary environment were residents (R20) reviewed with terns.				
	impairment, had an required extensive a and personal hygien During observation R20's room had an R20 was interviewe	R20 had no cognitive indwelling Foley catheter, and assist from staff for toileting ne.  on 10/13/14, at 5:31 p.m., overwhelming smell of urine. d at that time and stated his rine. R20 stated he had a				
	roommate up until a the roommate also stated his past room into urinals and leav for staff to collect. I about the strong sm	a couple of weeks ago, and had a Foley catheter. R20 nmate would empty his urine we the urinals all over the room R20 stated he had complained hell of urine to staff many urine smell was still in his				
	_	on 10/14/14, at 1:45 p.m., trong smell of urine. R20 was is time.				

OLATERO TOR MEDIO ME GIMENIO DE MICE					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		10/16/2014
	ROVIDER OR SUPPLIER	CENTER	64	REET ADDRESS, CITY, STATE, ZIP CODE IO THIRD STREET AYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 253	During interview on housekeeping (H)-A strong smell of uring the room." H-A state all the furniture and daily, but the urine stated maybe the u or walls."  During interview on nursing assistant (N R20's room had a seanother NA to get seanother NA	10/15/14, at 9:04 a.m. A stated R20's room had a e and it was like a, "Haze in ted housekeeping wiped down washed the floors in the room smell did not go away. H-A rine odor was, "In the curtains  10/15/14, at 9:30 a.m. NA)-C stated she had noted strong urine odor, and asked some odor spray to spray in the	F 253	F253: Resident 20 odor issue was addressed. On 10/15/14 the mai worker cleaned the room heater. 10/16/14 housekeeping supervised down privacy curtains, washed the re-installed them. The mattress a framework of the roommates' be examined and found to be odor from an air freshener was installed. Al 10/16 the maintenance supervisor examined the heater and thoroug cleaned all the coils. Audits of the are being logged daily by the houstaff and reviewed daily by house supervisor.  System Change: a Room Odor pollog have been developed listing a and resident rooms to be examined aily basis (see attachment A). The was shared with all maintenance housekeeping staff on 11/4/15 by housekeeping and maintenance supervisors. Divider curtains have on a 6-month rotation for cleaning	on 10/15/14 or took nem and HK supervisor and d was ree and so on or re- ghly is room sekeeping ekeeping ekeeping licy and all areas ed on a his policy and y the
room.		1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING COMPLETED				
		245473	B. WING_		10/16/2014			
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 640 THIRD STREET GAYLORD, MN 55334	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE			
F 253 F 353 SS=E	A policy was reque 483.30(a) SUFFIC PER CARE PLANS  The facility must he provide nursing an maintain the higher and psychosocial videtermined by resignidividual plans of the facility must provide numbers of each opersonnel on a 24-care to all residents care plans:  Except when waive section, licensed numbers of each opersonnel.  Except when waive section, the facility nurse to serve as a duty.  This REQUIREMED by:  Based on observative review, the facility further facility for sufficient nursing statimely manner for R11, R17, R53, R7, R3), and 4 of 5 fam FM-E, FM-G), who	sted but not provided. ENT 24-HR NURSING STAFF  ave sufficient nursing staff to d related services to attain or st practicable physical, mental, vell-being of each resident, as dent assessments and		F353: Residents 59, 25 76, 54, 44, 26 and 3 careviewed in detail at the Care Team meeting on being reviewed addition again at the Interdiscip meeting. Every resider and/or family member interviewed during the 11/7/14 by the Social States discuss resident frustrates resident suggestions.  System Enhancement: have implemented and duties requiring house to pass water to reside resident beds. This state eliminates these duties assistants and gives the answer call lights. We an "all hands on deck" heavy call light times, can be summoned to the will be shared with all on 11/4/14.	re plans were ne Interdisciplinary 10/30/14 and are smally on 11/6/14, slinary Team nt citied above is also being week of 11/3/14 to services Director to ations and hear  As of 10/15/14 we hange in staffing keeping personnel ents and make ffing change s for nursing em more time to have also instituted call so that during other departments he floors. This policy			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING		····	10/	16/2014
	ROVIDER OR SUPPLIER  RACE HEALTH CARE CE	ENTER		64	REET ADDRESS, CITY, STATE, ZIP CODE 10 THIRD STREET AYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Findings include:  R59's diagnoses on the 5/7/14, included over a stenosis. R59's 14 day dated 9/29/14, identific cognitive impairment a assistance of one staff toilet use, and personal distance to the bath to wait up to 30 minute bathroom, and someti [urinating or bowel more because he has to wait up to 30 minute bathroom, and someti [urinating or bowel more because he has to wait up to 30 minute bathroom, and someti [urinating or bowel more because he has to wait up to 30 minute bathroom, and someti [urinating or bowel more because he has to wait up to 30 minute bathroom, and someti [urinating or bowel more because he has to wait up to 30 minute bathroom, and someti [urinating or bowel more because of because of one staff personal hygiene, and During interview on 10 stated she did not feel staff available because go to bed at night, and she could not lay down	ne Admission Record dated active bladder and spinal y Minimum Data Set (MDS) ed R59 had moderate and required extensive if for transferring, dressing, al hygiene.  0/13/14, at 5:20 p.m. R59 enough staff to provide aroom. R59 stated he has es for help to go to the mes he has, "Accidents every it so long for help.  0/16/14, at 1:26 p.m. ad he was unable to provide R59 due to technical  10 Admission Record dated and required limited if with dressing and it supervision with toilet use.  10/14/14, at 8:45 a.m. R25 the facility had enough as he often had to wait to it was frustrated because	F	353	•	eing ically as e. Any utes is dent. y nuary	ministrator

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245473	B. WING_		10/16/2014
	ROVIDER OR SUPPLIER  RACE HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	1 10/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	stated the facility was with their call log syste provide some call light some residents for 9/1 complete log for the wable to provide any of response times.  A review of R25's incopartial month of 9/14, pthe following:  On 9/1/14, at 6:43 p.m 29:00 minutes. On 9/10/14, at 6:58 p.m for 29:58 minutes. On 9/13/14, at 6:07 a.m for 37:55 minutes. On 9/27/14, at 6:17 a.m for 33:29 minutes.  R11's diagnoses on the 3/10/05, included pain limbs, stress incontiner osteoarthritis. R11's an identified R11 had no crequired extensive assist transferring, dressing, at the bathroom, and at the bathroom when she nemot enough staff to assist R11 stated sometimes a because she cant wait	having technical difficulties am, and was only able to talog response times for 4, which was not a hole month, and was not October 2014, call light  mplete call light logs for the provided by M-B indicated  R25's call light was on for m. R25's call light was on m.	F 36	Discussions have been held with facilities to garner creative staff since the shortage throughout is currently at 1,800 Certified N Assistant positions. We are received contractual agreement with East High School for Certified N Assistants on-site training, which our facility to have additional to on hand to answer the resident are also working with our local center and have hired staff out FastTrac Certified Nursing Assist students educated through our Administrator is on the Workforat the Leading Age of Minnesot Department of Labor and Indus solutions to this crisis. The DON Care Cabinet at the Leading Age additional ideas for staffing. Whave 6 Certified Nursing Assistate enrolled in the Health Support Sprogram through the Leading A Minnesota to bring more creating to Oak Terrace. We have been it this program since 2/1/14.	fing ideas Winnesota ursing entering a h Sibley ursing ch allows rained staff s' calls. We workforce of the tant facility. The rce Council a try to find is on the e to garner e currently nts specialist ge we concepts

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245473	B. WING			10/16/2014	
	ROVIDER OR SUPPLIER	NTER		64	REET ADDRESS, CITY, STATE, ZIP CODE IO THIRD STREET AYLORD, MN 55334		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	sitting on a toilet that  During interview on 10 stated the facility was with their call log syst provide some call ligh some residents for 9/10 complete log for the wable to provide any of response time.  A review of R11's incorpartial month of 9/14, the following:  On 9/1/14, at 5:10 p.m. 59:32 minutes.  On 9/6/14, at 7:24 a.m. 35:26 minutes.  On 9/8/14, at 5:24 p.m. 40:09 minutes.  On 9/11/14, at 6:22 a.m. for 48:05 minutes.  On 9/12/14, at 6:22 a.m. for 37:06 minutes.  On 9/14/14, at 6:05 p.m. for 37:06 minutes.  On 9/27/14, at 6:10 p.m. for 30:09 minutes.  On 9/28/14, at 5:08 p.m. for 43:28 minutes.  On 9/29/14, at 7:36 a.m. for 33:43 minutes.  R17's diagnoses on till	long. It's all the time."  2/16/14, at 1:26 p.m. M-B having technical difficulties em, and was only able to t log response times for 14, which was not a whole month, and was not Cotober, 2014 call log  complete call light logs for the provided by M-B indicated  n. R11's call light was on for n. R11's call light was on for m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on m. R11's call light was on	F	353			
	and hip fracture. R17' 9/30/14, identified R1	eralized pain, history of fall, s admission MDS dated 7 had no cognitive red extensive assistance of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED	
		245473	B. WING_			10/16/2014	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, 2 640 THIRD STREET GAYLORD, MN 55334	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 353	one staff for transfers  During interview on a stated there wasn't e resident's needs. R1 many patients to take sometimes to get he  During interview on a maintence (M)-B state any call light logs for difficulties.  R53's diagnoses on 3/18/14, included chaistory of fall. R53's 8/12/14, identified Rimpairment and requitransferring and toiled buring interview on stated she had to we call light for up to a restated, "At night, I hawas embarrassed it, and it was okayI my light on and they buring observation of was laying in bed an Nursing assistant (N turned off the resider resident someone was 48:46 a.m., 43 min R53's call light and to assist her with car room to assist the resider resident someone was room to assist the resider room to assist the resident someone was room to assist the resider room to assist the resider room to assist the resider resident someone was room to assist the resider room to assist the resider room to assist the resider resident someone was room to assist the resider room to assist the resider resident someone was room to assist the resider room to assist the resider resident someone was room to assist the resider room to assist the resider resident someone was room to assist the resider room to assist the resider resident someone was room to assist the resider resident someone was room to assist the resider resident someone was room to assist the resider resident room to assist the resider resident room to assist the resident room to assist the resident room to assist room to as	s, dressing, and toileting.  10/13/14, at 7:16 p.m. R17 enough staff to meet the 7 stated, "The girls have too e care of; It can take an hour lp."  10/16/14, at 1:26 p.m. ted he was unable to provide R17 due to technical  the Admission Record dated ronic kidney disease and quarterly MDS dated 53 had no cognitive nired extensive assistance for ting.  10/13/14, at 4:24 p.m. R53 ait for someone to answer her half hour in the past. R53 ad to wait and I wet myself. I [staff] said don't worry about am on those fluid pillsI put could not get here in time."  20 10/15/14, at 8:03 a.m. R53 d had her call light on. A)-E entered R53's room, nts call light, and told the ould be in soon to help her. utes after NA-E turned off old her someone would be in res, NA-F entered R53's	F	353			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA _ IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			10/16/2014	
	ROVIDER OR SUPPLIER	ENTER		640 TH	T ADDRESS, CITY, STATE, ZIP CODE IIRD STREET ORD, MN 55334		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From pag	ne 13	F3	353			
		ted he was unable to provide R53 due to technical					
	9/17/14, included ch acute kidney failure. 9/30/14, identified R impairment and neer transfers, dressing, a During interview on stated, "Sunday was up for work and they had all of the people until 8:30. I thought breakfast." R72 state wait to use the bathr During a follow up in p.m. R72 and family didn't drink water what the facility because	ded extensive assistance for and toileting.  10/14/14, at 8:39 a.m. R72 awful. Two [staff] didn't show weren't replaced. She [staff] to get up I didn't get up					
	his pants. FM-D sta uncomfortable waitin bathroom and stated						
	stated the facility wa with their call log sys provide some call lig some residents for somplete log for the	on 10/16/14, at 1:26 p.m. M-B is having technical difficulties stem, and was only able to the log response times for 3/14, which was not a whole month, and was not of October, 2014 call log					

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245473	B. WING_			10/16/2014		
	ROVIDER OR SUPPLIER	ENTER		640 TH	TADDRESS, CITY, STATE, ZIP CODE IRD STREET ORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 353	had talked about connot having his needs  During interview on 1 stated the facility was with their call log sys	sponse." ce notes did not address R20 cerns of lack of staffing and	F3	353				
	able to provide any or response time.  A review of R20's inc	/14, which was not a whole month, and was not of October, 2014 call log complete call light logs for the , provided by M-B indicated						
	for 36:31 minutes. On 9/30/14, at 8:06 a for 32:45 minutes.	a.m. R20's call light was on a.m. R20's call light was on b.m. R20's call light was on						
	stated R20 had comp for along time to hav NA-D stated she had	10/14/14, at 1:56 p.m. NA-D blained about having to wait e his call light answered. It talked to RN-A and LPN-B ght response times, but there in staffing.						
	10/6/14, included uri fatigue. R76's entry I R76 had no cognitive	the Admission Record dated nary tract infection and MDS dated 10/6/14, identified e impairment and required with transfers, dressing,						

CENTERS FOR MEDICARE & MEDICAID SERVICES

0/16/2014
(X5) COMPLETION DATE

PRINTED: 10/27/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245473	B. WING		10/16/2014
	ROVIDER OR SUPPLIER	CENTER	64	REET ADDRESS, CITY, STATE, ZIP CODE O THIRD STREET AYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 353	stated there was no needs of the residents are in the all talk about having assistance with ADI During interview on maintence (M)-B stany call light logs for difficulties.  R54's diagnoses on 9/11/14, included podepression. R54's aidentified the reside impairment and requith transfers, dress During interview on stated when he turn half hour before the assist him. R54 stat and it takes too long he often had to urin "When I have to go, half hour. I get frust	10/13/14, at 6:42 p.m. R76 bit enough staff—to meet the ints. R76 stated when the dining room, they [residents] g to wait for a long time for L's and are frustrated.  10/16/14, at 1:26 p.m. ated he was unable to provide or R76 due to technical  at the Admission Record dated plymyalgia rheumatica and admission MDS dated 9/24/14, and had moderate cognitive uired extensive assistance uired extensive assistance sing, and toilet use.  10/13/14, at 4:27 p.m. R54 as his call light on, it can take a a staff come to his room to ted he has bladder issues, g for staff to come assist him, ate in his pants. R54 stated, I have to go. I can't wait a	F 353		
	maintence (M)-B sta	ated he was unable to provide or R54 due to technical			
	3/5/13, included der muscle weakness. 9/2/14, identified R4	n the Admission Record dated mentia and generalized R44's quarterly MDS dated 44 had severe cognitive puired extensive assistance			

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CLIVILLIA	G I ON MEDIONINE &	WEDICAID SERVICES				1	
- · · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245473	B. WING			10/	16/2014
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK TEDI	DACE HEALTH CARE CE	ENTED		64	40 THIRD STREET		
UAK IERI	RACE HEALTH CARE CE	ENTER		G	AYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	17		353			
1 333	with transfers, dressing		Г	333	•	1	
	with transfers, dressir	rg, and tollet use.				ļ	
	During interview on 1	0/13/14, at 7:17 p.m. R44's					
		B, stated while visiting the					
		g the evening, FM-G looked					
	all over the facility and was unable to locate any						
	staff to assist R44 wit	in cares.					
	During interview on 1	0/16/14, at 1:26 p.m.					
	maintence (M)-B stated he was unable to provide any call light logs for R44 due to technical difficulties.						
	Door II Alwinsin Decoupled to d					ļ	
	_	he Admission Record dated nary incontinence and					
	,	6's quarterly MDS dated					
		e resident had no cognitive				l	
	,	red extensive assistance	İ				
	with transferring and	toileting.					
	During intensious on 1	0/13/14, at 4:20 p.m. R26					
		ave enough help. There's					
	usually only one aide						
		llways in such a rushThey					
	don't wash me up as	well as I would like." R26					
		there is not enough staff to					
		g room and she had to pull					
		way on the railing, which she					
		ause she has no feeling in ed weekends are the worst					
		id she had complained to the					
		DON doesn't do anything					
	about it and stated, "I						
	During charactics	n 10/11/11 at 2:26 n m					
		n 10/14/14, at 2:26 p.m. lid not reach the chair in the					
	residents room she s						
	· · · · · · · · · · · · · · · · · · ·					i	1

During interview on 10/14/14, at 2:26 p.m. NA-D

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OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ' '	NG	, , ,	COMPLETED	
		245473	B. WING_			10/16/2014
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	call light cord was to given R26 a bell to u NA-D stated during was working alone hand wasn't replaced no one covered the NA-D stated R26 ne the bell like crazy, b NA-D stated R26 waincident.  During another inter p.m. R26 stated she cord wasn't long end she sat in her room bell when she rings "all" of the staff, and told them call light d staff didn't always had done nothing. I complained about s SW-A, but stated stated the stated R26 had commaintence (M)-B stated R26 had commaintence stated R26 had commaintence stated R26 had common	t in the chair in her room, the co short to reach. Staff had use to call staff for assistance. a recent weekend shift she because another NA called in 1. When NA-D went on break, unit where R26 resided. Beded assistance and "Rang ut no one heard the bell." as very frustrated about the eview on 10/14/14, at 3:01 as very frustrated the call light because staff can't hear the it. R26 stated she talked to 1 the maintenance man, and id not reach her chair and ear her bell, but the facility R26 stated she had hort staffing to the DON and affing has not gotten any  10/16/14, at 1:26 p.m. ated he was unable to provide in R26 due to technical  10/14/14, at 1:56 p.m. NA-D aplained about long wait times a tanswered and not having her tated she had told RN-A and complaining about not having to short staffing, however, ke of staffing to meet resident	F3	353		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

(X3) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

- · · · - · · · · · · · · · · · · · · ·		IDENTIFICATION NUMBER:	1 ' '	LE CONOTTION	COMPLETED	
		245473	B. WING		10/16/2014	
NAME OF PROVIDER OR SUPPLIER  OAK TERRACE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 353	R3's diagnoses on to 2/20/14, included rhenlarged prostate. R8/14/14, identified R impairment and requiransfers and toilet upon to be a some help for his Davier the hallways tryminute later, NA-Doentered R3's room.  During interview on was asked how his adown, closed his eyestated, "Just had an over looking for some was just shaking; It had been waiting, "a come and assist him couldn't wait any lor of stool. R3 continues head, and stated, "It During interview on NA-D stated R3 was that morning and stated fore. He always me some states and stated real ways me s	he Admission Record dated eumatoid arthritis and 23's annual MDS dated 3 had moderate cognitive uired extensive assistance for ise.  on 10/15/14, at 9:28 a.m. R3 is his room and was grimacing ited he needed to go to the was in the hallway and stated desk 10 minutes ago to get ad, and he was looking all ying to find someone. About a same down the hall and 10/15/2014, at 9:47 a.m. R3 day was going and he looked es, shook his head, and accident My son walked all heone. I had to go so bad, I hurt so much." R3 stated he a long time," for the staff to in to the bathroom, and he iger, resulting in incontinence ed to look down, shaking his its embarrassing."  10/15/2014, at 12:14 p.m. is incontinent of stool earlier ated R3 had, "Never done that makes it on time!'m sure he	F 35:			
	was embarrassed stated a man had to bathroom and the ca	I had to clean him up." NA-D Id her R3 needed to go to the all light was on also, however, bw long the resident had been				

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		ND HUMAN SERVICES						APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION				OMB NO, 0938-0391 (X3) DATE SURVEY		
			A. BUILDING				COMP	LETED
		245473	B. WING				10/	16/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
OAK TEDI	DAGE HEALTH CARE O	ENTED		640 THI	RD STREET			
OAK IERI	RACE HEALTH CARE C	ENIER		GAYLO	PRD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 353	Continued From pag	e 20	F 35	3				
	During interview on 1							
		-C, stated, "This isn't the first		ì				
	time. [R3] pushes his							
	time to get help." FM							
		ng for someone to help R3		1				
		d when he couldn't find		İ				
		ne front desk and told them						
		the bathroom bad." FM-C						
	; -	n waiting about 20 minutes C stated, R3, "Was just						
		so much pain from trying to						
		ting worse over the past few		İ				
		ring Depends [a product	į					
		e]. They tell him to just go in						
		n't hold it." FM-C stated he						
		aff that R3's "odor" had gotten						
		weeks and stated he notices						
	the odor as soon as	you walk in the room. FM-C						
		nt episode was not the first						
		d quite a bit when R3 has to						
	wait for assistance for	or long periods of time.						
		40/45/44 + 0:00 DON						
		10/15/14, at 3:00 p.m. DON						
		ved a complaint from R3's R3 had to wait a long time to						
		athroom. DON stated she						
		o the call light log to verify						
	how long R3's call lig							
	facility was having, "							
	system." DON stated							
		, extended an apology, and						
	told him she would c							
		10/16/14, at 1:26 p.m. M-B s having technical difficulties						

with their call log system, and was only able to provide some call light log response times for some residents for 9/14, which was not a complete log for the whole month, and was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING_			10/16/2014	
NAME OF PROVIDER OR SUPPLIER  OAK TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIA		
F 353	stated she completed audits monthly for Que the average call light minutes. DON provid 1/1/14 through 3/1/14 due to the size of the audit for 7/14, showing call light response time available. DON stated the call light logs due DON stated attempts someone calls in, how be replaced and they DON stated residents about long call light tiprovided timely. DON the residents and lister	call light response time ality Assurance. DON stated	F				

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245473		B. WING			10/16/2014		
NAME OF PROVIDER OR SUPPLIER  OAK TERRACE HEALTH CARE CENTER				640	REET ADDRESS, CITY, STATE, ZIP CODE DITHIRD STREET AYLORD, MN 55334		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	.		F3	353			
	able to provide any or response time.	October, 2014 call log					
		mplete call light logs for the provided by M-B indicated					
	36:51 minutes. On 9/4/14, at 6:39 a.r	n. R3's call light was on for n. R3's call light was on for					
	38:24 minutes. On 9/8/14, at 5:31 a.m. R3's call light was on for 36:10 minutes. On 9/27/14, at 4:45 p.m. R3's call light was on for						
	48:10 minutes.	.m. 103 call light was on for					
	NA-E stated the morr	n 10/15/2014, at 9:31 a.m. nings can be difficult to get res done and stated there are not able to get all the fast by 9:00 a.m.					
	stated most days are able to get all of the r NA-G stated some da what resident cares n resident's exercises of room. NA-G stated s	0/15/14, at 12:49 p.m. NA-G busy and she isn't always esident cares completed. It is she needed to decide of to complete, such as a straightening up their he had brought up concerns that magement in the past, but not improved.					
	stated she did not rer or staff coming to her	0/15/14, at 2:11 p.m. SW-A nember any residents and/ about short staffing, efer those complaints to the					
	During interview on 1	0/15/14, at 2:51 p.m. DON					



# **OAK TERRACE POLICY AND PROCEDURE**

**SUBJECT: Odors** 

ACCOUNTABILTY: Environmental Services(Maint/Hskpg)

**POLICY: Room Odor Policy** 

**PROCEDURE:** 

It is Oak Terrace Health Care Center of Gaylord's policy to ensure an odor free environment for our resident rooms and common areas.

### Observation/Reporting

All Staff are to report odors to their immediate supervisor, environmental supervisor, or housekeeping supervisor. Immediate supervisors responsible for communicating issue with housekeeping supervisor. If no supervisor is available, staff will communicate through the maintenance request form.

#### **Odor Present**

Housekeeping will identify the area, clean the immediate area and have maintenance look at all mechanical areas that may be of concern. Environmental services will communicate with nursing to investigate the origin of the odor for future preventative measures.

If an odor was present, housekeeping will monitor the area daily for 2 weeks. If the odor returns or continues to be present, housekeeping will monitor until the issue is resolved.

### Garbage Cans and Medical Waste

Nursing Department and Housekeeping will ensure all garbage and medical waste will be removed promptly and appropriately.

#### Linen/Curtains/Dividers

Housekeeping will clean the linen/curtains/dividers on a biannual basis or as needed or requested by staff and or family members.

If odor is not identified or eliminated the Maintenance Supervisor will develop a plan of action to correct the issue.

Room Oak - 11

	November	December	January	February	March	April
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
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16						
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28					-	
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31						
J- [						

## **Room Move Procedure**

In the event that a resident will be transferring rooms within the facility the following procedure should be implemented. Prior to the implementation of this procedure, the ID Team will have determined that a room move is appropriate, a resident, family member, and/or responsible party will have requested a room move.

- 1. Social services will initiate the process by informing Licensed Nursing Staff of the resident and the room number the resident is going to move too; at this time Social Services will provide the schedule for the room move.
- 2. The schedule for the move will include the date, time frame for the move and departmental/staff responsibilities before, during and after the move. If a room move is scheduled to occur during non-business hours, Licensed Nursing staff will complete a Change of Status Form and make a new Census Line On Pointe Click Care.
- 3. Generally, the following departments will be involved as follows:
  - a. Social services will:
    - I. Inform the resident, his/her family and/or responsible party of the date/time and reason for the move verbally and/or with the Room Change Dispute Form.
    - II. Will inform the roommate, his/her family, and/or responsible party that the resident will have a new roommate.
    - III. Document the process including the outcome of the move after speaking with residents, his/her family, and/or responsible party involved.
    - IV. Notifications to the resident, his/her family, and/or responsible party about room change or roommate change will be documented; by the Social Worker or person assigned by Social Worker or Director of Nurses
  - b. Nursing staff will move all resident personal belongings such as clothes from closet and personal items from bathroom, name tag, and other personal belongings.
  - c. Maintenance staff is to move all furniture and install as appropriate, telephone, cable service and other items such as shelving, large pictures, etc. Please schedule in advance if possible to allow proper planning of schedules.
  - d. Housekeeping staff is to clean the old room once the resident and his/her belongings are moved.
  - e. Medical records will make all appropriate changes, notifications, and other pertinent documentation as necessary.

## Addendum:

1.) A resident, family member, and/or responsible party can request a room move at any time. If a room is available that will safely meet the resident's needs the Room Move Procedure will be implemented.

Room Change Dispute

This dispute form is used if the resident, family member, and/or responsible party are not in agreement with the room move.

On, we pl	lan to transfer you/your loved one to room
from room	·
The reason for this room transfer	·is:
Your concerns or disagreement r	egarding this room transfer, please contact
Minnesota Department of Health Office of Facility Complaints 393 N. Dunlap P.O. Box 64970 St. Paul, MN 55164-0900 1-800-369-7994	Office of Ombudsman for Long-term Care P.O. Box 64971 St. Paul, MN 55164-0971 1-800-657-3591
Oak Terra 6 Gay	ocial Services ce Health Care Center 640 3 <sup>rd</sup> Street flord, MN 55334 607-237-8704
Notice Received By:	
Resident	Date
Facility Representative	Date
Responsible Party	 Date

Printed: 10/20/2014 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED B. WING 245473 10/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 THIRD STREET** OAK TERRACE HEALTH CARE CENTER GAYLORD, MN 55334 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 14, 2014. At the time of this survey, Building 01 of Oak Terrace Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Building 01 of Oak Terrace Health Care Center was constructed in 1974, is one-story in height. has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.

The facility has a 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 has a capacity of 48 beds and had a census of 38 at time of the survey.

> TITLE (X6) DATE

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

Printed: 10/20/2014 **FORM APPROVED** OMB NO. 0938-0391

10/14/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - 2008 ADDITION COMPLETED 245473 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER OAK TERRACE HEALTH CARE CENTER 640 THIRD STREET GAYLORD, MN 55334 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID

(X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 14, 2014. At the time of this survey. Building 02 of Oak Terrace Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Oak Terrace Health Care Center was constructed in 2008, is one-story in height. has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a 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 has a capacity of 48 beds and had a census of 38 at time of the survey.

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0716

October 27, 2014

Ms. Deborah Barnes, Administrator Oak Terrace Health Care Center 640 Third Street Gaylord, Minnesota 55334

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5473025

Dear Ms. Barnes:

The above facility was surveyed on October 13, 2014 through October 16, 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

Oak Terrace Health Care Center October 27, 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 Jessica Sellner at Minnesota Department of Health, 3333 W Division #212, St Cloud MN, 56301. 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,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SI COMPLE	
		00619	B. WING		10/1	6/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD 640 THIRD	RESS, CITY, STA	TE, ZIP CODE		
OAK TERI	RACE HEALTH CARE CE	ENTER GAYLORD,				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart.  Determination of whe corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessmit	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	surveyors of this Dep above provider and the orders are issued. W completed, please sig these orders and retu	n, 15th and 16th, 2014, artment's staff, visited the ne following correction hen corrections are n and date, make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw. Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health

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

TITLE (X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00619	B. WING		10/16/2014
					10/10/2014
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
OAK TERI	RACE HEALTH CARE CE	NTER	D STREET D, MN 55334		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Continued From page	: 1	2 000		
	Compliance Monitorin Certification Program, Suite 212, St Cloud, M	, 3333 West Division St,		The assigned tag number appears in a far left column entitled "ID Prefix Tag. The state statute/rule out of compliance listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state state after the statement, "This Rule is not reas evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Corr	" ce is e "To er. stee met ors stion. G OF
2 800	MN Rule 4658.0510 Staffing requirements	Subp. 1 Nursing Personnel;	2 800		
	home must have on d number of qualified in registered nurses, lice nursing assistants to residents at all nurses in all buildings if more	es relief duty, weekends,			

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00619	B. WING		10/16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
OAK TER	RACE HEALTH CARE CE	NTER 640 THIRD	STREET , MN 55334		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 800	by: Based on observation review, the facility fail sufficient nursing staff a timely manner for 1. R11, R17, R53, R72, R3), and 4 of 5 family FM-E, FM-G), who contimely assistance with (ADL's).  Findings include:  R59's diagnoses on the standard 9/29/14, included over stenosis. R59's 14 day dated 9/29/14, identific cognitive impairment assistance of one state to illet use, and person the standard person to the	t is not met as evidenced  a, interview, and document ed to consistently provide f to meet resident's needs in 2 of 39 residents (R59, R25, R20, R76, R54, R44, R26, members (FM-C, FM-D, implained of not receiving a activities of daily living  The Admission Record dated factive bladder and spinal by Minimum Data Set (MDS) fed R59 had moderate for transferring, dressing, al hygiene.  The Admission Record dated for transferring, dressing, al hygiene.  The Admission Record dated for transferring, dressing, al hygiene.  The Admission Record delated for help to go to the fines he has, "Accidents for help to go to the fines he has, "Accidents for help.  The Admission Record dated for the Admission Record dated for Admiss	2 800		

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00619	B. WING		10	/16/2014
	ROVIDER OR SUPPLIER	ENTER 640 THIRE	DRESS, CITY, STA D STREET D, MN 55334	TE, ZIP CODE		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	During interview on 1 stated she did not fee staff available becaus go to bed at night, an she could not lay down buring an interview of stated the facility was with their call log syst provide some call light some residents for 9/complete log for the vable to provide any of response times.  A review of R25's incorpartial month of 9/14, the following:  On 9/1/14, at 6:43 p.r. 29:00 minutes.  On 9/10/14, at 6:58 p for 29:58 minutes.  On 9/13/14, at 6:07 a for 37:55 minutes.  On 9/27/14, at 6:17 a for 33:29 minutes.  R11's diagnoses on the 3/10/05, included pair limbs, stress inconting osteoarthritis. R11's a identified R11 had no required extensive as transferring, dressing	ff with dressing and d supervision with toilet use.  0/14/14, at 8:45 a.m. R25 at the facility had enough se she often had to wait to d was frustrated because /n when she wanted.  n 10/16/14, at 1:26 p.m. M-B at having technical difficulties em, and was only able to not log response times for 14, which was not a whole month, and was not a whole month, and was not from October 2014, call light complete call light logs for the provided by M-B indicated  m. R25's call light was on	2 800			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		00619	B. WING		10/16/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		640 THIRI	O STREET		
OAK TERI	RACE HEALTH CARE CE	NTER	D, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 800	Continued From page	e 4	2 800		
	because she had to see the bathroom, and at bathroom when she mot enough staff to as R11 stated sometime because she cant was times she has to wait on the toilet waiting for sitting on a toilet that During interview on 1 stated the facility was with their call log syst provide some call light some residents for 9/complete log for the visit bathroom to see the state of the second seed to see the second seed to second seed to see the second seed to see the second seed to see the	not have enough staff it and wait while she is in times she can't go to the needed to because there is sist her to the bathroom. It she will go in her pants it anymore. R11 stated at up to 30-45 minutes sitting or help and, "It's not easy long. It's all the time."  10/16/14, at 1:26 p.m. M-B Is having technical difficulties em, and was only able to at log response times for 14, which was not a whole month, and was not If October, 2014 call log			
		omplete call light logs for the provided by M-B indicated			
	59:32 minutes. On 9/6/14, at 7:24 a.r 35:26 minutes. On 9/8/14, at 5:24 p.r 40:09 minutes. On 9/11/14, at 5:43 a for 48:05 minutes. On 9/12/14, at 6:22 a for 34:43 minutes.	m. R11's call light was on for m. R11's call light was on for m. R11's call light was on for .m. R11's call light was on .m. R11's call light was on			
	for 37:06 minutes. On 9/27/14, at 6:10 p for 30:09 minutes.	.m. R11's call light was on .m. R11's call light was on .m. R11's call light was on			

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00619	B. WING		10/16/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	ENTER GAYLORG	) STREET ), MN 55334			
040.45	CHMMADV CT		1	DDOV/DEDIS DI ANI OF CODDECTIO	N are	-
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	i.
2 800	Continued From page	e 5	2 800			
	On 9/29/14, at 7:36 a for 33:43 minutes.	.m. R11's call light was on				
	9/19/14, included gen and hip fracture. R17' 9/30/14, identified R1 impairment and requi	he Admission Record dated leralized pain, history of fall, is admission MDS dated 7 had no cognitive red extensive assistance of , dressing, and toileting.				
	stated there wasn't er resident's needs. R17	0/13/14, at 7:16 p.m. R17 nough staff to meet the stated, "The girls have too care of; It can take an hour o."				
	During interview on 1 maintence (M)-B state any call light logs for difficulties.	ed he was unable to provide				
	3/18/14, included chrohistory of fall. R53's of 8/12/14, identified R5	3 had no cognitive red extensive assistance for				
	stated she had to wai call light for up to a ha stated, "At night, I had was embarrassed [s it, and it was okay!	0/13/14, at 4:24 p.m. R53 t for someone to answer her alf hour in the past. R53 d to wait and I wet myself. I staff] said don't worry about am on those fluid pillsI put could not get here in time."				
	was laying in bed and Nursing assistant (NA	n 10/15/14, at 8:03 a.m. R53 I had her call light on. N)-E entered R53's room, ts call light, and told the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE	SURVEY	
			A. BUILDING: _			
		00619	B. WING	<del></del>	10	16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	ENTER	D STREET D, MN 55334			
0/A) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CO	ADDECTION .	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From page	e 6	2 800			
	resident someone wo At 8:46 a.m., 43 minu R53's call light and to to assist her with care room to assist the res	ould be in soon to help her. Ites after NA-E turned off Itel her someone would be in Les, NA-F entered R53's Sident.				
	During interview on 1 maintence (M)-B state any call light logs for difficulties.	ed he was unable to provide				
	9/17/14, included chroacute kidney failure. 9/30/14, identified R7	ed extensive assistance for				
	stated, "Sunday was up for work and they had all of the people until 8:30. I thought I breakfast." R72 state	0/14/14, at 8:39 a.m. R72 awful. Two [staff] didn't show weren't replaced. She [staff] to get up I didn't get up was going to miss d in the past he has had to com for up to half an hour.				
	p.m. R72 and family r didn't drink water who the facility because h bathroom and didn't v his pants. FM-D state uncomfortable waiting bathroom and stated,	erview on 10/14/14, at 2:15 member (FM)-D, stated R72 en he was first admitted to e had to wait to use the want to go to the bathroom in ed R72 gets very g for staff to help him to the "There's nothing worse the bathroom and not being				
	stated the facility was	n 10/16/14, at 1:26 p.m. M-B s having technical difficulties tem, and was only able to				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			D. WING			
		00619	B. WING		10	16/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	NTER	D STREET D, MN 55334			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
2 800	Continued From page	e 7	2 800			
	some residents for 9/complete log for the v	nt log response times for 14, which was not a whole month, and was not f October, 2014 call log				
		omplete call light logs for the provided by M-B indicated				
	for 36:12 minutes.	.m. R72's call light was on				
	3/5/12, included neur generalized pain. R20 9/16/14, identified R2	0's quarterly MDS dated 0 had no cognitive red extensive assistance				
	stated he has had to minutes to get help to staffing was worse or change, and he had o staffing to registered practical nurse (LPN) discussed it several to conferences with the and social worker (SV)	director of nursing (DON)  W)-A. R20 stated, "There's omplaints at all." R20 stated have enough staff to				
	family member, FM-E	0/15/14, at 2:32 p.m. R20's i, stated R20 had talked ong call light times at care imes. FM-E stated,				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	, , ,	SURVEY PLETED
			A. DOILDING			
		00619	B. WING			/16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE C	ENTER	D STREET D, MN 55334			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From page	e 8	2 800			
	[R20] waits in his own We bring it up at ever we brought it up agai [administrator] were a check into it No res  R20's care conference had talked about connot having his needs  During interview on 1 stated the facility was with their call log syst provide some call light some residents for 9/c complete log for the versidents.	te notes did not address R20 cerns of lack of staffing and met.  0/16/14, at 1:26 p.m. M-B a having technical difficulties tem, and was only able to not log response times for				
		omplete call light logs for the provided by M-B indicated				
	for 36:31 minutes. On 9/30/14, at 8:06 a for 32:45 minutes.	.m. R20's call light was on .m. R20's call light was on .m. R20's call light was on				
	stated R20 had comp for along time to have NA-D stated she had	0/14/14, at 1:56 p.m. NA-D blained about having to wait e his call light answered. talked to RN-A and LPN-B ht response times, but there in staffing.				
		he Admission Record dated nary tract infection and				

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00619	B. WING		10/16/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10/10/2014
OAK TER	RACE HEALTH CARE CE	NTER 640 THIRD	STREET , MN 55334		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 800	R76 had no cognitive extensive assistance hygiene, and toileting During interview on 1 stated there was not eneeds of the residents residents are in the diall talk about having tresidents and talk about having tresidents and call light logs for difficulties.  R54's diagnoses on tresident impairment and required with transfers, dressing During interview on 1 stated when he turns half hour before the stated and it takes too long free the stated and it takes too long free free had to urinate "When I have to go, I half hour. I get frustrate During interview on 1 maintence (M)-B stated any call light logs for difficulties.	inpairment and required with transfers, dressing,  0/13/14, at 6:42 p.m. R76 enough staff to meet the s. R76 stated when the ining room, they [residents] o wait for a long time for s and are frustrated.  0/16/14, at 1:26 p.m. ed he was unable to provide R76 due to technical  the Admission Record dated /myalgia rheumatica and mission MDS dated 9/24/14, thad moderate cognitive red extensive assistance ng, and toilet use.  0/13/14, at 4:27 p.m. R54 his call light on, it can take a taff come to his room to d he has bladder issues, for staff to come assist him, e in his pants. R54 stated, have to go. I can't wait a ted."  0/16/14, at 1:26 p.m. ed he was unable to provide	2 800		
		entia and generalized			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00619	B. WING		10/16/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10/10/2011
OAK TER	RACE HEALTH CARE CE	NTER 640 THIRD	STREET , MN 55334		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 800	9/2/14, identified R44 impairment and requi with transfers, dressir During interview on 1 family member, FM-G facility recently during all over the facility and staff to assist R44 with During interview on 1 maintence (M)-B state any call light logs for difficulties.  R26's diagnoses on the 3/20/13, included uring generalized pain. R26 10/1/14, identified the impairment and requi with transferring and the usually only one aide hallwaysThey are a don't wash me up as stated at meal times the assist her to the dining herself down the hallwated is difficult becamber fingers. R26 states with short staffing, and DON, but stated the Eabout it and stated, "I	44's quarterly MDS dated had severe cognitive red extensive assistance rig, and toilet use.  0/13/14, at 7:17 p.m. R44's red, stated while visiting the red evening, FM-G looked divided was unable to locate any red he was unable to provide R44 due to technical  The Admission Record dated resident had no cognitive red extensive assistance red ext	2 800		
	R26's call light cord d	id not reach the chair in the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		00619	B. WING		10/1	6/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAK TERI	RACE HEALTH CARE CE	ENTER 640 THIRD				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	, MN 55334	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
2 800	Continued From page	e 11	2 800			
	stated when R26 sat call light cord was too given R26 a bell to us NA-D stated during a was working alone be and wasn't replaced. no one covered the u NA-D stated R26 neet the bell like crazy, but NA-D stated R26 was incident.  During another intervipp.m. R26 stated she work cord wasn't long enougher sat in her room bell when she rings it "all" of the staff, and toold them call light did staff didn't always heat had done nothing. R2 complained about she SW-A, but stated staff better.	ort staffing to the DON and fing has not gotten any 0/16/14, at 1:26 p.m. ed he was unable to provide				
	stated R26 had comp to have her call light a needs met. NA-D sta LPN-B about R26 cor her needs met due to	0/14/14, at 1:56 p.m. NA-D plained about long wait times answered and not having her ated she had told RN-A and amplaining about not having short staffing, however, of staffing to meet resident ed.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		10/16/2014
	ROVIDER OR SUPPLIER	NTER 640 THIRD	RESS, CITY, STA	TE, ZIP CODE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	Continued From page	: 12	2 800		
	2/20/14, included rheenlarged prostate. R3 8/14/14, identified R3 impairment and requitransfers and toilet us.  During observation or was in his recliner in land shaking and state bathroom. R3's son whe had gone to the desome help for his Dacover the hallways trying and state bathroom.	l's annual MDS dated had moderate cognitive red extensive assistance for			
	was asked how his dadown, closed his eyes stated, "Just had an a over looking for some was just shaking; It had been waiting, "a loome and assist him couldn't wait any long of stool. R3 continue head, and stated, "It's During interview on 1 NA-D stated R3 was that morning and stat before. He always may was embarrassed! I stated a man had told bathroom and the cal	0/15/2014, at 12:14 p.m. incontinent of stool earlier ed R3 had, "Never done that akes it on time!'m sure he had to clean him up." NA-D I her R3 needed to go to the I light was on also, however, w long the resident had been			

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Minnesot	a Department of Healtl	<u>h</u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00619	B. WING		10/16/2014
NAME OF D	ROVIDER OR SUPPLIER	etdeet /	ADDRESS, CITY, STA	TE ZIR CODE	
NAIVIE OF FI	ROVIDER OR SUFFLIER			ile, zir Gode	
OAK TER	RACE HEALTH CARE CE	ENTER	RD STREET		
			RD, MN 55334		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	l l
				DEFICIENCY)	
2 800	Continued From page	e 13	2 800		
	During interview on 1	0/15/14, at 1:14 pm R3's			
		-C, stated, "This isn't the first			
		button and it takes a long			
	time to get help." FM	I-C stated this morning he			
	walked all over lookin	ng for someone to help R3			
		d when he couldn't find			
	•	e front desk and told them			
		he bathroom bad." FM-C			
	_	waiting about 20 minutes			
		Stated, R3, "Was just			
		so much pain from trying to			
	_	ing worse over the past few ring Depends [a product			
		e]. They tell him to just go in			
		n't hold it." FM-C stated he			
		ff that R3's "odor" had gotten			
		weeks and stated he notices			
	•	ou walk in the room. FM-C			
	stated this incontinen	t episode was not the first			
	time, and it happened	d quite a bit when R3 has to			
	wait for assistance fo	r long periods of time.			
	During interview on 1	0/15/14, at 3:00 p.m. DON			
		ed a complaint from R3's			
	-	R3 had to wait a long time to			
		athroom. DON stated she			
		the call light log to verify			
		ht was on because the			
		Technical difficulties with their she listened to R3's family			
	_	extended an apology, and			
	told him she would ch				
	tota filifi offic would cr	ion into it.			
	During interview on 1	0/16/14, at 1:26 p.m. M-B			
		s having technical difficulties			
	1	tem, and was only able to			
		nt log response times for			
	some residents for 9/	- ·			
		whole month, and was not			
	able to provide any of	f October, 2014 call log			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		00619	B. WING		10/16/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	
OAK TER	OAK TERRACE HEALTH CARE CENTER 640 THI				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ORD, MN 55334	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
2 800	Continued From page	e 14	2 800		
	response time.				
		mplete call light logs for the provided by M-B indicated			
	36:51 minutes. On 9/4/14, at 6:39 a.r 38:24 minutes. On 9/8/14, at 5:31 a.r 36:10 minutes.	m. R3's call light was on for m. R3's call light was on for m. R3's call light was on for .m. R3's call light was on for			
	NA-E stated the morn all of the residents ca	n 10/15/2014, at 9:31 a.m. nings can be difficult to get ares done and stated there are not able to get all the cfast by 9:00 a.m.			
	stated most days are able to get all of the re NA-G stated some da what resident cares n resident's exercises of room. NA-G stated s	0/15/14, at 12:49 p.m. NA-G busy and she isn't always esident cares completed. ays she needed to decide not to complete, such as a per straightening up their he had brought up concerns an agement in the past, but not improved.			
	stated she did not ren or staff coming to her	0/15/14, at 2:11 p.m. SW-A nember any residents and/ about short staffing, refer those complaints to the			
	stated she completed	0/15/14, at 2:51 p.m. DON I call light response time rality Assurance. DON stated			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
, and i Law C		SERTIFICATION NUMBER.	A. BUILDING: _		JOWN LI	
		00619	B. WING		10/1	6/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	ENTER 640 THIRE GAYLORD	) STREET ), MN 55334			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 800	1/1/14 through 3/1/14 due to the size of the audit for 7/14, showin call light response time available. DON stated the call light logs due DON stated attempts someone calls in, how be replaced and they DON stated residents about long call light time provided timely. DON the residents and listed A staffing policy was reprovided.  SUGGESTED METHE Facility administration could utilize employed to evaluate staffing paparages where those side adjusted and imples order to meet all residents. Facility policies/ practices. A developed to observe care, meeting all resident care plan. The facility and develop/actions for any pattern determinations for one	response time was 5 ed a call light audit from , which was not readable print. DON provided another g random rooms listed with les. No other audits were d she was unable to pull up to, "Technical difficulties." are made to replace staff if evever, sometimes they cant need to work short staffed. Is had complained to her mes and not getting cares In stated she apologizes to ens to their complaints.  Tequested, but was not  OD OF CORRECTION: In and the director of nursing te, resident and family input tatterns and identify times/ taffing patterns could/should thement those adjustments in then needs in a timely ties and procedures for and be reviewed/ revised. It could be retrained on those udit tools could be the for timely and complete dent needs as identified in facility's Quality Assessment the could review those implement corrective the or root/cause regoing compliance.	2 800	DEFICIENCY)		
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				

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Willinesota Department of Freatti			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	I COMP	COMPLETED	
00619 B. WING	10/	16/2014	
00019	I 10/	16/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
640 THIRD STREET			
OAK TERRACE HEALTH CARE CENTER  GAYLORD, MN 55334			
	ODDECTION	0/5)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIC		(X5) COMPLETE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		DATE	
DEFICIENCY	<b>'</b> )		
04400			
21426 MN St. Statute 144A.04 Subd. 4 Tuberculosis 21426			
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.			
regarding impromentation of the galdelines.			
(b) Written compliance with this subdivision must			
be maintained by the nursing home.			
be maintained by the harsing nome.			
This MALD assistance to get seek as a wideward			
This MN Requirement is not met as evidenced			
by:			
Based on interview and document review, the			
facility failed to complete required tuberculosis			
(TB) symptom screenings, for 5 of 5 residents			
(R24, R28, R39, R51, and R54) whose records			
were reviewed. In addition, the facility failed to			
ensure all employees were free from active TB			
prior to employment, for 1 of 5 employees,			
nursing assistant, (NA)-A whose personnel record			
was reviewed.			
Findings include:			
R24 was admitted to the facility on 7/16/14.			
R24's record lacked evidence of a completed TB			
symptom screen.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		00619	B. WING		10/16/	2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	NTER	D STREET D, MN 55334			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
21426	Continued From page	e 17	21426			
	R28 was admitted to record lacked evidence symptom screen.	the facility on 3/3/12. R28's ce of a completed TB				
	R39 was admitted to record lacked evidence symptom screen.	the facility on 4/26/14. R39's ce of a completed TB				
	R51 was admitted to the facility on 5/29/14. R51's record lacked evidence of a completed TB symptom screen.					
	R54 was admitted to record lacked evidence symptom screen.	the facility on 9/11/14. R54's ce of a completed TB				
	completed TB sympto	0/14/14, at 3:55 p.m. ON) stated the facility only om screens for employees, s were not completed for				
	· ·	e facility on 7/2/14. NA-A's sed evidence of both the two TB symptom screen.				
	resources (HR) stated employees was initiat stated the DON would completed forms perio anyone's responsibility	ted on orientation. HR d check through the odically, but it wasn't ty to monitor them. HR ord lacked evidence of TB				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00619	B. WING		10/16/2014
	ROVIDER OR SUPPLIER	640 THIR	DRESS, CITY, STA	TE, ZIP CODE	
OAK TER	RACE HEALTH CARE CE	NTER	D, MN 55334		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21426	completed. The DON to ensure each employed the required data and not have the two step screen.  The facility policy TB indicated all employed documentation of a nebefore providing direct and Control Program direction related to conscreening of newly accepted to the screening of newly accepted to the screening of the step to a tuberculosis monitoring designee could devel ensure all residents at TB symptom screening. The quality as committee could estatuberculosis testing to	stated HR had a checklist byee's record contained all wasn't sure why NA-A did TB test or the TB symptom  Testing for Staff, undated, es must provide egative reaction to a TB test of care to clients.  Iosis Screening, Prevention, dated 6/8/14, lacked empleting symptom dmitted residents.  OD OF CORRECTION:  g or designee could provide address the importance of eng. The director of nursing or op an auditing system to and employees receive their eng and tuberculin skin asurance and assessment blish a system to audit	21426		
21695		ation, & Maintenance uning. A nursing home must	21695		
	necessary to maintair comfortable interior, in	g and maintenance services n a clean, orderly, and ncluding walls, floors, tures, equipment, lighting,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		10/16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
OAK TER	RACE HEALTH CARE CE	ENTER 640 THIRD	STREET , MN 55334		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
21695	Continued From page	e 19	21695		
	and furnishings.				
	by: Based on observation review, the facility fail and maintenance sen an odor free and sani provided for 1 of 2 resenvironmental concernings include:  R20's quarterly Minim 9/14/14, identified R2 impairment, had an in	num Data Set (MDS) dated 0 had no cognitive ndwelling Foley catheter, and sist from staff for toileting			
	R20's room had an or R20 was interviewed room smelled like uring roommate up until a control the roommate also has stated his past roomn into urinals and leave for staff to collect. R2 about the strong sme times, however, the urroom.	n 10/13/14, at 5:31 p.m., verwhelming smell of urine. at that time and stated his ne. R20 stated he had a couple of weeks ago, and ad a Foley catheter. R20 nate would empty his urine the urinals all over the room 20 stated he had complained II of urine to staff many rine smell was still in his			
	During observation on 10/14/14, at 1:45 p.m., R20's room had a strong smell of urine. R20 was not in his room at this time.				
		0/15/14, at 9:04 a.m. stated R20's room had a and it was like a, "Haze in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	CONSTRUCTION		SURVEY PLETED		
				A. BUILDING:			
		00619		B. WING		10	/16/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAK TER	RACE HEALTH CARE CE	ENTER	640 THIRD GAYLORD,				
0(0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	GAI LOND,		PROVIDER'S PLAN OF	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE ACTOR CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From page	e 20		21695			
	all the furniture and w daily, but the urine sn	d housekeeping wiped ovashed the floors in the nell did not go away. He odor was, "In the curl	room -A				
	During interview on 10/15/14, at 9:30 a.m. nursing assistant (NA)-C stated she had noted R20's room had a strong urine odor, and asked another NA to get some odor spray to spray in the room for the urine smell.		ed				
	p.m. H-B and mainter strong urine odor in Find they had been aware room, but thought the better when the room weeks ago. H-B was curtains had last been curtains were not on suggested the facility the heating/cooling unformer roommate's burine odor, and H-B sprior roommate could well if needed to try to M-A and H-B stated in been completed to try in R20's room.	I tour on 10/15/14, at 12 nance (M)-A confirmed (R20's room. They both so of the urine smell in the urine odor had gotten mate moved out a few unsure of when the principal cleaned and stated the acleaning schedule. Moreould have tried cleaning it which was next to the detailed the mattress of the lawe been swapped out of get rid of the urine odd none of these things had you contained to get rid of the urine of the uri	the tated  vacy eA ng e h the e ut as or.				
		enance log revealed no ninating services in R20					
	A policy was requeste	ed but not provided.					
		OD OF CORRECTION: nce/ environmental serv					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		10/1	6/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
OAK TERRACE HEALTH CARE CENTER			STREET , MN 55334			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21695	Continued From page	21	21695			
21805	odor in the resident's cleaning/ maintenance as needed to remove and procedures could re-education on these pertinent employees. maintenance personnt tools to evaluate this for homelike qualities could be reviewed by Assessment & Assura and oversight for on-or-	e/ replacement processes the odor. Facility policies I be reviewed/ revised, with e policies provided to Facility administration and nel could develop auditing and other resident's rooms . Results from those audits the facility's Quality ance committee for input going compliance efforts.  CORRECTION: Twenty-one	21805			
	residents have the rig courtesy and respect employees of or personal health care facility.  This MN Requirement by: Based on observation review, the facility fail and services with tolk resident (R3), observer Findings include:  R3's annual Minimum	treatment. Patients and alth to be treated with for their individuality by ons providing service in a service in a service in a service.  It is not met as evidenced and interview, and document ed to provide dignified care eting assistance for 1 of 1 ed for toileting assistance.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.		
		00619	B. WING		10/16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
OAK TER	RACE HEALTH CARE CE	ENTER 640 THIRE			
			), MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21805	Continued From page	e 22	21805		
	assistance for transfe	ers and toilet use.			
	R3's bowel and bladd 10/8/14, indicated, "[F bladder. [R3] is alert at the need to void, so is need for assistance F assessment identified transfers and was at to decreased mobility dexterity, and daily us Staff were to assist R per the residents requestional R3's care plan dated impaired incontinence assistance with all tratoileting plan was identified buring observation or was sitting in the recition of the r	der assessment dated R3] is continent of bowel and and oriented and is aware of a able to alert staff to the PRN [as needed]." The d R3 required 1:1 assist with risk for incontinence related d, decreased manual se of diuretic medication. 3 with toileting as needed dest.  8/14/14, identified R3 had be related to requiring ansfers, and the residents antified as, "Per his request."  10/15/14, at 9:28 a.m. R3 aner in his room and was			
	grimacing and shaking. R3 stated he needed to go to the bathroom. R3's son was in the hallway and stated that he had gone to the desk 10 minutes ago to get some help from staff to assist R3 to the bathroom, and he was looking all over the hallways trying to find someone. About a minute later, nursing assistant (NA)-D came				
	down the hall and not and went in to R3's ro	ciced R3's call light was on com.			
	asked how he was do closed his eyes, shoo had an accident." My for someone. I had to shaking. It hurt so mu waiting a long time fo	e hallway. When R3 was bing, R3 looked down, ok his head, and stated, "Just son walked all over looking			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	1 ' '	
			A. BUILDING.				
		00619	B. WING		10/16/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
OAK TER	RACE HEALTH CARE CE	ENTER GAYLORD	) STREET ), MN 55334				
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION (X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET	ΓE	
21805	Continued From page 23		21805				
	any longer, resulting in incontinence of stool. R3 continued to look down and shake his head and stated, "It's [being incontinent of stool] embarrassing."						
	NA-D stated R3 had I that morning and stat before. He always mawas embarrassedI stated a man had told bathroom and R3's ca	0/15/2014, at 12:14 p.m. been incontinent of stool ed R3 had, "Never done that akes it on time!'m sure he had to clean him up." NA-D I her R3 needed to go to the all light had been on, not sure how long the call					
	R3 was continent with documented bowel m	ovements between 10/1/14, /15/14, an incontinent bowel					
	family member (FM)-the facility before whe for assistance to go to a long time to get help he walked all over loc R3 use the bathroom anyone, he went to the R3 needed to use the stated, "[R3] was just much pain from trying Depends [a product u [staff] tell him to just ghold it." FM-C stated about 20 minutes for morning. FM-C state "Odor" had gotten bar and noticed it as soon	O/15/14, at 1:14 pm R3's C stated they had been in en R3 turned his call light on the bathroom and it takes p. FM-C stated this morning oking for someone to help . When he couldn't find the front desk and told them to bathroom, "Bad." FM-C shaking[R3] was in so to hold it" [R3] is wearing tised for incontinence]. They go in his Depends if he can't the thought R3 had waited the had told staff R3's, d over last couple weeks that is not the first time R3					

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)  21805 Continued From page 24  had an incontinent stool, and it happens when he				_			
OAK TERRACE HEALTH CARE CENTER  640 THIRD STREET GAYLORD, MN 55334  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21805  Continued From page 24 had an incontinent stool, and it happens when he			00619	B. WING		10/10	6/2014
OAK TERRACE HEALTH CARE CENTER  GAYLORD, MN 55334  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21805 Continued From page 24 had an incontinent stool, and it happens when he	NAME OF PROV	VIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21805  Continued From page 24  had an incontinent stool, and it happens when he	OAK TERRACE HEALTH CARE CENTER						
had an incontinent stool, and it happens when he	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	(X5) COMPLETE DATE
FM-C stated, "They just don't have enough people [staff] to go around."  During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated the facility was having technical difficulties with their call log system, and was only able to provide some call light log response times for some residents for 9/14, which was not a complete log for the whole month, and was not able to provide any of October 2014, call log response time.  A review of R3's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following:  On 9/1/14, at 5:04 p.m. R3's call light was on for 36:51 minutes. On 9/8/14, at 6:39 a.m. R3's call light was on for 38:24 minutes. On 9/8/14, at 5:31 a.m. R3's call light was on for 36:10 minutes. On 9/27/14, at 4:45 p.m. R3's call light was on for 48:10 minutes.  During interview on 10/15/14, at 3:00 p.m. director of nursing (DON) stated she had received a complaint from R3's family member who stated R3 had to wait a long time to get help to use the bathroom. DON stated she had tried to review the call light log for R3 to see how long the resident had to wait for assistance, however, she was unable to because the facility was having, "Technical difficulties," with their system. DON stated she listened to R3's family member's complaint and told him she would check into it. DON had no formal complaint for interviews with	ha ha ha ha ha ha ha ha ha ha ha ha ha h	ad an incontinent stocas to wait for long per M-C stated, "They justeople [staff] to go aro during interview on 10 maintence (M)-B stated exchnical difficulties with vas only able to provide sponse times for son which was not a complement, and was not abortober 2014, call log areview of R3's incompartial month of 9/14, pare following:  On 9/1/14, at 5:04 p.m. 6:51 minutes. On 9/4/14, at 6:39 a.m. 8:24 minutes. On 9/8/14, at 5:31 a.m. 6:10 minutes. On 9/27/14, at 4:45 p.m. 8:10 minutes.	ool, and it happens when he riods of time for assistance. st don't have enough bund."  O/16/14, at 1:26 p.m. and the facility was having ith their call log system, and de some call light log me residents for 9/14, olete log for the whole ble to provide any of response time.  Inplete call light logs for the provided by M-B indicated  In. R3's call light was on for	21805	DEFICIENCY		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00619	B. WING		10/16/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE			
OAK TER	OAK TERRACE HEALTH CARE CENTER  640 THIRD STREET  GAYLORD, MN 55334						
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON OVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLETE ENCED TO THE APPROPRIATE DATE		
21805	Continued From page 25		21805				
	times.						
	A policy for dignified or residents was reques	care and services of ted, but not provided.					
	SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and/or designees could review and/or revise policies/ procedures related to dignified care and						
	timely toileting assista	nployees could be ctations for dignified and cance. Random audits of colleting assistance could be					
	completed for all residuassistance. The facil						
		ent corrective actions for any e determinations for					
	TIME PERIOD FOR (14) days.	CORRECTION: Fourteen					

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